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HEALTH SCRUTINY
Overview & Scrutiny Committee
Agenda

Date	Tuesday 7 March 2023
Time	6.00 pm
Venue	Crompton Suite, Civic Centre, Oldham, West Street, Oldham, OL1 1NL

Notes

1. DECLARATIONS OF INTEREST- If a Member requires advice on any item involving a possible declaration of interest which could affect his/her ability to speak and/or vote he/she is advised to contact Paul Entwistle or Constitutional Services at least 24 hours in advance of the meeting.

2. CONTACT OFFICER for this agenda is Tel.01617705151 or email constitutional.services@oldham.gov.uk

3. PUBLIC QUESTIONS - Any Member of the public wishing to ask a question at the above meeting can do so only if a written copy of the question is submitted to the contact officer by 12 noon on Thursday, 2 March 2023.

4. FILMING - The Council, members of the public and the press may record / film / photograph or broadcast this meeting when the public and the press are not lawfully excluded. Any member of the public who attends a meeting and objects to being filmed should advise the Constitutional Services Officer who will instruct that they are not included in the filming.

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https://www.oldham.gov.uk/homepage/1449/attending_council_meetings

MEMBERSHIP OF THE HEALTH SCRUTINY
Councillors Ball, Harrison, S Hussain (Chair), Ibrahim, Marland, McLaren, McManus and Nasheen

Item No

1 Apologies for Absence

2 Declarations of Interest

To Receive Declarations of Interest in any Contract or matter to be discussed at the meeting.

3 Urgent Business

Urgent business, if any, introduced by the Chair.

4 Public Question Time

To receive Questions from the Public, in accordance with the Council's Constitution.

5 Minutes (Pages 1 - 6)

The Minutes of the meeting of the Health Scrutiny Committee held on 17th January 2023 are attached for approval.

6 Northern Care Alliance - Care Quality Commission (Pages 7 - 292)

7 Drugs and Alcohol Service (Pages 293 - 300)

8 Emergency Paediatrics

Report to follow.

9 Health Scrutiny Committee Work Programme 2022/23 (Pages 301 - 304)

10 Key Decisions Document (Pages 305 - 312)

Key Decisions scheduled to be taken by the Council/Cabinet.

HEALTH SCRUTINY
17/01/2023 at 6.00 pm

Present: Councillor S Hussain (Chair)
Councillors Ball, Harrison, Ibrahim, McLaren, McManus and Nasheen

Also in Attendance:

Katrina Stephens	Director of Public Health
Mike Barker	Strategic Director of Commissioning/Chief Operating Officer
Emma Zurowski	HCRG Group
Andrea Entwistle	Senior Business and Commissioning Manager Public Health Oldham
Steve Giles	General Manager HCRG Care Group
Sarah Lunt	Business Unit Head HCRG Care Group
Raz Mohammed	Divisional Operations Lead (Weight Management and Wellbeing Services) and Head of Communities, ABL Health
Hayley Bibby	Head of Service (Weight Management and Wellbeing Services) ABL Health
Paul Rogers	Constitutional Services

1 **APOLOGIES FOR ABSENCE**

Apologies for absence were received from Councillor Marland.

2 **DECLARATIONS OF INTEREST**

There were no declarations of interest received.

3 **URGENT BUSINESS**

There were no items of urgent business received.

4 **PUBLIC QUESTION TIME**

There were no public questions for this meeting of the Committee to consider.

5 **MINUTES**

RESOLVED that the minutes of the meeting held on 6 December 2022 be approved as a correct record.

6 **DISAGGREGATION OF CLINICAL SERVICES FROM THE PREVIOUS PENNINE ACUTE HOSPITALS TRUST FOOTPRINT**

The Committee scrutinised a report of the Place Lead which updated the Overview and Scrutiny Committee for Health on the progress to disaggregate clinical services from the previous Pennine Acute Hospital Trust (PAHT) footprint and establish

clinical pathways between the Northern Care Alliance (NCA) and Manchester University Foundation Trust (MFT).

In 2021, MFT acquired the North Manchester General Hospital (NMGH) site, and Salford Royal Foundation Trust (SRFT) acquired the remaining sites of PAHT, creating the NCA. Since then, due to the way in which digital systems and clinical rotas operate, there are some services which operate across the two providers which have not yet been 'disaggregated'. This means that the services still need to be split between the two organisations using an agreed set of principles: including splitting of the workforce, budget and waiting lists.

The report provides an update about the work to date to split key services between the providers, and in particular to highlight those areas where this could potentially mean a change to the location where patients access services. It describes the process and criteria used to determine the best solution that ensures services previously part of PAHT continue to be safely delivered by the NCA and MFT respectively. Fundamentally, this process aims to deliver better care for patients through establishing services that are safe and sustainable, but also that use the best evidence available and operate as close to the patient as possible.

In the coming months, there are some key services that will go through this process of disaggregation including Cardiology, Gastroenterology, Urology and Rheumatology. Largely these changes will mean patients can choose to access services from an NCA site or from a MFT site. Initial assessment suggests there is minimal change for Oldham residents for these services.

The Committee was informed of the services that are affected, paragraph 4.1- Phase 2 of the report refers. At this stage it appears that there would be minimal changes in the way that the Oldham population access the services listed in Phase 2, and table I in paragraph 4.3 summarises the current understanding of the impact on Oldham patients.

The Place Lead informed the Committee that the report sets out the current position on Phase 2 with a finish target date to complete of March 2024. A further report will be presented to a future meeting of this Committee setting out detail on Phase 3. He advised that Phase 2 is evolving and further changes will take place between now and its completion.

A Member referred to the Joint Scrutiny Committee (JSC) which had previously been set up prior to the Pennine Acute Hospital Trust ceasing to exist and was dissolved which gave feedback to the Northern Care Alliance (NCA). The Member suggested that it would be beneficial to establish a new JSC comprising Member representatives from Bury, Rochdale, Oldham, Thameside and Stockport Councils to receive reports detailing progress on Phases 2 and 3 and would provide a vehicle for these authorities to give a combined approach and feedback to the NCA and participating authorities on progress.

The Place Lead supported the Joint Scrutiny Committee approach and was of the view that a combined coordinated response from the those Councils representatives to Phases 2 and 3 through that Committee would be advantageous to the Councils involved and the NCA.

Resolved:

1. That the report be noted and welcomed; and

2. That the officers explore the possibility of establishing a Joint Scrutiny Committee comprising representatives from Oldham, Bury, Rochdale, Thameside and Stockport Councils with a view receiving progress reports on the disaggregate clinical services from the previous Pennine Acute Hospital Trust (PAHT) footprint and establish clinical pathways between the Northern Care Alliance (NCA) and Manchester University Foundation Trust (MFT) enabling a combined approach to the NCA on Phases 2 and 3.

7 **MENTAL HEALTH IN OLDHAM - LOCALITY REFRESH**

The Committee received a presentation of the Place Lead, Oldham, NHS Greater Manchester Integrated Care, which gave a locality update on the current challenges facing Mental Health Care in Oldham and the transformation programme being put in place to address these challenges known as 'Living Well', a new model for improving mental health in Oldham neighbourhoods, to address these challenges.

The refresh centred on –

- Learning Disability and Autism (LDA)
- Dementia
- Mental Health Performance
- LDA Performance
- Dementia Performance

The Place Lead took the view that COVID has had a far more reaching affect on individuals than what the numbers on the waiting list portrays. Although the mental health PCT avenues are in place, individuals find it difficult to approach these. He informed the Committee that mental heath has been the victim of underinvestment and as a consequence there is a need to prioritise. With this in mind there would be a need to irradicate unnecessary duplication in the roles of staff and the way staff are working.

In response to a Member's question, the Place Lead agreed that the use of the voluntary sector as contact pathways for individuals needing information and help was a positive way forward. He advised that utilising the voluntary sector was not free and would require resources. He referred to the effective neighbourhood community and meeting places and what is currently available to individuals.

It was suggested that the Mental Health issue could be integrated into the suggested Joint Scrutiny Committee, minute no.6 to these minutes refers.

Resolved: That

1. a further update presentations be made to this Committee on the performance of mental health in Oldham; and

2. the officers investigate ways to establish connections within voluntary groups and organisations with a view to establishing informal network links in relation to mental care in Oldham; and

3. the Officers explore the integration of mental health into the suggested establishment of the Joint Scrutiny Committee, and

4. Mike Barker be thanked for the very informative presentation.

8 **HEALTH IMPROVEMENT AND WEIGHT MANAGEMENT SERVICE - UPDATE**

The Committee received a report of Andrea Entwistle, Senior Business and Commissioning Manager, on Health Improvement and Weight Management Service (HIWMS) which updated the Health Scrutiny Committee on the progress made by the Health Improvement and Weight Management Service, Your Health Oldham, delivered by ABL Health Limited, during the last 12 months, as requested by the committee in January 2022.

Having a high functioning health improvement offer is an essential component of the range of activity required to achieve better population health and reduce demand on health and social care services.

'Your Health Oldham', delivered by ABL Health Limited, is Oldham's Health Improvement and Weight Management Service and commenced delivery in January 2021 following a comprehensive tender process.

The Committee received a presentation from Raz Mohammed and Hayley Bibby representing ABL Health to support the report.

The Committee was informed that the following was key to their work -

- supporting residents of Oldham to live healthier and happier lives for longer.

- Giving a health and wellbeing service that combines prevention, building community capacity, and reducing health inequalities.

The presentation referred to –

- Referrals from January 2021 – 2022
- Supporting the most deprived communities
- Tackling health inequalities
- Age Well
- Trim Down Shape Up
- Health MOTs
- Events and Campaigns
- Co-production with Communities
- Challenges – Solution and Mitigation

In response to a query on the doubling of referrals since the first year, Raz Mohammed informed the Committee that they were almost at the limit on receiving more referrals.

It was suggested that help to promote and develop the service could be via District Teams, Councillors and public events.

Resolved: That

1. the Committee acknowledges the excellent progress made by the Health Improvement and Weight Management Service, Your Health Oldham delivered by ABL Health Limited and note the highlights and challenges of the last 12 months.

2. the officers set up a meeting with ABL Ltd to consider and a report on the outcome be submitted to the next Committee meeting,

3. Regular report updates for Health Improvement and Weight Management Service, Your Health Oldham be included in the Health Scrutiny Committee work programme.

9 **INTEGRATED SEXUAL HEALTH SERVICE - UPDATE**

The Committee considered a report of Andrea Entwistle, Senior Business and Commissioning Manager (Public Health, Oldham Council) which updated the Health Scrutiny Committee on the progress made the Integrated Sexual Health Service (ISHS), delivered by HCRG Care Group, during the first 9 months of the new contract, as requested by the committee in January 2022.

Oldham, Rochdale and Bury Councils (ORB) collaboratively commission the provision of a high quality Integrated Sexual Health Service (ISHS) to support better population health and meet our mandated responsibilities for open access sexual health services.

HCRG Care Group provide Oldham, Rochdale and Bury Integrated Sexual Health Service (ORBISH) and commenced

delivery of the new contract, with revised specification, on 1 April 2022.

Stephen Giles and Emma Zurbrowski made a presentation updating Members on the progress made by the service during the first year of the current contract.

It was suggested that ways to establish connections and informal links between groups and organisations to build a network be explored.

Resolved: That

1. a further report be submitted to the next Committee to update Members on progress on the service;

2. the proposed meeting between ABL and scrutiny members described above be extended to include HCRG Ltd as well as other major providers of public health commissioned services.

10 **HEALTH SCRUTINY COMMITTEE WORK PROGRAMME 2022/23**

The Committee received a report inviting consideration of the Committee's Work Programme for 2022/23 as at the 17 January 2023.

Resolved:
That the Health Scrutiny Committee's Work Programme 2022/23 be noted.

11 **KEY DECISION DOCUMENT**

The Committee considered the latest Key Decision Document which set out the Authority's Key Decisions scheduled to be made from 22 December 2022.

Resolved:
That the Key Decision Document be noted.

The meeting started at 6.00 pm and ended at 8.15 pm

Northern Care Alliance NHS Foundation Trust

Inspection report

Stott Lane
Salford
M6 8HD
Tel: 01612064100
www.northerncarealliance.nhs.uk

Date of inspection visit: 08 August 2022 to 26 September 2022
Date of publication: 22/12/2022

Ratings

Overall trust quality rating	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Requires Improvement**
Are services caring?	**Good**
Are services responsive?	**Requires Improvement**
Are services well-led?	**Requires Improvement**

Our findings

Our reports

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

Overall summary

What we found

Overall trust

Northern Care Alliance NHS Foundation Trust was formed on 1 October 2021 when Salford Royal Hospital NHS Foundation Trust legally acquired Pennine Acute Hospitals NHS Foundation Trust.

The trust operates a range of acute, community health and social care services which are provided by the trust's four care organisations; Salford, Oldham, Rochdale and Bury.

The trust has over 20,000 staff and has four acute hospitals – Salford Royal Hospital, Royal Oldham Hospital, Fairfield General Hospital and Rochdale Infirmary which provide a full range of acute services, including acute medicine, urgent and emergency care, acute frailty units, rehabilitation services, dental services and surgical services, to a population of approximately 1 million people within hospital settings and the community. The trusts had been working in partnership from 2016 until the acquisition. This included a shared executive leadership team.

When a trust acquires another trust in order to improve the quality and safety of care, we do not aggregate ratings from the previously separate trust at trust level for up to two years from date of acquisition. The ratings for the trust in this report are therefore based only on the ratings for Salford Royal Hospital and our rating of leadership at the trust level.

Our normal practice following an acquisition would be to inspect all services run by the enlarged trust. However, our usual inspection work has been curtailed by the COVID-19 pandemic.

At the Northern Care Alliance, we inspected only those services where we were aware of current risks. We did not rate the hospitals overall.

In our ratings tables starting on page 30 we show all ratings for services run by the trust, including those from earlier inspections and from those hospitals we did not inspect this time.

This was our first inspection since the formation of the Northern Care Alliance NHS Foundation Trust.

Our findings

We carried out this unannounced (staff did not know we were coming) inspection of Northern Care Alliance NHS Foundation Trust as part of our continual checks on the safety and quality of healthcare services and because it was a new provider which ran services formerly run by different trusts.

We visited Salford Royal Hospital, Royal Oldham Hospital, Fairfield General Hospital and Rochdale Infirmary as part of our inspection between 8 and 11 August and on 12 September 2022. Our inspection was unannounced to enable us to observe routine activity.

In addition, we inspected the well-led key question for the trust overall. The Well Led inspection was announced and took place between 13 and 15 September 2022.

We did not inspect all the core services provided by the trust as this was a risk-based inspection. We continue to monitor all services as part of our ongoing engagement and will re-inspect them as appropriate.

This is our first rating of the Northern Care Alliance. We rated them as requires improvement because:

We rated safe, effective, responsive and well-led as requires improvement, and caring as good. In rating the trust, we took into account the current ratings of the Salford services not inspected this time.

Leaders had the skills, abilities and experience to run the service. Most leaders understood the priorities and issues the trust faced. However, some expressed different levels of understanding of the drivers for change and the priorities articulated by their executive colleagues. Staff reported leaders were not always visible and approachable.

Staff did not always feel respected, supported and valued. However, they remained focused on the needs of patients receiving care. Some staff expressed reservations about raising concerns and others did not always feel listened to. The service had a culture where patients and their families could raise concerns without fear.

Leaders did not operate consistent, effective governance processes throughout the service. There were differences in policies and clinical practice which did not reflect best-practice guidelines. Most leaders were clear about the need to review these functions to ensure they were fit for purpose.

Leaders and teams did not consistently use systems to manage performance effectively. They identified and escalated relevant risks and issues but did not always take actions to reduce their impact. Staff did not always have the opportunity to contribute to decision-making and help avoid pressures compromising the quality of care.

The service collected data and analysed it. However, not all staff were assured that the data was always accurate. Staff could not always find the data they needed, in accessible formats to understand performance, make decisions and improvements. Data was not recorded or presented uniformly across the trust and some important data was not captured. Data or notifications were submitted to external organisations as required. The information systems were secure. However, they were not always reliable or integrated well. The trust had recently appointed an experienced executive with specific responsibility for improving the management of digital data.

Leaders did not always actively and openly engage with patients and staff to plan and manage services. However, they had plans in place to improve these. The trust engaged with external stakeholders and local partners to help improve services for patients.

However:

Our findings

The trust had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and most staff understood and knew how to apply them and monitor progress.

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research. Improvement projects were at various stages of development and completion across the trust. The trust reported and investigated complaints and incidents. However, these were not always completed in a timely manner and learning was not always shared with relevant departments across the trust.

How we carried out the inspection

During our inspection we spoke with a variety of staff including consultants, doctors, therapists, nurses, healthcare support workers, pharmacists, patient experience staff, domestic staff, administrators and the trust's board. During the inspection we also spoke with patients and relatives. We visited numerous clinical areas across the hospital sites. We reviewed patient records, national data and other information provided by the trust.

We held several staff focus groups with representatives from all over the trust to enable staff who were not on duty during the inspection to speak to inspectors. The focus groups included junior and senior staff from pharmacy, junior and senior nursing staff, junior doctors and consultants, allied health professionals, staff representing equality, diversity and inclusion. We also had focus groups for the non-executive directors and governors.

You can find further information about how we carry out our inspections on our website: www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Outstanding practice

Royal Oldham Urgent and Emergency Care

- The department had developed a training session to raise awareness around support for victims of domestic abuse. The program was developed in partnership with and delivered by a survivor of domestic abuse. The training program linked in with local services for survivors, familiarised staff with relevant referrals, and developed discreet methods of providing victims with helpline contact details. Staff said this training provided them with confidence in supporting victims and using professional curiosity to raise or challenge signs of domestic abuse.

Fairfield Urgent and Emergency Care

- Local leaders supported and encouraged staff to suggest and make improvements within the department in order to improve staff wellbeing. For example, a member of staff had suggested a garden be built for staff outside the department. Local leaders supported the member of staff in drafting and submitting a business case and through the process of having the garden built. Local leaders were working with staff to improve the garden, for example planting herbs and vegetables and new furniture.

Our findings

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve:

Trust wide

- The trust must ensure there is consistent assessment, monitoring and improvement of the quality and safety of the services provided and that this is presented uniformly to decision makers to ensure they have effective oversight. (Regulation 17 (2)(a))
- The trust must ensure that effective structures and processes are in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of patients which arise from the carrying on of the regulated activity; including an effective audit programme and good quality data that monitors actions to improve patient care. (Regulation 17 (2)(b))
- The trust must ensure that services are always safely staffed by people with the necessary skills, knowledge and experience. (Regulation 18 (1))
- The trust must ensure staff complete mandatory training in accordance with the relevant schedule and receive sufficient training, supervision and appraisal to perform their duties competently. (Regulation 18 (2)(a))
- The trust must ensure they are effectively assessing and managing the risks to the health and safety of patients receiving care and treatment. The trust must ensure they are doing all that is reasonably practicable to mitigate any such risk. (Regulation 12 (a)(b))
- The trust must ensure it is effectively and appropriately assessing and managing the risks to service users who are waiting to receive care and treatment by ensuring clinical need and priorities are regularly reviewed. (Regulation 12 (2)(a)(b))
- The trust must ensure it aligns relevant policies and procedures to reduce unwarranted variation in clinical practice, and that policies are up to date. (Regulation 17 (1))
- The trust must take action to improve performance and reduce variation in medicines reconciliation rates across the organisation. (Regulation 12 (2)(a)(b))

Location/core service

Salford Royal Hospital Surgery

- The service must ensure that staff receive appropriate training, supervision and appraisals. This should include, but not be limited to, training in life support training, as is necessary to enable them to carry out the duties they are employed to perform. (Regulation 18 (1)(2)(a))
- The service must take action to monitor staff compliance for sepsis training and develop a more comprehensive mandatory training package to enable staff to support complex patients such as those living with dementia, autism, or a learning disability. (Regulation 18 (1)(2)(a))

Our findings

- The service must ensure that there are sufficient numbers and skill mix of nursing staff that can meet peoples care and treatment needs and keep them safe from avoidable harm. (Regulation 18 (1))
- The trust must ensure it aligns relevant policies and procedures to reduce unwarranted variation in clinical practice, and that policies are up to date. (Regulation 17 (1))
- The service must continue to monitor and take appropriate actions to improve average length of patient stay, readmission rates and referral to treatment waiting time performance in line with national standards. (Regulation 12 (1))
- The service must implement clear plans, with set timescales and actions, to improve patient's access to care and to achieve their timely discharge from hospital. (Regulation 17 (2)(a)(f))
- The service must ensure there are suitable systems in place to assess, monitor and improve quality and performance of key processes effectively. (Regulation 17 (2)(a)(f))
- The service must ensure that staff comply with all aspects of the surgical safety checklist. (Regulation 12 (1))

Royal Oldham Hospital Surgery

- The trust must ensure that there are sufficient numbers and skill mix of nursing staff that can meet peoples care and treatment needs and keep them safe from avoidable harm. (Regulation 18 (1))
- The trust must ensure that staff receive training in key skills including mandatory training including resuscitation and safeguarding appropriate to their role. (Regulation 18 (1)(2)(a))
- The trust must ensure that patient risk assessments are consistently completed and reviewed in a timely manner for all patients. (Regulation 12 (1)(2)(a)(b))
- The trust must ensure that action is taken to improve timeliness of medicines reconciliation and of the administration of time sensitive medicines to support safer medicines prescribing and administration. (Regulation 12 (2)(g))
- The trust must ensure that all staff are using the most up to date version of the intranet policy store. (Regulation 17(1))
- The trust must take action to develop a more comprehensive mandatory training package to enable staff to support complex patients such as those living with dementia, autism, or a learning disability and monitor staff compliance. Regulation 18 (1)(2)(a))
- The trust must ensure that processes are followed to reduce the risk that medicines will be used outside their expiry date. (Regulation 12 (2)(g))

Salford Royal Hospital Medical Care

- The service must ensure that staff receive appropriate support, training, professional development, supervision and appraisals. (Regulation 18 (1)(2)(a))
- The service must ensure that staff receive the appropriate training relevant to their roles to enable them to carry out their duties and maintain the necessary skills to keep patients safe. (Regulation 18 (1))
- The service must ensure that there are sufficient numbers of both medical and nursing staff that can meet people's care and treatment needs and keep them safe from avoidable harm. (Regulation 18 (1))
- The service must ensure mandatory training compliance is improved to support patient safety. (Regulation 18 (1))

Our findings

- The service must take actions to improve referral to treatment waiting time performance in line with national standards. (Regulation 17 (2)(b))
- The service must effectively and appropriately assess and manage the risks to service users who are waiting to receive care and treatment. (Regulation 12 (1))

Royal Oldham Hospital Medical Care

- The service must ensure that they have enough medical or nursing staff to keep patients safe and that patients requiring one to one observations receive this level of care. (Regulation 18 (1))
- The service must ensure that all emergency trolleys are sealed, with a record of checks to show they are ready for use. (Regulation 12 (2)(e))
- The service must ensure that all medicines are kept securely on the wards. (Regulation 12 (2)(g))
- The service must ensure that levels of medical and nursing staff training in safeguarding, resuscitation techniques and other mandatory training courses meet trust targets. (Regulation 18 (2)(a))
- The service must ensure that substances that are hazardous to health are properly controlled and kept securely. (Regulation 15 (1)(a))
- The service must ensure that all staff follow infection control principles, including the use of personal protective equipment (PPE). (Regulation 12 (2)(h))
- The service must ensure that guidance and training on treating patients with eating disorders is adequately rolled out and delivered to all relevant staff. (Regulation 18 (2)(a))
- The service must ensure that referral to treatment times for patients and national standards for treatment of patients with suspected cancer are met. (Regulation 17 (1))
- The service must ensure that all staff are using the most up to date version of the intranet policy store. (Regulation 17 (1))

Fairfield General Hospital Medical Care

- The trust must ensure that staff receive appropriate training, supervision and appraisals. This should include, but not be limited to, training in life support as is necessary to enable them to carry out the duties they are employed to perform. (Regulation 18 (1)(2)(a))
- The trust must ensure that there are sufficient numbers of nursing and medical staff that can meet people's care and treatment needs and keep them safe from avoidable harm. (Regulation 18 (1))
- The service must ensure they participate in clinical audit to demonstrate the effectiveness of care and treatment. (Regulation 17 (1)(2)(a))
- The trust must ensure that effective and timely care is provided to improve patient access and flow through the hospital to safe discharge or transfer to inpatient services. (Regulation 12 (1)(2)(i))
- The trust must take actions to improve referral to treatment waiting time performance in line with national standards. (Regulation 17 (2)(b))
- The trust must take actions to improve the timeliness of patient complaint responses to within the timescales specified in the trust complaints policy. (Regulation 16 (2))

Salford Royal Hospital Urgent and Emergency Care Page 13

Our findings

- The service must ensure staff receive the required training to enable them to carry out the duties they are employed to perform. This includes but is not limited to life support, training on learning disabilities and autism and safeguarding training. (Regulation 18 (1)(2)(a))
- The service must deploy sufficient numbers of suitably qualified nursing and support staff to keep patients safe. (Regulation 18 (1))
- The service must ensure all areas of the department are clean and staff have access to enough equipment that is secure, suitable and properly maintained. This includes but is not limited to checks of specialist equipment and rooms used for assessing a patient's mental health. (Regulation 15 (1)(a)(b)(c)(e))
- The service must ensure they effectively assess risks to patients and do all that is possible to mitigate such risks. This includes but is not limited to risk relating to patients placed on corridors, patients with suspected sepsis and other specific risk issues. (Regulation 12 (1)(2)(a)(b))
- The service must ensure patients are treated with dignity and respect and ensure the privacy for patients is maintained, particularly for those cared for on the corridor. (Regulation 10 (1)(2)(a))
- The service must ensure it acts to mitigate the risks to patients waiting in the department including those waiting for triage, treatment, admission or on a trolley. It must ensure patients can access the service when they need it. (Regulation 12 (1)(2)(b))
- The service must ensure it operates effective systems and processes to assess, monitor and improve the quality and safety of services. (Regulation 17 (1)(2)(a))

Royal Oldham Hospital Urgent and Emergency Care

- The service must ensure staff receive the required training to enable them to carry out the duties they are employed to perform. This includes but is not limited to safeguarding and training on learning disability and autism. (Regulation 18 (1)(2)(a))
- The service must deploy sufficient numbers of suitably qualified nursing and support staff to keep patients safe. (Regulation 18 (1))
- The service must ensure all areas of the department are clean and staff have access to enough equipment that is secure, suitable and properly maintained. This includes but is not limited to checks of specialist equipment and rooms used for assessing a patient's mental health. (Regulation 15 (1)(a)(b)(c)(e))
- The service must ensure they effectively assess risks to patients and do all that is possible to mitigate such risks. This includes but is not limited to risk relating to patients placed on corridors, patients awaiting triage and treatment, patients with suspected sepsis and other specific risk issues. (Regulation 12 (1)(2)(a)(b))
- The service must ensure it operates effective systems and processes to assess, monitor and improve the quality and safety of services. (Regulation 17 (1)(2)(a))

Fairfield General Hospital Urgent and Emergency Care

- The service must ensure staff receive the required training to enable them to carry out the duties they are employed to perform. This includes but is not limited to life support, learning disabilities and autism and safeguarding training. (Regulation 18 (1)(2)(a))
- The service must deploy sufficient numbers of suitably qualified nursing and support staff to keep patients safe. (Regulation 18 (1))

Our findings

- The service must ensure it acts to mitigate the risks to patients waiting in the department including those waiting for triage, treatment, admission or on a trolley. It must ensure patients can access the service when they need it. (Regulation 12 (1)(2)(b))
- The service must ensure all areas of the department are suitable and properly maintained. This includes but is not limited to the size and design of the department and rooms used for assessing a patient's mental health. (Regulation 15 (1)(b)(c)(d))
- The service must ensure it operates effective systems and processes to assess, monitor and improve the quality and safety of services. (Regulation 17 (1)(2)(a))

Royal Oldham Hospital Maternity

- The trust must ensure that staff receive training in key skills including mandatory training including resuscitation, safeguarding and Practical Obstetric Multi-Professional Training (PROMPT) appropriate to their role. (Regulation 18(1)(2)(a))
- The trust must ensure that equipment is maintained in a timely manner and staff have assurance that it safe to use. (Regulation 12(1)(2)(e))
- The trust must ensure that daily safety checks of equipment are fully completed. (Regulation 12(1)(2)(e))
- The service must ensure that trust processes are followed to reduce the risk that medicines will be used outside their expiry date including for medicines with a shortened expiry once opened. (Regulation 12(1)(2)(g))
- The trust must ensure that any shortfalls in midwifery staffing have mitigations in place to ensure safe levels. (Regulation 18(1))
- The trust must ensure that there are robust processes for medicines management. (Regulation 12(1)(2)(g))
- The trust must ensure that records are completed contemporaneously and all are accessible to staff providing care. (Regulation 17(1)(2)(c))
- The trust must ensure that staff complete an annual appraisal and are supported to develop their skills. (Regulation 18(1)(2)(a))
- The trust must ensure that all action plans continue to be monitored and are embedded to help drive improvement and outcomes for women. (Regulation 17(1)(2)(a)(b))

Rochdale Infirmary Maternity

- The trust must ensure that staff receive training in key skills including mandatory training including resuscitation, safeguarding and Practical Obstetric Multi-Professional Training (PROMPT) appropriate to their role. (Regulation 18(1)(2)(a))
- The trust must ensure that equipment is maintained in a timely manner and daily checks are completed so that staff have assurance that equipment is safe to use. (Regulation 12(1)(2)(e))
- The trust must ensure that any shortfalls in midwifery staffing have mitigations in place to ensure safe levels. (Regulation 18(1))
- The trust must ensure that there are robust processes for medicines management. (Regulation 12(1)(2)(g))
- The trust must ensure that records are completed contemporaneously and all are accessible to staff providing care. (Regulation 17(1)(2)(c))

Our findings

- The trust must ensure that staff complete an annual appraisal and are supported to develop their skills. (Regulation 18(1)(2)(a))
- The trust must ensure that all action plans continue to be monitored and are embedded to help drive improvement and outcomes for women. (Regulation 17(1)(2)(a)(b))

Action the trust SHOULD take to improve:

Trust wide

- The trust should ensure there is clarity in the roles and responsibilities of executive leads and that roles allow equitable capacity for the executive directors. (Regulation 17 (1))
- The trust should ensure serious incidents are investigated in a timely manner and learning is shared across the organisation as required. (Regulation 17 (2)(a)(b))
- The trust should ensure staff understand relevant strategies and can comment and contribute where appropriate. (Regulation 17 (2)(e)(f))
- The trust should ensure it continues to improve culture and support staff to speak up. (Regulation 17 (2)(e)(f))
- The trust should ensure it effectively manages the administration of the fit and proper persons checks. (Regulation 19 (2))
- The trust should ensure complaints are investigated and responded to in accordance with the relevant policy and best practice. (Regulation 16 (1)(2))

Location/core service

Salford Royal Hospital Surgery

- The service should ensure it takes appropriate actions to improve timeliness and compliance for completing risk assessments and intentional rounding observations in line with trust targets. (Regulation 12 (1)(2)(a)(b))
- The service should ensure it takes action to improve clinical audit outcomes and take appropriate actions to reduce the number of outstanding reports and overdue action plans. (Regulation 17 (1))
- The service should ensure it takes action to implement a more dementia-friendly environment across the surgical wards and theatre area. (Regulation 9 (3)(b))
- The service should ensure it takes action to encourage and improve the utilisation of ‘this is me’ documents or ‘hospital passports’.(Regulation 9 (3)(b))
- The service should ensure it takes action to improve the timeliness of patient complaint responses to within the timescales specified in the trust complaints policy. (Regulation 16 (1)(2))
- The service should continue to take action to enlist a clinical director of general and oral surgery and ensure that all required staff have job plans in place. (Regulation 18 (1))

Royal Oldham Hospital Surgery

- The trust should ensure emergency medicines checks are completed. (Regulation 12 (1)(2)(g))
- The trust should ensure that patient observations are carried out in a timely manner. (Regulation 12 (1)(2)(a)(b))

Our findings

Salford Royal Hospital Medical Care

- The service should ensure that cleaning schedules are completed appropriately. (Regulation 12 (1)(2)(h))
- The service should consider developing a more comprehensive mandatory training package to enable staff to support complex patients such as those living with dementia, autism or a learning disability. (Regulation 18 (2)(a))

Royal Oldham Hospital Medical Care

- The service should ensure that mixed sex breaches are avoided on medical wards. (Regulation 10 (2)(a))
- The service should ensure that ward moves are not completed after 8pm, unless clinically required, to avoid disturbing rest and disorientating patients. (Regulation 12 (1)(2)(b)(i))
- The service should consider developing a vision and strategy that is specific to the medicine division.

Fairfield General Hospital Medical Care

- This service should ensure tools to identify patients at risk of deterioration are used in an accurate and timely manner by staff. (Regulation 12 (1)(2)(a)(b))
- The service should ensure that the premises are safe to use for their intended purpose and are used in a safe way. (Regulation 12 (1)(2)(d))

Salford Royal Hospital Urgent and Emergency Care

- The service should ensure that all staff use, and wear, required personal protective equipment, including the correct use of surgical face masks. (Regulation 12 (1)(2)(h))
- The service should ensure staff store patient records and information securely. (Regulation 17 (1)(2)(c))
- The service should ensure they meet the nutritional and hydration needs of patients. (Regulation 14 (1)(2)(b))
- The service should ensure patients receive timely pain relief to ensure that care and treatment meets their needs. (Regulation 9 (1)(2)(3)(b))
- The service should ensure care and treatment is carried out with the informed consent of the patient and such consent is clearly recorded. (Regulation 11(1))

Royal Oldham Hospital Urgent and Emergency Care

- The service should ensure staff store patient records and information securely. (Regulation 17 (1)(2)(c))
- The service should ensure patients receive timely pain relief to ensure that care and treatment meets their needs. (Regulation 9 (1)(2)(3)(b))

Fairfield General Hospital Urgent and Emergency Care

- The service should ensure that all staff use, and wear, required personal protective equipment, including the correct use of surgical face masks.(Regulation 12 (1)(2)(h))
- The service should ensure staff store patient records and information securely.(Regulation 17 (1)(2)(c))
- The service should ensure they meet the nutritional and hydration needs of patients. (Regulation 14 (1)(2)(b))

Our findings

- The service should ensure patients receive timely pain relief to ensure that care and treatment meets their needs. (Regulation 9 (1)(2)(3)(b))
- The service should ensure care and treatment is carried out with the informed consent of the patient and such consent is clearly recorded. (Regulation 11(1))

Royal Oldham Hospital Maternity

- The trust should ensure that consumables are stored securely in clinic rooms. (Regulation 12 (1)(2)(e))
- The trust should ensure that all minority groups are included in service planning. (Regulation 17 (1)(2)(e))
- The trust should ensure that leaders communicate the vision and strategy to all staff. (Regulation 17 (1)(2)(e)(f))
- The trust should ensure that lone worker arrangements are robust to keep community staff safe. (Regulation 17 (1)(2)(b))
- The trust should ensure that information to provide feedback, including how to complain, is clearly displayed in all areas. (Regulation 16 (1)(2))
- The trust should consider the use of Situation, Background, Assessment, Recommendation (SBAR) for handover processes.
- The trust should consider applying for re accreditation with the UNICEF baby friendly initiative.
- The trust should consider readmitting babies for phototherapy to paediatric wards rather than maternity.

Rochdale Infirmary Maternity

- The trust should ensure that leaders communicate the vision and strategy to all staff. (Regulation 17 (1)(2)(e)(f))
- The trust should ensure that lone worker arrangements are robust to keep community staff safe. (Regulation 17 (1)(2)(b))

Is this organisation well-led?

This is our first rating of the Northern Care Alliance. We rated it as requires improvement.

Leadership

Leaders had the skills, abilities and experience to run the service. Most leaders understood the priorities and issues the trust faced. However, some expressed different levels of understanding of the drivers for change and the priorities articulated by their executive colleagues. Staff reported leaders were not always visible and approachable.

The trust operated a range of acute and community health and social care services which were provided by the trust's four care organisations; Salford, Oldham, Rochdale and Bury. The care organisations were responsible for the day to day running of their community services as well as the four acute hospitals; Salford Royal Hospital, The Royal Oldham Hospital, Rochdale Infirmary and Fairfield General Hospital. Each care organisation had a core senior leadership team with management responsibility for these services. However, the Northern Care Alliance (NCA) Board of Directors was accountable for the overall performance, quality and safety of all its services.

Our findings

Each care organisation's senior leadership team included key roles such as; Chief Operating Officer, Medical Director, Director of Nursing and Director of Human Resources, as well as others dependent on the size of the care organisation. These roles were replicated within the overall trust leadership team which also included the trust Chief Executive Officer (CEO), Chairperson, Chief Financial Officer, Chief Strategy Officer and the new Chief Digital and Information Officer role.

Although many of the care organisation leadership team had worked within the group structure for long periods of time, a large proportion of the board executive team were appointed shortly before or after the acquisition. These included the trust CEO, Chief Nursing Officer and Chief Digital and Information Officer. The trust had also recently appointed a new Chairperson and Chief Financial Officer who had not yet taken up their posts. We saw there was scope to review and refine the management model within finance, including the distribution of responsibilities between Group and Care Organisation finance teams and stronger collaboration between the Care Organisations.

The trust CEO had been in post since November 2021 and had experience as a CEO at another NHS trust. At the time of the inspection the trust had an interim chairperson. A permanent chairperson with extensive experience in the public sector was appointed and was due to commence in post after the inspection. There was a varied mix of skills and experience across the non-executive directors (NEDs). There was acknowledgement that the knowledge and expertise of the board needed to be broader. The interim chairperson told us the existing skill set was reviewed to determine any specific requirements when new NEDs were recruited. There was a process for induction of NEDs. There were some new NED appointments planned at the time of our inspection.

The trust had a council of governors, with sub-groups representing each care organisation. Regular governor meetings were attended by varying non-executive directors and some executive directors. There was a mix of longer serving and newer governors on the council. Members of the council we spoke with were well-informed and generally positive about the trust's position and strategy.

The trust had good succession planning in place for key posts. They had strengthened their teams through strategic recruitment.

All senior leaders had extensive experience in the NHS or within their field of expertise. We received positive feedback about new appointments to the board and their vision for their portfolio areas. However, many of the plans they had developed had not yet had time to evidence impact or sustainability.

The trust was an active member of the local integrated care board. Senior leaders regularly met with system partners to discuss priorities and concerns and plan for effective responses across Greater Manchester. For example, leaders told us about the work they were doing with system partners to improve delayed discharges and look at diversion pathways to improve access and flow.

The CEO was actively pursuing a quality improvement agenda and spoke passionately about the need for change within the trust. They clearly outlined the drivers for change and described the strategy in place to achieve the trust's objectives. Their initial focus was on; maternity services, patient safety, waiting times, health inequalities, improving accountability at board level and delivery of effective digital systems. Most executive team members articulated their agreement with the need to make changes in these areas. However, when asked, some did not identify a significant need for change.

The trust had a council of governors, with regular governor meetings which were attended by varying non-executive directors and some executive directors. There was a mix of longer serving and newer governors on the council. Council members spoke positively about the trust's improvement plans.

Our findings

During our core service inspections, several staff told us they did not feel executive and senior leaders were visible and approachable. Many staff told us this had improved since the CEO came into post in late 2021 but they felt there was still work to do.

We received mixed feedback regarding the visibility and approachability of leaders. The published results of the most recent NHS staff survey pre-date the formation of the NCA. Therefore, results from the former Pennine Acute Hospitals Trust cannot be reported as part of this inspection. The results from Salford Royal Hospital were representative of the average across all trusts for all relevant measures including engagement. However, most of the staff we spoke with across all four care organisations said senior leaders were not normally visible within the hospital. There was no discernible difference in the responses provided from each care organisation. A significant proportion reported the CEO was visible and the situation had improved since his appointment.

Pharmacy leadership

Pharmacy transformation focussed on aseptic services, digital systems, workforce, policy, clinical trials and outsourcing. A risk-based approach was employed for example, to policy and PGD [patient group direction] alignment and review. Progress and risks were monitored through the NCA Pharmacy Transformation Board, reporting to Divisional Operations and Performance with updates to the Executive Quality Committee (May and October 2022).

Following disaggregation of pharmacy services at North Manchester General Hospital (NMGH) senior pharmacy staff drafted a new pharmacy senior management structure, to facilitate the bringing together of pharmacy services across the trust, and to drive forward equity in service provision. Capacity within the pharmacy team to support transformation work was a challenge due to provision of support to the vaccination programme and difficulties in recruiting to technician vacancies.

Fit and proper persons

There is a requirement for providers to ensure that directors are fit and proper to carry out their role. This includes checks on their character, health, qualifications, skills, and experience. During the inspection we carried out checks to determine if the trust was compliant with the requirements of the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014).

The trust had a fit and proper persons policy to manage compliance with the regulation, this was approved in April 2022. The policy applied to group board level executive and non-executive directors and directors of individual care organisations. However, interim members of the board were not within the scope of the policy.

The policy did not clearly define the format in which the records should be stored and monitored. The trust advised us they had moved from a paper-based to electronic storage system for the records in recent years.

We reviewed staff files for members of the board of directors. However, we found that documents such as annual fit and proper persons self-declaration, disclosure and barring service, insolvency and registration checks were difficult to find between the paper-based and electronic systems. Some records were uploaded to the electronic system in bulk making it difficult to locate specific documents. In some cases, we located documents in generic folders as opposed to folders specific to the individual board members we were reviewing.

Our findings

The corporate services team used a spreadsheet to monitor compliance with the regulation. However, the tracker did not capture due dates for some of the evidence required annually. We found some annual checks were significantly overdue. The team sent required evidence to the chairperson of the board when new members of the board were recruited and when they received annual checks for existing members. However, the team were not able to provide a complete audit trail for the chairperson's ongoing oversight of the monitoring spreadsheet.

A senior member of the corporate services team stated the files for newer members of the board were complete and accurate but that there was work to do to ensure established files were complete and easy to check. They acknowledged that, although the trust did have a lot of the required evidence, the administration of the fit and proper process checks was not robust at the time of our inspection and that the team needed to be more proactive in terms of ensuring annual checks at their due date.

Vision and Strategy

The trust had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and most staff understood and knew how to apply them and monitor progress.

The NCA VIS10N (Vision 10) strategy was launched in 2021 to coincide with the formation of the trust. The overarching goal of the strategy was defined as, *Saving Lives, Improving Lives.* The strategy outlined six ambitions under the headings of:

Population health

Our people (staff)

Improving quality

Transforming performance

Supporting development

Financial sustainability

Each ambition included medium-term objectives with target dates in 2025, and longer-term objectives with target dates beyond 2025.

Not all the objectives were specific enough to allow for measurement of progress. For example;

'Reduce access inequalities for patients in our most disadvantaged communities and *Increase the percent of people returned to their usual place of residence.'*

However, other objectives reflected realistic, measurable ambitions which would benefit patients and staff. Including;

Our findings

'Diagnose over 75% of all cancers at early stages (stage one and two) and, *(to be in the) Top 10% of NHS employers for taking positive action on health and wellbeing.'*

Vision 10 was developed through engagement with patients, staff and system partners. The strategy was aligned to their needs and the priorities of the regional Integrated Care Board. Each ambition was 'owned' by a nominated member of the board and subject to regular review. Promotion of the strategy was extensive and addressed internal and external audiences. However, some front-line staff did not have a clear understanding of the strategy and a small number were unaware of it. The trust had a number of supporting strategies with a more specific focus including those for digital and people development. The financial strategy required further development and was not fully aligned to the overall trust' strategy. Work was underway to ensure incorporation of NHS England's Working in Partnership with People and Communities into strategy development.

The trust was active in research and action to address health inequalities and was a member of the Greater Manchester Patient Safety Research Collaboration. It was recently confirmed as the host for a major research project into the subject. The National Institute for Health and Care Research (NIHR) funded a programme of research in conjunction with the University of Manchester, the University of Nottingham and the University of Leicester. The programme was scheduled to run from 2023 through to 2028.

Some members of the board recognised the challenges of measuring progress when data and intelligence was not gathered and presented consistently across the four care organisations. The CEO and other board members described the need to reconcile the management of data and intelligence to monitor performance and progress as a priority.

Within pharmacy, the recent focus had been on disaggregation with North Manchester General Hospital and pharmacy transformation. However, the Pharmacy Blueprint 2022-24 identified a high-level vision for pharmacy services mapped to the trust's strategic priorities. A key theme for pharmacy was pharmacy workforce and provision of an equitable service, supporting improved safety and patient outcomes. Strategic focus was on development of effective, harmonised medicines optimisation structures and digital development for example, to facilitate learning from audit.

Culture

Staff did not always feel respected, supported and valued. However, they remained focused on the needs of patients receiving care. Some staff expressed reservations about raising concerns and others did not always feel listened to. The trust had a culture where patients and their families could raise concerns without fear.

Before, during, and after the inspection, we received information of concern from staff regarding the culture at the trust. Staff reported poor communication and feedback from leaders when concerns were raised. We were given examples when incidents and significant concerns had been reported, but there had been no communication with staff to outline what action was taken. The examples shared with us related to culture, behaviours and clinical practice. We discussed this with a senior executive and were assured that the issues were known and had been addressed. They acknowledged historic issues and failures to communicate effectively. They outlined procedures and strategies to improve transparency, accountability and communication.

The trust had a Freedom to Speak-Up (FTSU) lead with an additional lead in each of the care organisations. The team structure also included voluntary freedom to speak-up champions for key operational areas. The chief nurse held executive responsibility and a non-executive director was the nominated representative at board level. The FTSU governance process included a requirement for scheduled meetings with the CEO and Director of People as well as report production to share information of concern. The team monitored the number and nature of concerns in relation

to key measures. For example, those received from colleagues from a black and minority ethnic background. Common themes in 2022 included; staffing shortages, patient safety and leadership. The FTSU lead spoke positively about the influence of the CEO on reporting culture across the trust. The trust reviewed the FTSU strategy in 2021 and made it easier for staff to report concerns through the development of an improved intranet site and social media channels. Staff had the option to report externally if they lacked confidence in internal systems.

Representatives of unions spoke positively about the trust's strategy and the quality improvement agenda. They also told us about improved attendance at meetings from members of the executive team. However, they highlighted inconsistencies in the timeliness and completeness of responses to issues raised and the differences in key policies for the care organisations within the trust. For example, policies relating to sick pay which included different thresholds. We raised this with members of the executive and were told the differences were a legacy of staff contracts in place prior to the creation of the trust.

The trust had an equality, diversity and inclusion (EDI) network with a broad range of representation. Members of the network spoke with enthusiasm and positivity about their work and the support offered by the trust. They shared examples of joint working to challenge inequalities and discrimination. For example, in relation to recruitment where members of the network joined interview panels and shared learning. Members told us there was a positive culture regarding EDI. Data from the most recent workforce race equality standards report showed positive performance with one exception. Staff from black and ethnic minority backgrounds were increasingly likely to enter formal disciplinary processes. This result was reported to us during the inspection. The trust has implemented a plan to identify the cause and implement corrective action where necessary.

The trust's SCARF (Supporting, Caring, Assisting, Recognising our NCA Family) programme offered staff support, practical resources, information, helplines and training at home and at work. The programme sought to provide staff with a wide range of assistance and advice to support their mental and physical health. It reflected the importance of maintaining a healthy, motivated workforce to the provision of high-quality care. Staff we spoke with were aware of the programme and some had accessed the services. However, one strand of the programme which was consistently highlighted by senior staff at the trust had limited take-up. Part of the programme allowed staff to take four hours of paid time to access services and support their health and wellbeing. Most of the staff we spoke with who referenced the programme said that they could not find time in the working week to make use of the allocation of hours.

The pharmacy workforce group engaged with staff and provided strategic direction to support recruitment, career development and retention of the pharmacy workforce. There was a focus on delivery of 'social value' through providing apprenticeships and training opportunities targeted to the local community. The pharmacy department had developed a single NCA pharmacy 'welcome handbook' and following feedback, was working with new starters across the hospitals to improve induction processes. Staff engagement events had taken place and a communications strategy had been developed and disseminated.

Governance

Leaders did not operate consistent, effective governance processes throughout the trust. There were differences in policies and clinical practice which did not reflect best-practice guidelines. Most leaders were clear about the need to review these functions to ensure they were fit for purpose.

The trust operated different governance and oversight structures within the group than most other NHS trusts. Most assurance committees were executive-led rather than non-executive. Non-executives held additional, informal meetings

with executives outside of the formal structures to ensure they maintained effective oversight of issues and priorities. We were provided with examples of how issues had been dealt with effectively by the governance structure. However, the trust's governance relied heavily on good will and non-executives using the informal touch points to inform themselves.

The Head of Internal Audit (HoIA) is required to give an annual opinion on the overall suitability and effectiveness of the trust's risk management, control and governance processes. Northern Care Alliance contract out their internal audit to a known provider of assurance services to the NHS. The trust's Head of Internal Audit Report (2021-22) found the trust had adequate systems for internal controls to meet its organisational objectives but that these controls were not always applied consistently across the trust. However, as the report also acknowledged, these reviews were conducted during, and soon after, the acquisition of Pennine Acute Hospitals NHS Trust by Salford Royal NHS Foundation Trust and thus the formation of the Northern Care Alliance, as well as against the backdrop of the COVID-19 pandemic.

The report identified some of the key issues we found during our inspection of the trust's core services such as the notable failure of the trust to make timely progress against key actions to mitigate risks in maternity services. The report also highlighted inconsistencies in the trust's development and implementation of LocSSIPS between the four care organisations. LocSSIPs are locally derived safety standards which apply to invasive procedures with the aim of reducing surgical never events. During our review of the trust's LocSSIPS library we found significant variation in the content of some of the safety standards used at each care organisation for example LocSSIPs used for nasogastric tube insertion. During our well-led inspection, the chief medical officer told us a project was in progress to ensure all care organisations had LocSSIPS relevant to the procedures they perform and these would align to national guidance.

Committee structure, Board Assurance Frameworks (BAFs) and risk registers

The trust presented a committee governance structure for each care organisation which showed each care organisation had various sub-committees which reported into five key care organisation level committees. These were; quality and patient experience, people, clinical effectiveness, operations and performance and finance, estates and IT. These committees reported into the care organisations' assurance and risk committee (CORAC). However, we found variation between the care organisations' structure, scope and agendas for some of these committees as well as the format and integrity of some of the data available to inform them. Furthermore, some of the senior staff we spoke with, were not able to clearly articulate this committee structure.

Each CORAC reported into the group executive risk assurance committee (GRAC) which was also fed by the executive people, executive quality, executive capital, executive digital, executive research and innovation, executive sustainability, executive hosted services and executive strategic finance and information committees. However, it was unclear whether there was structured interface between the matching care organisation committees and the relevant executive level committee. For example, whether the care organisation people committees collaborated with each other and had consistent and standardised input into the group level people committee. The trust's independent well-led assessment identified that there were tensions between group and care organisations about responsibilities and the risk of duplication meaning there was a need to be more explicit around accountability. Nevertheless, most of the board and senior staff we spoke with during our well-led inspection were positive about the interaction between group and place.

Unusually, each CORAC and the GRAC maintained their own integrated board assurance framework (BAF) and corporate risk register which combined both strategic and operational risks together rather than identifying these in separate documents. Within these, the care organisations assessed the likelihood, impact and controls of each of their principal and operational risks to determine a risk profile score of up to 15. The trust provided its risk management strategy and

policy, which was due to expire on 30 September 2022, it identified that care organisation risks scoring 12 or above were adopted on to the group BAF, managed through the GRAC and reported to the board. However, when asked, some senior and board level staff were not able to articulate how the trust determined which care organisation risks were escalated to the group BAF.

We requested the current BAF for the group and for each care organisation. We found that there were examples of principal risks with a risk profile score of 12 (or above) which were not explicit within the group BAF. We also found the format, content and level of detail between some of the care organisation BAFs differed significantly. For example, the BAF we received for Oldham care organisation was not recorded using the group template as directed by the trust's risk management policy and did not give sufficient detail of the controls established to mitigate risks or gaps in assurance. Some included the risks scoring a risk profile score of above and below the group threshold of 12, some did not.

The trust had an independent audit committee appointed by the board to provide non-executive oversight of the trust's governance, risk management and performance. The audit committee was chaired by a non-executive director (NED) and was the key forum for NEDs to scrutinise these areas. However, we found there was no non-executive membership at GRAC and NEDs appeared to attend care organisation risk assurance committees on an ad-hoc basis. Between this and the variation in format and integrity of the information at care organisation committees and sub-committees, we were not assured that NEDs had effective line of sight to challenge the trust's governance, risk management and performance.

All senior leaders we interviewed were able to articulate some of the trust's top risks including; maternity services, data and intelligence and the elective recovery agenda.

During our inspection leaders told us NEDs were buddied to executive staff members and significant work had taken place to strengthen the interface between GRAC and the audit committee. This was also referenced within the Chief Executive's annual governance statement. The NEDs we spoke with were positive about the committee structures in place. They described informal meetings they held to triangulate risk or performance information and make appropriate challenge. However, these appeared to rely on their individual levels of experience and goodwill rather than forming part of the formal risk and performance management structures.

Policy governance

We found that policy governance within the trust required significant improvement. The trust operated a central online policy hub. However, during our inspection of the core services, we found that some services were using legacy policies from the previous trusts or accessing a suite of policies separate to the central Northern Care Alliance hub. As part of our ongoing monitoring of the trust, and throughout the inspection, we found there was a need to align some legacy Salford and Pennine policies to ensure there were trust-wide versions that reflected national or best practice guidance where appropriate.

During our inspection, we conducted a review of the central policy hub. We found there were 1,702 documents on the policy hub. Of these, only 283 were categorised as applicable to all Northern Care Alliance services. There were 789 policies categorised as relating only to Salford Royal Hospital and 642 to the other hospitals previously part of Pennine Acute trust. Others related to corporate services. We found numerous examples of there being two policies, standard operating procedures or quick reference guides relating to the same topic where the guidance within them varied significantly. For example, we found two versions of policies relating to Deprivation of Liberty Safeguards and two relating to the management of equipment within surgery. We also found that a significant number of policies were out of date.

Our findings

These policy issues were a key driver behind the unwarranted variation in clinical practice we found across the trust during our core service inspections. Although the trust advised us that work was underway to harmonise policies, we found recent examples where care organisations appeared to have produced and implemented their own versions of clinical policies in a silo, which created significant variation in clinical practice between hospitals. For example, between February and July 2022, two quick reference guides about the management of patients with eating disorders were in use, however the criteria for admission, risk stratification scores and mandated baseline investigations differed between the two. We also found significant differences in the trust's policies and approaches to identifying and treating patients with suspected sepsis.

We escalated these concerns to the trust during our core service inspections. The trust took immediate action to align these policies and ensure they reflected best practice guidance. However, we were not assured that there were not many other examples of similar issues that had yet to be identified and acted upon to ensure staff have consistent and up to date guidance to perform their duties and keep patients safe.

The trust commissioned an independent well-led assessment which also found gaps in the approval processes for policies, a need to differentiate between policies and standard operating procedures and need to prioritise a systematic approach to identifying policies for harmonisation and review. Some corporate teams we spoke with told us they had identified the policies relevant to their area that required alignment and review and had assigned staff to progress these. The trust had a plan in place to progress this work.

Medicines governance

There were recognised gaps in providing assurance for medicines optimisation. The Medicines Optimisation Group subcommittee structure was not yet fully established and wider representation across a range of disciplines was being actively sought. Medicines management reporting was inconsistent across the trust. Whilst quarterly hospital level assurance, escalation and exception reports were presented to the Bury, Rochdale and Oldham Clinical Effectiveness Committees, a similar report was not presented in Salford. The pace of change had been affected by North Manchester General Hospital disaggregation and pharmacy staffing pressures throughout the pandemic including support to the mass vaccination centres.

Work was progressing to harmonise Antimicrobial Stewardship [AMS] committees across the trust, with the first joint meeting planned for October 2022. A Consultant Antimicrobial Pharmacist post had also been established to provide oversight of the AMS strategy across the Care Organisations. A lack of standardised treatment regimens across the trust and inequity in the supply of readymade treatments for sepsis was also identified and addressed during our inspection.

The trust’s Controlled Drugs Accountable Officer ensured that the required controlled drugs quarterly reports were submitted to the Local Intelligence Network.

Management of risk, issues and performance

Leaders and teams did not consistently use systems to manage performance effectively. They identified and escalated relevant risks and issues but did not always take actions to reduce their impact. Staff did not always have the opportunity to contribute to decision-making and help avoid pressures compromising the quality of care.

Operational risk

Our findings

We were not assured the trust was managing operational risks well. Throughout our core service inspections, we found staffing levels were below required levels in several areas. Leaders told us each care organisation held safer staffing calls twice daily. These calls allowed wards to escalate their immediate staffing concerns to the assistant director of nursing who would prioritise and re-allocate staff to ensure safe staffing levels could be maintained. However, some of the staff we spoke with told us they often did not receive more staff through these channels, and they felt leaders did not listen to their concerns. Staff also raised concerns about being moved to unfamiliar wards without training and support.

On the first day of our inspection of the emergency department in Salford Royal Hospital, we found there was insufficient staffing to manage the risks of patients when the department was busy. We escalated this to senior leaders during our inspection who arranged for staff to support from other areas of the hospital. Following the inspection, the trust developed a new protocol for managing risks when the department was at maximum capacity. This included an uplift in the staffing establishment.

Risk management processes such as fire safety, health and safety, manual handling, resuscitation, infection control, safeguarding patients, blood transfusion and information governance formed part of staff's mandatory training. However, during our core service inspections, we found compliance with mandatory training was below the trust target in several areas.

Risk appetite

The trust's risk management strategy and policy states that the trust does not tolerate risk that significantly impacts on patients or staff safety but that it has a higher risk appetite relating to undertaking innovation and transformation objectives. However, when we asked about the trust's risk appetite, some of the board level staff we spoke to did not recognise the term and were unable to comment on the trust's approach to risk in this way.

Performance

In line with the national picture, the trust was experiencing significant issues with access and flow. At the time we inspected, the trust had high volumes of delayed admissions, bed occupancy was above 95% each week for the three months leading up to the inspection and the trust had the second highest percentage of patients with no right to reside (assessed as clinically fit for discharge) in the North West region. In August 2022 this figure stood at 93.7%.Prior to our core service inspection, data indicated the trust's proportion of patients with no right to reside attributable to 'hospital reasons', rather than factors external to the trust, was significantly higher than other trusts in the region. However, data we reviewed in October 2022 showed the trust had reduced this from 48% in August to 24% in September.

Senior leaders told us about the trust's triple plus strategy to improve access and flow across its hospitals. The strategy focused on a programme of work to improve same day emergency care, frailty and discharges. The trust also identified that Rochdale Infirmary was underutilised, and some patients brought to its other emergency departments may have been suitable to be treated there. They told us care organisations would review their admissions data to look for missed opportunities of this nature. However, they identified both data capability and workforce challenges as risks to the advancement of this work.

In February 2022 NHS England set out elective recovery ambitions for trusts to eliminate routine elective waits of more than 104 weeks by July 2022. During routine engagement with the trust in early July, leaders told us the trust was on track to achieve this.

More recently, NHS England introduced ambitions to return the number of people waiting more than 62 days from an urgent referral for suspected cancer back to pre-pandemic levels by March 2023, and to eliminate routine elective waits of over 78 weeks by April 2023. The trust acknowledged these ambitions were significantly more challenging for them. In May 2022, the trust had 835 patients who had been waiting for treatment for more than 78 weeks. In August 2022 the trust was in the worst performing 25% of trusts nationally for patients waiting more than 62 days from an urgent referral for suspected cancer; with only 48% treated within the required timescale. Although the trust was not meeting the 62-day target for suspected cancer referrals; for patients diagnosed with cancer, the trust was meeting the national standard for first definitive treatment within 31 days of decision to treat. In August 2022, 97% of these patients were treated within 31 days of decision to treat compared with 92% nationally and 93% regionally.

The trust had some plans in place to address these shortfalls. For example, a new community diagnostic hub was due to open in Oldham in November 2022. The trust had also submitted a business case to introduce a diagnostic hub in Salford but, if successful, this was not due to go live until spring 2023. The trust told us that waiting lists were being performance managed effectively and that all patients waiting above the expected timescales received clinical reviews at 12-week intervals. However, they acknowledged there was scope for further improvement including standardising the differences in approach across the trust as services managed their own lists at Salford as opposed to them being managed by a central booking team in other parts of the trust.

Pharmacy risk management

Pharmacy risks across the hospitals had been amalgamated into a single risk register reviewed at the pharmacy governance meeting with oversight from Divisional Operations and Performance. Systems were in place to appropriately escalate higher level pharmacy and medicines related risks [10+].

There was a single trust-wide response to national medicines related alerts, recalls and NICE technology appraisals. For example, the NatPSA [National Patient Safety Alert] to reduce the risk of Inadvertent oral administration of potassium permanganate, tailored to the different electronic systems. Similarly, a review of policy relating to high strength insulins was completed in response an incident within the ICS. Learning was shared trust-wide via nursing safety huddles and through use of the 'take 5' safety bulletin.

There was recognised inequity in pharmacy service across the trust in terms of service provision. For example, performance in medicines reconciliation at The Royal Oldham Hospital at both 24 and 72 hours was consistently below trust target (~28% (24h), ~82% (72h) Q1 2022-23). At Salford Royal Hospital there was no dedicated pharmacy support to the Emergency Department [ED]. However. A business case was underway for support to ED and the enhanced receiving area within the new trauma building. Pharmacy were engaged with the NCA Discharge Group to look at how pharmacy supports improvement to patient flow.

Work to harmonise audits had recommenced, after being put on hold, due to the time needed for the implementation of a new e-Audit tool.

Information Management

The service collected data and analysed it. However, not all staff were assured that the data was always accurate. Staff could not always find the data they needed, in accessible formats to understand performance, make decisions and improvements. Data was not recorded or presented uniformly across the trust and some important

data was not captured. Data or notifications were submitted to external organisations as required. The information systems were secure. However, they were not always reliable or integrated well. The trust had recently appointed an experienced executive with specific responsibility for improving the management of digital data.

Most of the leaders we spoke with identified data and information management as a key area for improvement in the trust. Several of the trust risk registers identified data availability and/ or integrity as a key issue or gap in control against many principal risks. Leaders recognised there was a need to significantly improve this to both manage risk and to further the trust's ambition to lead on health inequalities within the care organisation footprints. Earlier this year, the trust created a new Chief Digital and Information Officer who commenced in post shortly before our well-led inspection. Despite being very new in post, we found they were well sighted on the range and depth of some of the issues and had identified their priorities in addressing them. These included an assessment of the governance, team structures and capabilities within the digital and information portfolio.

There were several factors which impacted on the quality of data and information. For example, only one of the trust hospitals operated an electronic patient record. The legacy Pennine Acute Trust Hospitals still used predominantly paper-based systems to manage patient information. This meant that a significant amount of data collection for quality, performance and risk monitoring was collected manually by staff. We found some examples where the method of collection and format of the data collected differed between the hospitals and thus impacted on the integrity of the data overall. For example, some hospitals collected and presented data about equipment and clinical audits differently. The trust produced performance scorecards for each care organisation, some senior leaders acknowledged the data within these sometimes needed to be manually 'sense checked' to understand whether they were accurate.

As part of our inspection of core services, we requested data and information relating to safety, quality and performance. The data supplied by the trust was sometimes incomplete or presented in a way which made it difficult to evaluate. This meant the trust could not be assured the data was accurate and complete and made it difficult to measure safety, quality and performance effectively. For example, resus trolley audits were difficult to interpret in terms of audit frequency and compliance across each hospital.

In some instances, the trust was able to provide data for some hospitals but not others. For example, we found that the trust was not able to provide compliance figures for sepsis training at one of its hospitals. This was because the trust had not yet aligned the electronic staff record training requirements for staff at Salford Royal Hospital to those at the other hospitals (or vice versa) following the acquisition in October 2021. Given the difficulties we experienced in accessing and interpreting core service data as part of the inspection, we were not assured that leaders had enough good quality data to properly identify some quality and safety issues.

The trust operated different systems for tracking patients on some waiting lists across the trust. Some lists were managed by a central team; however, some teams managed these manually at department level. During our routine monitoring of the trust prior to the inspection, we found examples where patients had been lost to follow up due to errors in the manual tracking process.

In March 2022 the trust declared a serious incident within the specialist medicines department at Salford Royal Hospital. Team members identified that the excel based report used to manage the list of patients waiting for a particular procedure was not accurately reporting the number of patients waiting. This was found to be due to a difference between some of the patient codes entered by frontline staff being different from those built into the report by the corporate information team. The incident caused 261 patients to be lost from the waiting list for a period. The trust has since reviewed other relevant reports to ensure the issue had not been replicated elsewhere and taken further actions to

improve waiting list surveillance whilst they plan the implementation of longer-term digital solutions. The trust also completed a review of patient harm following this incident and found that two of the 261 patients had suffered harm as a result. This was because most patients were not on urgent care pathways and would have waited a significant amount of time to be seen, consistent with national NHS waiting list delays.

On 18 May 2022 the trust experienced a major failure of some of its key information systems which affected three of the four care organisations. As a result, a critical IT incident was declared. The trust announced the issues were fully resolved on 20 June 2022. The failure disrupted diagnostic, pathology and pharmacy services, and referral pathways from GPs and primary care services. During the downtime, staff used manual systems to transfer important information and maintain services. Staff at all levels in the trust highlighted the need to upgrade systems to improve reliability, performance and compatibility. The recently appointed Director of Digital reflected on issues with the existing IT infrastructure and offered an honest appraisal of the resources required to generate the improvements needed.

During our core service inspections, we found patient records were not always accurate and did not always follow the record keeping standards for doctors, nurses and allied health professionals. This was also evident within data provided to us by the trust. For example, the trust's most recent Mental Capacity Audit data showed that documentation of best interests meetings and decisions was poor across the trust. Core service inspectors found both electronic and paper records were stored securely and only accessed by authorised personnel.

Data, where available, was starting to be used to highlight and address health inequalities, for example, access to bariatric services had been analysed used indices of multiple deprivation which indicated that patients from the most deprived areas were less likely to access services.

Pharmacy information management

The trust was installing new and upgraded prescription tracking software across the trust to support more standardised and reliable data collection. The pharmacy department was also seeking Power BI support to improve reporting, as the trust moves towards a single (mirrored) electronic medicine prescribing and administration system.

Engagement

Leaders did not always actively and openly engage with patients and staff to plan and manage services. However, they had plans in place to improve these. The trust engaged with external stakeholders and local partners to help improve services for patients.

Patient engagement

The trust was working to its 'NCA plan to deliver person-centred care', support and treatment (2019-2024)' plan, which was introduced to replace the patient experience strategies used by Salford Royal Hospital NHS and Pennine Acute Hospitals Trusts. The plan was a short document developed through joint working with people with lived experience who accessed trust services including, patients, service users, carers, key stakeholders and staff.

The patient and service user experience and volunteer team had identified the need to develop a comprehensive and co-designed strategy to incorporate statutory guidance recently published by NHS England; Working in Partnership with People and Communities. They were also keen to ensure the strategy aligned with other relevant new strategies such as the quality improvement strategy which was due to be completed in September 2022.

Our findings

We saw the team had presented their proposal for the new strategy to the group executive quality committee in September 2022 which included six core themes for the strategy and a timeline for completion. The proposal also provided an update on the work of the service user collaborative around co-production and a celebration event due to be held at the end of September 2022. They also planned to produce a new patient experience champions charter in collaboration with staff.

Staff engagement

The trust used a range of mechanisms to engage and communicate with staff. The Equality and Diversity and Inclusion (EDI) group, and the people with specialist interests which contributed to it, were regularly consulted regarding proposals for change. Representation within the group was drawn from a range of disciplines across the four care organisations. Each representative had a particular area of interest or specialism which they used to consider proposals and respond to concerns from a number of perspectives for both patients and staff. The group included representation from; staff with disabilities, staff from the BAME community and other groups with protected characteristics.

The group actively engaged with local and national networks. It was sufficiently mature and confident to comment and challenge the trust in areas such as culture and bias. For example, members of the group reported an issue with the under-representation of BAME staff at middle-management levels. This led to a change in recruitment practice which had a positive impact. The group also cited work with system partners to reduce health inequalities as an example of positive impact. Members of the group expressed increased confidence in working with the executive team. They noted the increased attendance of executives at staff network meetings. However, they shared examples where inequality was still evident across the trust. For example, in relation to the disproportionate level of disciplinary procedures for staff from some minority groups.

The trust had a staff experience team which was established in October 2020. Understandably, the team's work focused predominantly on staff wellbeing throughout the first year of the COVID-19 pandemic. More recently they began work on wider projects such as women's wellbeing, flexible working and reward and recognition.

The team planned to take a layered approach to reward and recognition for staff. They were conscious there had been different approaches to this between care organisations and did not want staff to feel they were losing something through new the corporate approaches. However, they planned to implement some trust-wide initiatives such as to formal 'thank you' mechanisms, employee of the month and award ceremonies. They also wanted to continue to promote the trust's SCARF (Supporting, Caring, Assisting, Recognising our NCA Family) programme. Leaders told us they were also working closely with staff side to understand how best to support colleagues on long-term sick.

A key mechanism for staff to raise personal and professional issues was through the annual appraisal cycle. However, during our inspection of core services, we found that staff appraisals were overdue in several teams across the trust.

The people committees told us they used the results of the most recent NHS staff surveys to inform the various people projects. However, they were mindful the survey was completed prior to the acquisition of Pennine Acute Trust and therefore the feelings of staff may have changed significantly.

The trust engaged with trade union representatives of nursing and ancillary staff over matters of individual performance and discipline. They were also formally engaged in discussions about concerns and proposals for the care organisations

and the wider trust. The trade union representatives we spoke with highlighted a recent improvement in communication and engagement with executives. There were regular documented meetings with broad representation from the trust. However, we were told the minutes of these meetings were often delayed, actions arising were not always accurately recorded and communication was inconsistent.

System collaboration

The trust was an active partner in the local health and social care system. We saw evidence of effective partnership working and resource sharing with other trusts and primary care services in the area. For example, the trust provided the facilities for the management of maternity services managed by a different trust. The trust regularly met with system partners to discuss priorities and concerns and plan for effective responses across Greater Manchester. For example, leaders told us about the work they were doing with system partners to improve delayed discharges and look at diversion pathways to improve access and flow.

Care organisations had developed strong partnerships at place level to support local people. For example, Rochdale care organisation worked with local charities to develop initiatives to support patients who may have experienced domestic violence.

Pharmacy engagement

The trust Group Director of Pharmacy was engaged with the Greater Manchester Health and Social Care partnership workstreams relating to medicines optimisation. The trust had adopted the CQUIN indicator for referral into the community pharmacy NHS discharge medicines service (DMS). The DMS aims to reduce avoidable patient harm and readmissions caused by medicines by supporting medicines reconciliation for patients discharged from hospital. However, the DMS service was only live at Salford Royal Hospital.

Pharmacy teams worked within the community, intermediate care homes, care homes and in the Salford GP practices helping to foster good links with primary care. Pharmacy staff in community services were part of the 'Home First' team, supporting patients in their own homes to take medicines safely. Home First worked across acute and community teams to provide community-based care and reduce unnecessary hospital stays.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research. Improvement projects were at various stages of development and completion across the trust. The trust reported and investigated complaints and incidents however, these were not always completed in a timely manner and learning was not always shared with relevant departments across the trust.

Complaints

The trust had a complaints and patient advice and liaison service (PALS). The service covered all four of the trust's acute hospitals and provided advice and information to patients, their families or carers and managed complaints. During our review of the trust's complaints function, we saw complaints were received from a variety of sources which indicated that the complaints and PALS team were accessible, and that people knew how to complain. However, this data reflected formal complaints to the trust, and therefore did not consider how well frontline staff were handling feedback at a local level.

The trust told us that all PALS staff were provided with local training and were supervised within the role for several weeks to ensure competency. They told us that the PALS team had delivered Communication, Attitude, Responsiveness, Evidence (CARE) training to some frontline staff through ward huddles in 2021 but the information provided did not capture who or how many staff were trained. The trust did not have a complaints handling e-learning package in place at the time of our inspection. However, the trust told us that a package was in development and expected to be completed in January 2023.

The trust had a complaints handling policy in place at the time of our inspection. However, the policy was past its review date of 15 March 2022 and a six-month extension to the review date had been approved and applied. As a result, the trust's complaints policy did not reflect best practice guidance such as the Parliamentary Health Service Ombudsman's (PHSO) NHS complaints standards 2021. The guidance referenced within the trust policy dated back to 2014 and before.

The trust policy stated that formal complaints should be responded to in writing within three working days, and that a written response will be provided within 25 days or 60 days where the complaint was complex or the subject of an incident investigation. The trust provided data which showed that between January and August 2022 the trust received a total of 998 formal complaints, an average of 125 per month. As expected, the bigger trust hospitals received a higher volume of complaints. We did not see evidence that any hospital or month saw a significant spike or reduction in complaints across this timeframe. However, trust data showed the trust only met its 90% target for complaints closed within timescales in one month between January and July 2022. Trust data showed that the department received 3,153 other enquiries during this timeframe, however it did not differentiate how many of these were handled as informal complaints.

During our inspection of well-led, we reviewed a sample of six complaint files. The complaints response letters offered an apology to people for having to complain and for the delayed response where appropriate. However, in some cases, we noted that there was no explicit apology for any lapse in care identified. Our review acknowledged that delays in responses to complaints may be related to a backlog of complaints following the COVID-19 pandemic.

The trust had commissioned an independent review into the complaints function at the trust. The review identified several issues and recommended a widespread programme of improvement was required. We saw the results of the review were presented to the group executive quality committee in June 2022 and an improvement programme had been agreed. The plan identified five phases for improvement: internal engagement, architecture development, collaboration and intelligence, training and monitoring and governance.

Serious incidents

The trust identified, reported and investigated serious incidents in line with the NHS serious incident framework. However, these were not always completed within the required timescales.

The trust provided data which showed they had completed 118 serious incident investigations in the six months prior to our inspection. Of these, 62 were signed off within the recommended 60 days, 56 were not. Of the 56 not signed off within the timescale, 22 were less than ten days overdue. There was a need to improve compliance in terms of the length of time for investigations to be completed. However, we acknowledged that some delays were outside of the trust's control.

We reviewed a sample of six serious incident files from across the four care organisations. We found the investigations met NHSE guidelines and, overall, the investigations were sufficient to identify appropriate root causes of the incidents.

The investigation reports did not identify the level of harm caused or whether duty of candour was completed. However, these were captured within the trust's incident management system. The reports included an action plan to support learning from incidents. The reports were not updated to show when actions were completed, however evidence of completed actions was uploaded to the incident management system.

None of the investigations we reviewed were independent. We found that each care organisation investigated their own incident, and this was often completed by the individual department where the incident occurred.

The trust had a variety of mechanisms for sharing learning such as through daily huddles, team meetings, 'take five' learning bulletins and newsletters. We saw evidence that learning from these incidents had been shared, however this was also within the care organisation the incident related to. During our inspection, some senior staff told us some learning from incidents was shared across the whole trust, however they were not able to explain who or what determined this would happen.

Mortality Reviews

Mortality reviews were completed in accordance with accepted practice by a team of medical examiners. Each was suitably skilled and experienced for the role. Medical examiners maintained an appropriate degree of distance and formality to ensure impartiality if they were required to assess a case involving a colleague. The criteria for completion of a review were not always clear. For example, in one case a patient died immediately following surgery. Policy indicated a requirement for a structured judgement review (SJR) as a minimum. Neither an SJR nor a mortality review was completed. Mortality reviewers sat under the trust-wide patient safety governance structure. Staff told us this promoted consistency in their approach and reporting. As part of the inspection we sampled seven mortality reviews. Each was completed to an appropriate standard and identified areas of learning for dissemination across the trust. The mortality reviewers we spoke with stated they received support from the executive, and this had improved opportunities to share learning.

Talent management

The trust was at the start of rolling out its new accelerated leadership programme. The programme had four key pillars; care, collaborate, deliver and inspire. Which were broken down into the overarching responsibilities of leaders to; promote culture and wellbeing, ensure services are well-led, deliver service improvement and to develop themselves and their teams.

The programme offer was tailored to leader's positions within the organisation starting at a level three apprentice offer for team leader roles up to a senior leadership level programme. The organisational development team told us they had plans to build clinicians' revalidation into the programme and they had also introduced psychometric testing before and after the programme to capture its impact.

At the time of our inspection the trust was delivering the programme to 400 leaders across the organisation and planned to deliver this to 1,400 others within the next 12 months.

All the senior leaders we spoke with were enthusiastic about the programme and the potential for it to support succession planning within the trust.

Quality improvement

Our findings

The new director of quality improvement (QI) commenced in post at the end of August 2022 but had previously worked in the QI team for Salford Royal NHSFT. They acknowledged that QI work had taken a backseat during the COVID-19 pandemic but a robust plan had been developed to refamilarise and promote QI with frontline staff over the next year. They were in the process of developing a longer-term and refreshed QI strategy for the trust, the team were confident this would be championed by the Chief Executive at board level.

The QI team was largely directed corporately but had small teams of staff based within each care organisation. At the time of our inspection, the team were working with frontline staff on four concurrent QI programmes, one with each care organisation. The programmes centred around four pillars; harm, quality, leadership and service user collaboration and incorporated best practice methodology and resources from the institute of healthcare improvement.

The trust had seen positive outcomes from the projects carried out so far. For example, as a result of the nutrition and hydration harm programme carried out at Rochdale Infirmary, teams had seen a reduction in prescribing for urinary tract infections as well as improved MUST scores. MUST is a screening tool used to detect patients who are at risk from malnutrition. The frailty programme in Salford brought together groups of elderly care medical staff to collaborate on actions to improve outcomes for their patients.

The team were keen to ensure that learning from QI programmes was captured and shared across the whole trust. As well as using existing mechanisms to do this, the team were awaiting roll out of a virtual 'campus blackboard' platform purchased by the trust's education and development team to share learning with all staff. They had also proposed trust-wide steering groups focusing on harms such as nutrition and hydration and pressure ulcers.

The team were committed to raising the profile of QI through the development of QI coaches within frontline staff teams and increasing their input at care organisation and group risk and assurance committees.

Research and innovation

Although the NCA was only recently formed, the trusts which joined to create it had a history of research and innovation. The trust was actively researching the impact of health inequalities in the region and seeking to address them in partnership with other health and social care providers. At the time of the inspection the trust was working in partnership with three local universities and other independent specialist organisations. Their Centre for Clinical and Care Research aimed to provide a foundation for Nurses, Midwives, Allied Health Professionals, Pharmacists and Healthcare Scientists to gain the skills and confidence to become research leaders. The Geoffrey Jefferson Brain Research Centre was a project run in conjunction with the University of Manchester and the Manchester Academic Health Science Centre. It maintained a focus on discovery science and experimental medicine. Other current fields of research included; cancer, stroke, surgery, anaesthesia and dementia. Innovation and developments arising from research projects were regularly subject to clinical trials at the trust.

Key to tables

Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	➔➔	↑	↑↑	↓	↓↓

Month Year = Date last rating published

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires Improvement ↓ Dec 2022	Requires Improvement ↓ Dec 2022	Good ↓ Dec 2022	Requires Improvement ↓↓ Dec 2022	Requires Improvement ↓↓ Dec 2022	Requires Improvement ↓↓ Dec 2022

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Salford Royal Hospital	Requires Improvement ↓ Dec 2022	Requires Improvement ↓ Dec 2022	Good ↓ Dec 2022	Requires Improvement ↓↓ Dec 2022	Requires Improvement ↓ Dec 2022	Requires Improvement ↓↓ Dec 2022
Fairfield General Hospital	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
Rochdale Infirmary	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
Royal Oldham Hospital	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
Overall trust	Requires Improvement ↓ Dec 2022	Requires Improvement ↓ Dec 2022	Good ↓ Dec 2022	Requires Improvement ↓↓ Dec 2022	Requires Improvement ↓↓ Dec 2022	Requires Improvement ↓↓ Dec 2022

Ratings for the trust are from combining ratings for hospitals. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for Salford Royal Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Requires Improvement ↓ Dec 2022	Good →← Dec 2022	Good →← Dec 2022	Requires Improvement ↓↓ Dec 2022	Good →← Dec 2022	Requires Improvement ↓ Dec 2022
Services for children & young people	Good Mar 2015	Good Mar 2015	Good Mar 2015	Good Mar 2015	Requires improvement Mar 2015	Good Mar 2015
Critical care	Good Aug 2018	Good Aug 2018	Outstanding Aug 2018	Good Aug 2018	Good Aug 2018	Good Aug 2018
End of life care	Good Mar 2015	Good Mar 2015	Outstanding Mar 2015	Outstanding Mar 2015	Outstanding Mar 2015	Outstanding Mar 2015
Surgery	Requires Improvement ↓ Dec 2022	Requires Improvement ↓ Dec 2022	Good →← Dec 2022	Requires Improvement ↓ Dec 2022	Requires Improvement ↓ Dec 2022	Requires Improvement ↓ Dec 2022
Urgent and emergency services	Inadequate ↓↓ Dec 2022	Requires Improvement ↓ Dec 2022	Requires Improvement ↓ Dec 2022	Requires Improvement ↓ Dec 2022	Requires Improvement ↓ Dec 2022	Requires Improvement ↓ Dec 2022
Outpatients	Good Aug 2018	Good Aug 2018	Good Aug 2018	Good Aug 2018	Good Aug 2018	Good Aug 2018
Overall	Requires Improvement ↓ Dec 2022	Requires Improvement ↓ Dec 2022	Good ↓ Dec 2022	Requires Improvement ↓↓ Dec 2022	Requires Improvement ↓ Dec 2022	Requires Improvement ↓↓ Dec 2022

Rating for Fairfield General Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Requires Improvement ↓ Dec 2022	Requires Improvement ↓ Dec 2022	Good ↓ Dec 2022	Requires Improvement ↓↓ Dec 2022	Requires Improvement ↓ Dec 2022	Requires Improvement ↓↓ Dec 2022
Critical care	Requires improvement Feb 2020	Good Feb 2020	Good Feb 2020	Good Feb 2020	Requires improvement Feb 2020	Requires improvement Feb 2020
End of life care	Good Feb 2020	Good Feb 2020	Outstanding Feb 2020	Outstanding Feb 2020	Good Feb 2020	Outstanding Feb 2020
Outpatients and diagnostic imaging	Good Aug 2016	Not rated	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016
Surgery	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018
Urgent and emergency services	Requires Improvement ↓ Dec 2022	Requires Improvement ↓ Dec 2022	Good →← Dec 2022	Requires Improvement ↓ Dec 2022	Requires Improvement ↓ Dec 2022	Requires Improvement ↓ Dec 2022
Overall	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated

Rating for Rochdale Infirmary

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Good Feb 2020	Good Feb 2020	Good Feb 2020	Good Feb 2020	Good Feb 2020	Good Feb 2020
Outpatients and diagnostic imaging	Good Aug 2016	Not rated	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016
Surgery	Good Feb 2020	Good Feb 2020	Good Feb 2020	Requires improvement Feb 2020	Good Feb 2020	Good Feb 2020
Urgent and emergency services	Good Feb 2020	Good Feb 2020	Good Feb 2020	Good Feb 2020	Good Feb 2020	Good Feb 2020
Maternity	Requires Improvement Dec 2022	Not rated	Not rated	Not rated	Requires Improvement Dec 2022	Requires Improvement Dec 2022
Overall	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated

Rating for Royal Oldham Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Requires Improvement ↓ Dec 2022	Requires Improvement ↓ Dec 2022	Good →← Dec 2022	Requires Improvement ↓ Dec 2022	Requires Improvement ↓ Dec 2022	Requires Improvement ↓ Dec 2022
Services for children & young people	Requires improvement Mar 2018	Requires improvement Mar 2018	Good Mar 2018	Requires improvement Mar 2018	Requires improvement Mar 2018	Requires improvement Mar 2018
Critical care	Good Feb 2020	Good Feb 2020	Good Feb 2020	Good Feb 2020	Good Feb 2020	Good Feb 2020
End of life care	Good Feb 2020	Good Feb 2020	Outstanding Feb 2020	Outstanding Feb 2020	Good Feb 2020	Outstanding Feb 2020
Maternity and gynaecology	Requires improvement Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018
Outpatients and diagnostic imaging	Requires improvement Aug 2016	Not rated	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016
Surgery	Requires Improvement ↓ Dec 2022	Requires Improvement ↓ Dec 2022	Good →← Dec 2022	Requires Improvement →← Dec 2022	Requires Improvement ↓ Dec 2022	Requires Improvement ↓ Dec 2022
Urgent and emergency services	Requires Improvement →← Dec 2022	Requires Improvement ↓ Dec 2022	Good →← Dec 2022	Requires Improvement →← Dec 2022	Requires Improvement ↓ Dec 2022	Requires Improvement →← Dec 2022
Maternity	Requires Improvement Dec 2022	Requires Improvement Dec 2022	Good Dec 2022	Good Dec 2022	Requires Improvement Dec 2022	Requires Improvement Dec 2022
Overall	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated

Rating for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community dental services	Good Aug 2018	Good Aug 2018	Good Aug 2018	Good Aug 2018	Good Aug 2018	Good Aug 2018

Overall ratings for community health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Fairfield General Hospital

Fairfield General Hospital
Rochdale Old Road
Bury
BL9 7TD
Tel: 01612065646
www.northerncarealliance.nhs.uk

Description of this hospital

Northern Care Alliance NHS Foundation Trust was formed on 1 October 2021 when Salford Royal Hospital NHS Foundation Trust legally acquired Pennine Acute Hospitals NHS Foundation Trust.

The trust has four hospitals – Salford Royal Hospital, Royal Oldham Hospital, Fairfield General Hospital and Rochdale Infirmary which provide a full range of acute services, including acute medicine, urgent and emergency care, acute frailty units, rehabilitation services, dental services and surgical services, to a population of approximately 1 million people. The trusts had been working in partnership from 2016 until the acquisition. This included a shared executive leadership team.

When a trust acquires another trust in order to improve the quality and safety of care we do not aggregate ratings from the previously separate trust at trust level for up to two years. The ratings for the trust in this report are therefore based only on the ratings for Salford Royal Hospital and our rating of leadership at the trust level.

Our normal practice following an acquisition would be to inspect all services run by the enlarged trust. However, our usual inspection work has been curtailed by the COVID-19 pandemic.

At Northern Care Alliance we inspected only those services where we were aware of current risks. We did not rate the hospital overall.

In our ratings tables starting on page 30 we show all ratings for services run by the trust, including those from earlier inspections and from those hospitals we did not inspect this time.

Medical Care

We rated it as requires improvement because:

- The service provided mandatory training in key skills but not all staff completed it, this was particularly evident for resuscitation training. The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff did not always identify patients at risk of deterioration. The service did not always have enough nursing and medical staff to keep patients safe from avoidable harm and to provide the right care and treatment.

Our findings

- There was limited evidence that the medical division monitored the effectiveness of care and treatment and used the findings to make improvements and achieved good outcomes for patients. There were gaps in management and support arrangements for staff, such as staff appraisals.
- People could not always access the service when they needed it or received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards. Complaints were not always responded to within the timescales specified in the trust complaints policy.
- The service did not have a fully developed or implemented vision and strategy at the time of our inspection.

However:

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff used equipment and control measures to protect patients, themselves and others from infection. Records were clear, up-to-date, stored securely and easily available to all staff providing care. The service used systems and processes to safely prescribe, administer, record and store medicines. Staff recognised and reported incidents and near misses.
- The service provided care and treatment based on national guidance and evidence-based practice. Staff gave patients enough food and drink to meet their needs and improve their health. Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. Key services were available seven days a week to support timely patient care. Staff supported patients to make informed decisions about their care and treatment.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.
- The service planned and provided care in a way that met the needs of local people and the communities served. The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.
- Leaders had the skills and abilities to run the service. They were visible and approachable in the service for patients and staff. Staff mostly felt respected, supported and valued. The service promoted equality and diversity in daily work and provided opportunities for career development. Leaders operated effective governance processes throughout the service. Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services.

Urgent and emergency services

- The service did not always have enough nursing staff and support staff with the right qualifications, skills, training, and experience to keep patients safe from avoidable harm and to provide the right care and treatment.
- The children's emergency department did not have paediatric consultant or doctor cover in line with national guidance.
- Staff were experienced and qualified but did not always have right skills and knowledge to meet the needs of patients. This was because not all staff completed the required mandatory and job-related training.
- Not all staff completed training on how to recognise and report abuse. The service did not consistently control infection risk well. Staff did not consistently use equipment and control measures to protect patients, themselves, and others from infection.

Our findings

- Staff did not always monitor the effectiveness of care and treatment. Findings were not used to make improvements and achieve good outcomes for patients.
- The design, maintenance and use of facilities, premises and equipment did not always keep people safe.
- Staff did not consistently support patients to make informed decisions about their care and treatment.
- People could not access the service when they needed it and had to wait too long for treatment.
- Staff did not always give pain relief in a timely manner.

However:

- The service managed medicines well. Medicines including controlled drugs were safely stored with the trust's monthly audits showing good compliance.
- Managers monitored the effectiveness of the service and encouraged staff to complete mandatory training.
- Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families, and carers.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work.
- Staff felt respected, supported, and valued. They were focused on the needs of patients receiving care. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

Medical care (including older people's care)

Requires Improvement ↓↓

Is the service safe?

Requires Improvement ↓

Since we last carried out a comprehensive inspection of this service, it had become part of a newly formed NHS trust. As such we cannot compare previous ratings with this one. We rated safe as requires improvement.

Mandatory Training

The service provided mandatory training in key skills but not all staff completed it, this was particularly evident for resuscitation training.

Nursing staff and medical staff did not keep up to date with their mandatory training. At the time of our inspection, mandatory training compliance for staff within the medical division was 86% for nursing staff and 76% for medical staff. The trust target of 90% had not been achieved.

Senior leaders told us that releasing medical staff to complete mandatory training had been challenging due to staffing pressures. Library time slots had been created to allow staff to complete training.

The mandatory training was comprehensive and met the needs of patients and staff. The training covered topics such as infection prevention control, conflict resolution, fire safety, equality diversity and inclusion, health and safety and information governance.

Staff received life support training for adults and children. However, training compliance rates for basic life support (BLS) was 59%. The nursing staff compliance rate for immediate life support (ILS) was 48%. The medical staff compliance rate for advanced life support (ALS) was 64%.

Managers monitored mandatory training and alerted staff when they needed to update their training. However, some staff told us they did not always receive protected time to complete their training.

From 1 July 2022, all registered health care providers were required to ensure their staff received training in learning disability and autism, including how to interact appropriately with autistic people and people who have a learning disability. This training should be at a level appropriate to their role. At the time of the inspection, the NCA had not made completion of this training mandatory, and staff had not completed the necessary programme of learning as required. This meant staff may not have had the skills and knowledge to communicate effectively and provide safe care to these patient groups.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. However, not all staff had completed training on how to recognise and report abuse.

Safeguarding training compliance for level one and two adults and children was 88%. Nursing staff compliance for level three safeguarding adults and children was 75%. However, medical staff compliance was 59%.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. They knew how to make a safeguarding referral and who they could contact if they had concerns. A staff member told us they had identified a safeguarding concern for a patient who was admitted onto a ward. The staff member contacted the hospital safeguarding team and completed a digital referral form. The safeguarding team provided feedback to the staff member.

Safeguarding information was displayed on notice boards throughout the hospital.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Medical wards were visibly clean and we observed staff cleaning during our inspection. Cleaning records were up to date and demonstrated that all areas were cleaned regularly.

There were hand wash sinks across all the medical wards we visited including posters which displayed the correct hand washing technique.

Staff followed infection control principles including the use of personal protective equipment (PPE). There was adequate supply of masks, aprons and gloves. We observed staff wearing the correct PPE, and donning and doffing before entering and on leaving a patient's room.

PPE and hand hygiene compliance were monitored as part of monthly matron audits. From February to August 2022 PPE compliance across the medical wards was around 91%. For the same time period hand hygiene compliance across the medical wards was around 95%.

We observed the side rooms where patients were being treated for an infection, or were at risk of infection, had doors which could be closed. All doors were closed during the time of our inspection.

We observed staff and visitors to the ward areas being asked to wear masks and sanitise their hands on entry to the wards. PPE was available at the entrance of all wards and clinical areas we visited.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Staff used green 'I am clean' stickers to indicate equipment that had been cleaned and was ready for use.

Infection prevention and control level one training compliance was 92%. Nursing staff compliance for level two infection prevention and control training was above 87%. However, medical staff compliance was 68%.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe.

The service had enough suitable equipment to help them safely care for patients. We reviewed a sample of equipment such as defibrillators, suction machines and blood pressure monitors which had stickers to indicate that they had been serviced within the last 12 months. However, on the hyper acute stroke unit we found five pieces of equipment that were due for servicing in February 2022. Staff on the unit told us that the equipment had been serviced and the stickers had not been updated. During our inspection, the inspection team returned to the unit and the stickers had been updated.

Data from the June 2022 quality matron report showed that medical device compliance across the medical wards had decreased from 68% in March 2022 to 49% in June 2022.

Areas of the Acute Medical Unit (AMU) were cluttered with equipment. This was because the area that was used to store medical equipment had been turned into an escalation area for additional beds. Staff told us that the AMU environment was challenging due to limited space and lack of staff facilities. For example, there was one staff toilet in the whole unit. We were told that health and safety inspectors and fire inspectors had recently inspected the AMU and action plans had been implemented to support improvements.

The service did not always have suitable facilities to meet the needs of patients' families. For example, we were told that the patient relatives' room on ward 20 was often turned into an escalation area for additional beds.

Medical wards were made up of a mix of side rooms and same sex bays. A number of medical wards had side rooms and bays which were not visible from the nurse's station. Staff told us that bay nursing was used as this allowed for increased observation of patients who may be at risk of falls.

At the entrance to each ward there was a notice board which displayed staffing numbers for each shift, it also gave the names of the staff on duty. There were open and honest care boards which highlighted the number of days since the last fall incident, hospital acquired pressure ulcer and healthcare-associated infection.

Patients could reach call bells from their beds and call bells in the toilets and wash areas which were in suitable places for a patient to reach if they needed assistance. During our inspection we observed staff attending to patients promptly when a call bell had sounded.

Resuscitation trolleys were checked daily. We reviewed these checklists, and each had been completed appropriately. The resuscitation trolleys were correctly stocked, oxygen cylinders were full, suction machines and defibrillators were in working order.

On wards such as the hyper acute stroke unit there was specialist monitoring equipment which allowed for monitoring information to be displayed at a nurse's station to allow for remote monitoring.

Staff disposed of clinical waste safely. Sharps bins were clean, not overfilled and were partially closed when not in use. However, not all sharps bins we observed had been dated from the date they had first been used.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. However, staff did not always identify patients at risk of deterioration.

Staff used the nationally recognised national early warning scores (NEWS2) tool to identify deteriorating patients. NEWS scores were displayed on a screen at the nurses' station on each ward which also showed when they were due to be

repeated. This information was updated in 'real time'. However, staff we spoke with said patient observations were sometimes delayed due to staff shortages. National guidance states patients with a NEWS2 of one should have their observations reassessed between four and six hourly. On the acute respiratory care unit and AMU we saw delays to patient observations. These delays ranged between two and six hours.

Patients who scored a NEWS2 of six or above were automatically assessed for sepsis, staff understood the importance of recognising the signs of sepsis early and knew how to escalate a patient so that they would receive treatment quickly. Medical wards had posters which alerted staff to the sepsis screening tool and the urgency for antibiotics of patients who had shown red flags.

Staff were able to describe the process for escalation of a deteriorating patient. They would continue to monitor the patient and escalate to a doctor and the nurse in charge.

Staff completed sepsis training as part of their mandatory training requirements. Nursing staff and medical staff compliance within the medicine division was 90%.

Staff we spoke with knew about and dealt with any specific risk issues. Staff completed risk assessments for each patient on admission using a recognised tool, and reviewed this regularly, including after any incident. Risk assessments included falls, pressure ulcers and Waterlow.

Staff told us about the 'Take 5 Enhanced Patient Observation' (EPO) bundle. EPO is a process that is used for patients who are unable to maintain their own safety whilst in hospital and are at risk of coming to or causing harm to self or others. The bundle covered the patient assessment process, bay tagging and one to one supervision.

Staff carried out intentional rounding observations, however nursing staff told us that this was assessed on an individual basis and that patients could be reviewed more frequently when required. This meant that any changes to a patient's medical condition could be identified promptly and escalated appropriately. Patient records we reviewed confirmed this.

On the medical wards there was a patient board in each nursing bay which provided a clear oversight of their individual risks. For example, there was information relating to NEWS2, nutrition and hydration, position changes, and one to one status. There was a system for highlighting patients who had complex needs, for example patients living with dementia had a blue flower on their board.

Staff shared key information to keep patients safe when handing over their care to others.

Shift changes and handovers included all necessary key information to keep patients safe. We observed safety huddles and handovers where key information about patients on the wards was given to staff verbally and in written format including; patients at risk of falls or confusion, patients with pressure ulcers, diabetes management, nutrition and hydration and patients who had a 'do not attempt cardio-pulmonary resuscitation' (DNACPR) in place.

The service had 24-hour access to mental health liaison and specialist mental health support. Staff told us they would liaise with the mental health team to review patients who were at risk of suicide or self-harm.

Staff completed and arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide.

Medical care (including older people's care)

Nurse staffing

The service did not always have enough nursing and support staff to keep patients safe from avoidable harm and to provide the right care and treatment. However, managers regularly reviewed and adjusted staffing levels and skill mix and gave bank and agency staff a full induction.

The service did not always have enough nursing and support staff to keep patients safe. The number of nurses and healthcare assistants did not always match the planned numbers.

We reviewed the fill rates for registered nursing staff from March 2022 to July 2022 excluding May 2022 as the trust did not provide data for this month. The average day shift fill rate was 86% and the average night shift fill rate was 82%. Ward 8 consistently had the lowest fill rates across day shifts with the average shift fill rate reported at 79%. The AMU consistently had the lowest fill rates across night shifts with the average shift fill rate reported at 78%. We did see evidence that non-registered staffing had been increased when qualified nursing fill rates were low.

These figures included ward managers being counted as nursing staff, taking time away from their management duties.

Staff we spoke with stated that the medical wards often felt unsafe due to staff shortages. We were told that staff shortages had resulted in an increase in patient falls and hospital acquired pressure ulcers.

Staff were frequently moved from areas of specialty to meet skill mix requirements and to support the wards with the highest acuity level of patients when required.

The discharge unit was described as a medical ward and there were 16 inpatients on the unit at the time of our inspection. We were told that this number could increase if required. However, the unit did not have a staffing establishment and planned staffing numbers were for a discharge lounge which was significantly below requirements. During our inspection the discharge lounge had to be closed due to staff shortages.

Managers calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. Senior leaders told us the service conducted nurse staffing establishment reviews. The service had recruited two additional band 7 managers on AMU.

The lead nurse could adjust staffing levels daily according to the needs of patients. A lead nurse was allocated to manage staffing across the medical wards. A daily call was held with all ward managers to review staff numbers, patient acuity and patient safety.

The service had a hyperacute stroke unit which was used to care for patients for the first 72 hours following a stroke. During and after our inspection the trust told us the unit was staffed by a 1:4 nurse to patient ratio. This staffing was not in accordance with national guidance. However, the trust told us any patients who required a higher level of care were transferred to the high dependency unit and regularly reviewed.

The vacancy rate for nursing staff across the division was 13%. AMU had the highest number of vacancies, there were 16 registered nurse vacancies.

The staff turnover rate across the division was 11%.

The sickness rate across the division was 5%.

The service had high rates of bank nurses used on the wards. From February 2022 to July 2022 around 53% of shifts were filled via bank staff.

Managers made sure all bank and agency staff had a full induction and understood the service.

Medical staffing

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

The service did not always have enough medical staff to keep patients safe. We were told that filling medical staffing rotas was a challenge, and gaps were filled with regular locums and agency staff.

Senior leaders told us the hospital leadership team had not identified what the medical staffing requirements were for the hospital. However, a project manager had been appointed to benchmark the service at junior doctor, middle grade doctor and consultant level to identify requirements and help reduce the reliance on locum staff. We were told that there was around a 30% gap between the number of medical staff working at the hospital compared to what was required.

Staff we spoke with said there was not enough medical staff to provide care for the acuity of patients. Staff told us there was an over reliance on junior doctors.

The junior doctors we spoke with told us they received good support and could easily access middle grade or consultant support if needed.

The service always had a consultant on call during evenings and weekends. There was sufficient on-site and on-call consultant cover over a 24-hour period including cover outside of normal working hours and at weekends.

The vacancy rate for consultants was 23%. The vacancy rate for other medical roles within the division was 11%.

The staff turnover rate across the division was 19%.

The sickness rate across the division was less than 1%.

Records

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

Patient notes were comprehensive, and all staff could access them easily. Records consisted of both electronic and paper notes. During our inspection of the medical wards we looked at a total of 13 patient records, and we found that records were completed comprehensively by staff.

The electronic system contained relevant risk assessments bundles such as falls, nutrition, pressure ulcers and sepsis. Risk assessments had been carried out when patients had been admitted to the wards and do not attempt cardiopulmonary resuscitation forms (DNACPR) and deprivation of liberty safeguard (DoLS) forms had been completed correctly if needed.

When patients transferred to a different area of the hospital, there were no delays in staff accessing their records. Staff told us that all patient records were easily accessible.

Records were stored securely in lockable drawers. We observed staff checking cabinets were locked and secure when they had finished reviewing patient notes.

Electronic record systems were accessed through computers throughout the ward. These computers were username and password protected. Staff ensured that computers were locked when they were not attended.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Ward staff dispensed an average of 44% of discharge medicines without the need to send the prescription to pharmacy. This meant the average preparation time was approximately one hour. However, during our inspection we saw one patient had a six hour wait in the discharge lounge.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. Medicines reconciliation was completed by pharmacy staff and records showed the trust target of 50% in 24 hours following admission had been achieved. However, this target was not compliant with the current guidance National Institute for health and Care Excellence (NICE) guidance which indicates 100% of patients' medicines should be reconciled within 24 hours or sooner if clinically necessary. This meant staff could not always be assured they had a complete understanding of the medicines each patient took and the potential impact on their diagnosis and treatment.

Specialist pharmacists were available to provide guidance for staff and patients and trust procedures were on the intranet.

Staff stored and managed all medicines and prescribing documents in line with trust policy. Treatment rooms were secure, and we saw high risk medicines had been identified on one ward and had additional security in place. The trust's monthly safe storage of medicine audits showed good compliance improving from 87% in April 2022 to 95% in July 2022.

We saw that appropriate action was taken in response to medicine audits. For example, a recent trust antimicrobial audit (June 2022) showed 98% overall compliance with policy. However, one medical ward fell below standard for documenting a review of antimicrobial prescribing. Individual feedback and advice was provided to the ward by the trust pharmacy team to support improvement.

Staff followed current national practice to check patients had the correct medicines. We checked eight patient records and found records had sufficient details for appropriate prescribing and monitoring. However, we found discrepancies in one patient record regarding times and route of administration.

Staff used systems and processes to safely prescribe, administer, record and store medicines. However, the medicines management system was not aligned with other NHS trusts and was not integrated with primary care. This was work in progress.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. However, some staff had a lack of understanding when this should be actioned.

Medicines management training for nursing staff was 90%. However, medical staff compliance was 63%.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. 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. Managers ensured that actions from patient safety alerts were implemented and monitored.

All staff knew what incidents to report and how to report them. Staff we spoke with were able to give examples of incidents they had reported on the electronic reporting system. For example, there had been two reported hospital acquired pressure ulcer incidents on ward 8 in the last two months.

Staff raised concerns and reported incidents and near misses in line with trust policy.

From October 2021 to July 2022, 13 serious incidents were reported in relation to the medical division at Fairfield General Hospital. The most frequent type of incidents was sub-optimal care of a deteriorating patient (six incidents) and slips, trips and falls (three incidents).

From October 2021 to July 2022, the service had reported one never event. This was in relation to the administration of medication by the wrong route. 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.

Learning from incidents was shared with staff across the service and divisions through lead nurse, ward manager and governance meetings. Staff told us that incidents and learning were discussed during handovers and safety huddles.

There was evidence that changes had been made as a result of feedback. Learning from a recent incident on AMU had resulted in staff receiving training on central lines.

Staff understood the 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 'notifiable safety incidents' and provide reasonable support to that person. Staff we spoke with were aware of the term and the principle behind the regulation and could give examples of when the duty of candour would be applied.

Is the service effective?

Requires Improvement ↓

Since we last carried out a comprehensive inspection of this service, it had become part of a newly formed NHS trust. As such we cannot compare previous ratings with this one. We rated effective as requires improvement.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Medical care (including older people's care)

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Staff could view policies on the trust's intranet system and on the wards. Policies we reviewed were in date and had a review date.

The trust operated a central online policy hub. However, during our inspection of the core services, we found that some services were using legacy policies from the previous trusts or accessing a suite of policies separate to the central Northern Care Alliance hub. As part of our ongoing monitoring of the trust, and throughout the inspection, we found there was a need to align some legacy Salford and Pennine policies to ensure there were trust-wide versions that reflected national or best practice guidance where appropriate.

Patients who were thought to be having a stroke were assessed by the specialist stroke consultant or nurse in the emergency department or on the ward where they were admitted. Once they had been assessed, if a stroke was confirmed they went onto the stroke pathway and were automatically referred to therapy teams which included speech and language therapy, occupational therapy and physiotherapy.

Nurses on the acute stroke unit had received training in the National Institute of Health Stroke Score (NIHSS). This assessment tool is used to evaluate and document neurological status in acute stroke patients.

The endoscopy service was accredited by the Joint Advisory Group on gastrointestinal endoscopy.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. Staff were able to explain what mental capacity was and how they assessed for this. At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. During our inspection, we saw staff providing patients with food and drinks.

Staff fully and accurately completed patients' fluid and nutrition charts where needed.

Nutritional status boards were situated on all the wards we visited which included information about patients' dietary requirements such as if they were "nil by mouth" or required soft food.

Notice boards promoting the importance of nutrition and hydration were displayed on the wards that we visited.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Staff completed the Malnutrition University Screen Tool (MUST) for each patient, this screening tool is used to identify patients who are malnourished or at risk of malnutrition. The tool includes management guidelines which can be used to develop a care plan. If a patient scored high on the assessment, then staff would request input from the dietetics team.

Patients had choice of food they were given and there were optional menus for patients who had specific dietetic or religious requirements. The ward we visited had protected mealtimes, which allowed nurses and clinical support workers to be available to support patients who may need it.

Medical care (including older people's care)

Pain relief

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

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice.

Pain was assessed during a process known as intentional rounding, this is a structured process whereby nurses carry out regular checks of individual patients to address issues of positioning, pain and personal needs. For patients who were experiencing high levels of pain they would be reviewed more often if needed.

The hospital had a designated pain team and contact information was displayed on notice boards on the wards.

Patients we spoke with told us they had received pain relief soon after requesting it.

Staff prescribed, administered and recorded pain relief accurately.

Pain management information was displayed on notice boards on some of the wards we visited such as AMU.

Patient outcomes

There was limited evidence that the medical division monitored the effectiveness of care and treatment and used the findings to make improvements and achieved good outcomes for patients.

The service participated in some relevant national and local clinical audits. However, the senior leadership team told us that the medical division had not participated in several national clinical audits such as the national audit of dementia, bowel cancer, chronic obstructive pulmonary disease (COPD) and lung cancer.

The service submitted their audit data for the Sentinel Stroke National Audit Programme (SSNAP) (measures the quality and organisation of stroke care in the NHS). Between January and March 2022 inclusive, the overall patient centred SSNAP level was B out of a scale A to E, of which A is the best. This level had deteriorated from the previous quarter where the trust scored an A.

For patient centred and team centred indicators the trust maintained a score of A. However, on both indicators the stroke unit was rated E which was the worst score available. This suggested there was an issue with the flow around time getting onto the stroke unit. We were told that only around 50% of stroke patients got to the stroke unit within four hours of arrival at the hospital in the last quarter.

From the trust's most recent sepsis screening and treatment of inpatients audit data provided, it was shown that for patients who had red flagged for sepsis 100% had NEWS2 recorded within one hour of hospitals admission, 87.5% had received antibiotics within one hour of being diagnosed, 93% had a senior review and 91.3% of patients received intravenous fluids when required.

The medical wards had recently restarted participating in the Nursing Assessment and Accreditation System (NAAS) audits. These audits had been paused due to COVID-19. NAAS is the performance assessment framework to measure the quality of nursing care delivered by teams across the trust. NAAS audits covered topics such as; patient safety, environment safety, nutrition and hydration, safeguarding, pain management, medicines management, pressure ulcers, communication and infection control. Each ward or unit received a red, amber or green rating.

Hospitals measure the average number of actual nursing care hours spent with each patient per day. On average similar trusts spend 8.3 hours with patients per day and the national average is 8.1 hours per day. Across the medical division at Fairfield General Hospital nurses spent 8.79 hours per day with patients. On ward 8 this increased to 9.17 hours and on ward 21 this increased to 10.57 hours.

Managers shared and made sure staff understood information from the audits. Managers told us that information gained from audits would be shared through staff meetings and group emails.

Competent staff

The service made sure staff were competent for their roles. However, there were gaps in management and support arrangements for staff, such as staff appraisals.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.

Managers gave all new staff a full induction tailored to their role before they started work.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. For example, a staff member on AMU had progressed from their previous role to a patient tracker. Their role was to assist with the streaming of patients from AMU and to assist with patient discharges.

The practice-based educators supported the learning and development needs of staff. The hospital had practice-based educators in place who had assisted in the development in both newly qualified and international nursing recruits. The hospital had a band six nurse who worked closely with the international nurses and supported them in their role.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. If staff members were not able to attend a team meeting the meeting minutes were shared through group email, to allow staff the opportunity to keep up to date with any changes or learning which had been highlighted.

Managers made sure staff received any specialist training for their role. Stroke nurses were trained to offer thrombectomy (the removal of a thrombus (blood clot) under image guidance) and thrombolysis (treatment to dissolve dangerous clots in blood vessels) and had all the necessary equipment.

Managers identified poor staff performance promptly and supported staff to improve. For example, we were told there had been several reported pressure ulcer incidents on AMU, therefore a tissue viability nurse (TVN) had visited the ward to provide additional training.

We were told that the trust had recently changed the staff appraisal process. The staff appraisal focussed on five key elements including wellbeing, contribution, future, focus and development.

Managers did not always support staff to develop through yearly, constructive appraisals of their work. The data provided showed that 57% of staff across the medical division had received an appraisal in the last 12 months.

Managers did not always support nursing staff to develop through regular, constructive clinical supervision of their work. The data provided showed that 66% of nursing staff across the medical division had received an appraisal in the last 12 months.

Medical care (including older people's care)

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care.

The stroke unit held multidisciplinary team meetings which consisted of doctors, nurses, speech and language therapists (SALT), dieticians and allied health professionals such as physiotherapists and occupational therapists.

Staff we spoke with commented on the positive culture throughout the medical wards, they said they felt there was good team working across all clinical staff.

Staff referred patients for mental health assessments when they showed signs of mental ill health and depression. Staff knew how to contact the mental health team and told us the team would review a patient within 24 hours of a referral being made.

Patients had their care pathway reviewed by relevant consultants.

Seven-day services

Key services were available seven days a week to support timely patient care.

Consultants led daily ward rounds on all wards, including weekends. Patients were reviewed by consultants depending on the care pathway.

Speech and language therapy teams were available six days a week, for stroke patients who had been admitted at the weekend the SALT team had trained stroke nurses to carry out swallowing and dysphagia assessments so that stroke patients could get assessments in a timely manner.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week.

The stroke unit had nine stroke consultants who provided medical cover Monday to Friday. Consultants were on call at weekends and had a rota to attend on Saturday and Sunday to assess newly admitted stroke patients.

Therapy services such as physiotherapy and occupational therapy were provided seven days a week.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on the wards and units. Information leaflets were readily available for patients.

Staff assessed each patient’s health when admitted and provided support for any individual needs to live a healthier lifestyle.

Medical care (including older people's care)

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used measures that limit patients' liberty appropriately.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. We observed staff gaining informed consent before treatment or a procedure was carried out, such as taking blood samples.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. On ward 21 we saw example copies of best interest decision making records displayed on notice boards.

Staff made sure patients consented to treatment based on all the information available.

Staff clearly recorded consent in the patients' records. During our inspection we reviewed 13 sets of patient records. Patient consent had been obtained and documented correctly where appropriate.

We reviewed five DNACPR forms during our inspection, the forms were all completed correctly. The forms included information on a reason why the DNACPR had been put in place, if a discussion had been had with the patient and where the patient lacked capacity a discussion was documented with a family member.

Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them. Staff completed DoLS appropriately and once a DoLS had been initiated a referral would be made to the safeguarding team to make them aware of that patient.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff received training in the Mental Capacity Act and Deprivation of Liberty Safeguards. However, compliance data provided by the trust showed medical wards overall had a compliance of 75%.

Is the service caring?

Good 

Since we last carried out a comprehensive inspection of this service, it had become part of a newly formed NHS trust. As such we cannot compare previous ratings with this one. We rated caring as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed kind caring interactions between patients and staff. Staff explained to patients what they were doing when providing care and treatment.

Data from a patient survey showed that 100% of patients said they received help from staff when eating their meals.

Patients said staff treated them well and with kindness. Patients told us that communication was good and that staff knew a lot of information about their care and treatment which was shared with them. The patient survey showed that 78% of patients felt they were involved in decisions about their care and treatment.

We saw staff interact with patients who were living with dementia in a calm and caring manner.

Staff followed policy to keep patient care and treatment confidential. The patient survey showed that 89% of patients felt they were treated with respect and dignity. We did not witness any notes being left unattended and staff made a conscious effort to ensure records were locked away when not in use.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it and supported patients who became distressed in an open environment and helped them maintain their privacy and dignity.

The hospital had a chaplaincy service and a bereavement service which staff could access to provide support to patients and their relatives. The hospital had a 'Swan' team. The Swan model (sign, words, actions, needs) was used to support and guide the care of patients and their loved ones where they were being cared for at the end of life and after the patient has passed away.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

We saw comments on the AMU open and honest care board which included positive feedback from patient relatives regarding the exceptional end of life care provided by staff.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. Patients we spoke with during our inspection understood their treatment plans and were involved in decision making about their care. The patient survey showed that 89% of patients said staff gave their family, friends or carers all the information needed to help care for them.

The trust supported John's campaign, which supports the rights of people living with dementia to have a carer to advocate for them and be with them whenever they most need it.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Information on how to provide feedback was displayed on notice boards across the medical wards.

Patients gave positive feedback about the service. Thank you cards from patients and their families were displayed on the wards we visited.

Is the service responsive?

Requires Improvement 

Since we last carried out a comprehensive inspection of this service, it had become part of a newly formed NHS trust. As such we cannot compare previous ratings with this one. We rated responsive as requires improvement.

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

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the changing needs of the local population. The trust worked closely with community stakeholders, including commissioners and GP's to discuss any changes.

The service had wards with specialities such as cardiology, respiratory and endoscopy where staff with specialist skills were available including advanced nurse practitioners.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. All wards inspected were adhering to the guidance regarding mixed sex accommodation.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia. Staff described positive working relationships with the mental health liaison team and told us they were proactive in responding to requests for support and managers held regular meetings with the team.

The service had systems to help care for patients in need of additional support or specialist intervention. Appropriate notification systems were in place to 'flag' patients who had specific or complex needs.

The hospital had an integrated discharge team who supported patients with their discharge from hospital, where care and support needs had been identified. However, there were challenges for the provision of care in the community across the region, which impacted on staffs ability to discharge patients.

Medical care (including older people's care)

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Staff could access help and support from the learning disability and dementia teams. These teams provided support and training to staff for people with a learning disability, autism and dementia. Staff told us that these teams would come to the ward to advise on support needs.

The service made reasonable adjustments to allow additional visiting for some patients for example those in the last hours of their life, or who required a carer due to their condition. The service used signage to indicate if patients were at end of life and tried to provide a side room for them.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. The hospital had a blue flower scheme. A blue flower was placed on the board behind the bed for patients living with dementia.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. The trust had an interpretation and translation service which was available 24 hours a day, seven days a week.

Patients were given a choice of food and drink to meet their cultural and religious preferences.

We visited the discharge lounge where patients waited for transport after they had been discharged. Patients were offered hot and cold drinks and if there were long delays waiting for their transport then food was offered.

Staff praised the activity coordinators who were based on some of the wards we visited. Activities included; music reminiscing, gardening, board games and art and crafts. We observed the activity coordinators interacting positively with patients and providing cold refreshments due to the hot temperatures.

Access and flow

People could not always access the service when they needed it or received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards.

Managers did not always ensure that patients could access services when needed to receive treatment within agreed timeframes and national targets.

Data from quarter one in 2022/2023 showed that around 77% of cancer patients received treatment within two weeks of referral from their GP. This was below the national standard of 93%.

For the same time period around 35% of cancer patients received treatment within 62 days of referral from their GP. This was below the national standard of 85%.

Medical care (including older people's care)

NHS England data showed the trust treated 51.2% of patients within 18 weeks of referral in July 2022. This was below the national standard of 92%.

The AMU was open 24 hours, seven days a week and had access to medical cover. The purpose of the unit was to allow patients to be 'streamed' in a timely way from the emergency department and to help reduce admissions to the main wards. However, we found from inspecting the emergency department that the trust experienced regular ongoing challenges in admitting patients in a timely manner to AMU. Large numbers of patients waited hours in the emergency department to be admitted. For example, we saw 16 patients in the emergency department waiting for an inpatient bed.

We were told that patients sometimes stayed too long in AMU due to bed capacity constraints on the other wards. Trust data showed that from February 2022 to July 2022 the average length of stay on AMU was 2.5 days.

Bed management meetings were held three times per day. These were held online and included discussion on patient moves, discharge plans and use of escalation areas.

Senior leaders told us the patient with no criteria to reside list was monitored daily. In addition, there were weekly meetings to review those patients who had a long length of stay. At the time of our inspection we were told around 30% of patients were medically optimised to leave hospital but were unable to do so as they were waiting for further assessments or care packages.

From February 2022 to July 2022, the average length of stay for elective and non-elective admitted patients at the hospital was 4.2 days. However, we saw evidence of much longer lengths of stay on the wards we visited. We were told that patients could spend several weeks on the discharge unit.

Staff we spoke with told us the biggest challenges to discharging patients were those who required ongoing care in a nursing home or who needed complex packages of care. There was some difficulty in accessing providers who could accept these patients.

Staff did not always plan patients' discharge carefully. This was evident from the number of patient discharges between 5pm and midnight. Trust data showed that in July 2022, 791 patients were discharged from the hospital after 5pm.

Staff moved patients between wards at night. Trust data showed that from February 2022 to July 2022, there were 429 ward moves after 8pm within the medical division.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. However, complaints were not always responded to within the timescales specified in the trust complaints policy.

Patients, relatives and carers knew how to complain or raise concerns.

The service clearly displayed information about how to raise a concern in patient areas. The service had a patient advice and liaison service (PALS) and displayed information to direct patients how to make a complaint if they needed to.

From February 2022 to July 2022 the medical division at Fairfield General Hospital received 25 formal complaints and 98 enquiries via PALS. However, the division's compliance for responding to these complaints within the agreed time frame was 46%.

Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes. The outcomes from complaints was shared at the daily safety huddle meetings so that staff could learn and improve patient safety and experience.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Senior leaders told us about sharing the experience of people who have complained. They have recently brought people back to share their experiences with staff to enable them to identify what they could have done better.

Managers shared feedback from complaints with staff and learning was used to improve the service. For example, the acute stroke unit introduced pink communication sheets in patients records to indicate when the unit had last communicated with the patient's families and relatives.

Staff could give examples of how they used patient feedback to improve daily practice.

Is the service well-led?

Requires Improvement ↓

Since we last carried out a comprehensive inspection of this service, it had become part of a newly formed NHS trust. As such we cannot compare previous ratings with this one. We rated well-led as requires improvement.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The trust had four care organisations, which focussed on the geographical area each of the four hospitals served. Each care organisation was managed by a medical director, director of nursing, director of operations, HR director and finance director. Fairfield General Hospital was part of the Bury care organisation.

The division of medicine was split into emergency and urgent care, general medicine, specialist medicine, stroke and frailty and cardiology. Each division had a triumvirate leadership team with a divisional clinical director, a divisional managing director and a divisional director of nursing. Some teams also had a leadership role across the whole trust for specific service provision.

The hospital was developing their own leaders to provide career progression and succession planning. There were several training courses including the junior clinical fellow programme, leadership by all development programme and accelerated leader development programme.

Ward managers said that they were supported by the directors and assistant directors for the division. We were told that the divisional director of nursing regularly attended safety huddles on AMU. The triumvirate team completed weekly walkarounds to communicate with staff on the wards and increase visibility.

Medical care (including older people's care)

On the wards and units that we visited during the inspection we saw that there was strong clinical leadership from the ward managers and the lead nurses. Staff told us that they were supported and valued by these managers and they were proud of the work that they did.

The division had identified gaps in nursing and medical staffing. However, plans to retain and increase staffing were in the early stages.

Vision and Strategy

The service did not have a fully developed or implemented vision and strategy at the time of our inspection.

The trust had developed a vision and strategy for 2021 called 'Vision 10: NCA 10 Year Strategy' with the vision to be the safest and most effective organisation in the NHS and the place where people want to work. This strategy focussed on improving population health, caring for and inspiring people, improving quality, improving performance, supporting social and economic development and financial sustainability.

However, each directorate within the medical division was in the process of setting their own objectives in line with the ten-year strategy. Staff we spoke with during the inspection were not always clear about the current strategy and objectives of the division.

Senior leaders told us the aim for the Bury care organisation was to provide high and safe quality care for patients and look after their staff. Senior leaders were focussed on key risks such as recruitment and retention, maintaining staff health and wellbeing and delivery of key performance standards.

Culture

Staff mostly felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Most staff told us that the culture in the division was positive. They highlighted staffing as the main issue that impacted on their work and understood the challenges for their work areas and for the division. Team working was recognised as a strength and staff said that the pandemic had strengthened teamwork and how they valued each other.

Senior leaders told us that staff sickness was linked to anxiety and stress at work.

The trust had a staff support programme called 'SCARF' (which stands for Supporting, Caring, Assisting, Recognising the NCA Family). This was a support programme to help staff look after their physical, emotional and psychological wellbeing and to make it easier for staff to find access to practical resources and information. As part of the programme all staff were allocated four hours to take time away from work. Staff we spoke with were aware of the 'SCARF' programme, however they said it was difficult for them to be able to take their allocated hours due to staffing pressures on the wards.

Most staff told us they felt able to raise concerns with their line manager and most felt they were supported and encouraged to develop.

Senior leaders commented on the high levels of resilience shown by staff, they believed staff had risen to the challenges that had been presented over the last 12 months. All staff were seen to be keen to get involved in improvement of the service.

Medical care (including older people's care)

Staff were committed to improving care for patients and learning from when things went wrong.

Governance

Leaders operated effective governance processes throughout the service. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There were effective governance processes in place in the service. Leaders attended directorate, divisional and care organisation quality and performance meetings. The divisional governance meetings took place monthly and were led by the divisional managing director. We reviewed the minutes of a recent medical division governance and assurance meeting. These included key discussions around workforce, current risks, clinical effectiveness and performance issues in relation to each speciality area.

Ward managers in the division met every month and information from this meeting was communicated to staff.

Consultants from the acute medical unit and the emergency department attended joint monthly patient safety meetings to discuss, share and identify learning.

Team meetings were held on the wards and staff had the opportunity to add agenda items.

Staff we spoke with understood what their individual roles and responsibilities were, what they were accountable for and to whom they were accountable. Staff told us that they were provided with information relating to learning and performance via themes of the week, safety huddles and staff meetings.

Management of risk, issues and performance

Leaders and teams used systems to manage performance. They identified and escalated relevant risks and issues but actions to reduce their impact were not always effective.

There was a division risk register with actions and due dates. However, the large number of risks on the register made it difficult to effectively scrutinise and manage. There were five overdue risks on the services register, with review dates ranging from October 2021 to July 2022.

Senior leaders were able to verbalise their top risks which were access and flow, nursing and medical staffing and recent issues that had occurred within the silver heart unit. However, the issues relating to cardiology were not on the service risk register.

We were told that risk registers were reviewed on a quarterly basis and each directorate had the opportunity to provide an update on risk progress.

Senior leaders recognised they were behind in terms of submitting national audit data. There was limited assurance that the senior leadership team for the division was sighted on how the division was going to deliver the national audit data and drive improvements through these audits.

The service had issues with access and flow and delayed discharges and there was evidence of work ongoing within the division to make improvements.

Ward managers were aware of the risks in their areas of work and were able to verbalise these and the plans in place to mitigate these risks. Whilst staffing was an issue for ward managers, they told us about their risks specific to their ward which included pressure ulcers and falls. They had action plans in place to try to mitigate the risks.

The directorate teams within the division were in the process of going through the trust's Service Accreditation System (SAS) which was part of the high-performance management system programme. The system focussed on ensuring minimum core service standards/key performance indicators were being met, identifying high performing services and highlighting good and innovative practice and provide a platform for facilitating service integrated leadership.

Information Management

The service collected data and analysed it. However, some staff were not confident the data was always accurate. In addition, staff could not always find the data they needed in accessible formats to help them understand performance, make decisions and drive improvements. Data was not recorded or presented uniformly across the trust and some important data was not captured.

The information systems were secure. However, they were not always reliable or integrated well. On 18 May 2022 the trust experienced a major failure of some of its key information systems which affected Bury, Rochdale and Oldham care organisations. As a result, a critical IT incident was declared. The trust announced the issues were fully resolved on 20 June 2022. The failure disrupted diagnostic, pathology and pharmacy services, and referral pathways from GPs and primary care services.

The service had not participated in several national clinical audits meaning there was limited evidence to monitor the effectiveness of care and treatment.

Staff received training on information governance as part of their mandatory training, and the compliance rate across the medical division was 91%. Staff could access policies, procedures and clinical guidelines through the trust intranet site. Staff told us they could access patient information and up to date national best practice guidelines and prescribing formularies when needed.

Senior staff in the division used data to review performance of their wards. This provided oversight of patient safety and patient experience. Support could be given to areas where it was needed. This was disseminated to matrons and ward managers.

There was data available to ward managers that provided the outcomes of the ward accreditation outcomes. These formed the basis of the action plans for improvement for each ward which were monitored at division level.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Ward managers and lead nurses engaged with patients as part of the ward accreditation process. They used feedback to improve services.

The division used friends and family data for service improvement.

The trust worked with Healthwatch to monitor and understand service provision and to make changes as necessary.

The division worked with the local authority and other community partners to improve patient safety and patient experience.

Senior leaders told us there had been a focus on prevention of admission to the hospital. The trust had identified several adult social care providers that had been sending an increasing number of patients to the emergency department. Trust colleagues had done some work with these providers with support from a GP and this had reduced admissions.

The Bury care organisation worked closely with the other trust care organisations in relation to stroke, surgical and paediatric care pathways.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

There was a culture of learning in the division and we saw that staff at all levels wanted to improve services for patients and their relatives.

We saw that there were quality improvement projects taking place across the division and that staff were participating in these projects. They were using 'plan, do,study, act' cycles to support the quality improvement.

The ward accreditation process supported continual improvement to services.

Urgent and emergency services

Requires Improvement ↓

Is the service safe?

Requires Improvement ↓

Since we last carried out a comprehensive inspection of this service, they have become part of a newly formed NHS trust. As such we cannot compare previous ratings with this one. We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills including the highest level of life support training to all staff. However, the service did not always make sure everyone completed it.

Staff did not have the time to keep up to date with their mandatory training. The department was not always able to release staff to attend external training.

Data received from the trust indicated low compliance of staff in completing key elements of training, including basic life support (58%), paediatric basic life support (62%), and fire safety (46%).

The mandatory training was comprehensive and met the needs of patients and staff. Staff received core trust mandatory training. Staff did not always receive an induction upon commencement of their role.

Staff could access the support from a part time practice educator. Plans were in place to increase this service for staff.

From 1 July 2022, all registered health care providers were required to ensure their staff received training in learning disability and autism, including how to interact appropriately with autistic people and people who have a learning disability. This training should be at a level appropriate to their role. The service provided information that showed 14 members of staff across the department had completed training on learning disabilities and autism. This meant some staff may not have had the skills and knowledge to communicate effectively and provide safe care to these patient groups.

Staff completed mandatory equality diversity and human rights training and compliance was 91.6% for the division. However, clinical staff did not complete specific training on recognising and responding to patients with mental health needs and dementia. Managers monitored mandatory training and alerted staff when they needed to update their training. The service displayed the mandatory compliance rates in the staff area and individual mandatory training letters were accessible for staff.

Safeguarding

Staff mostly understood how to protect patients from abuse and the service worked well with other agencies to do so. However, not all staff had training on how to recognise and report abuse.

The department had a dedicated safeguarding nurse. Staff had access to safeguarding referral forms and had links to local safeguarding authorities and were aware how to report safeguarding concerns.

The percentage of staff who had completed adult safeguarding level two and three training was below the trust compliance of 90%, with level three being the lowest at 35%.

The percentage of staff who had completed child safeguarding level two and three training was below the trust's compliance of 90%, with level three being the lowest at 65%.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Safeguarding information was displayed in the department when entering the staff area, detailing who to contact. Victim support leaflets were available for patients and staff.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. Staff did not consistently use equipment and control measures to protect patients, themselves, and others from infection. They kept equipment and the premises visibly clean.

All areas were clean and had suitable furnishings which were clean and well-maintained. The department had regular domestic staff and saw regular use of the green 'I am clean' stickers throughout the department.

Signs around the department asked patients and visitors to wear face masks. However, this was not monitored or promoted by staff. We observed 13 patients in the waiting area, six wearing face masks incorrectly and two with no masks and nothing to identify them as exempt. COVID-19 screening was not being completed upon arrival to the department and patients were not segregated when suspected COVID-19 positive.

The emergency department did not have a designated area for patients who had been identified as positive for COVID-19. Patients who self-presented were screened before entering the department. Point of care testing was completed for patients and the result would be logged on the patient tracking system.

The Same Day Emergency Care Unit (SDEC) would not see patients until a negative point of care test had been received.

We saw hand washing facilities and alcohol hand gel at the entrance of each area and throughout the department. All staff followed 'bare below elbows' guidance. The service provided evidence of weekly hand hygiene audits for the service which showed compliance at 95% for March 2022.

The service had no cases of clostridium difficile between February and July 2022.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff were trained to use the equipment. Staff managed clinical waste well.

Patients could not always reach call bells. Patients cared for on the corridor did not have access to call bells. However, all patients were placed in direct line of sight of the nursing station and doctors' station.

The design of the environment did not follow national guidance. We reviewed the mental health assessment room and saw it did not meet the 2017 Psychiatric Liaison Accreditation Network (PLAN) Quality Standards for Liaison Psychiatry Services. This was because one of the two doors only opened outwards, and a notice board was displayed in the room. Guidance states that doors should open outwards or both ways to enable staff to enter and exit the room quickly.

The design of the environment did not allow for patients' privacy and dignity to be maintained at all times. The department was restricted in size. The department, at busy times, therefore relied upon the use of corridors to hold patients.

The department had a separate, suitably furnished and designed paediatric waiting area with murals and children's furniture and a baby changing room.

The paediatric department did not have a suitable mental health assessment room and a cubicle was used. The cubicle did not meet the 2017 Psychiatric Liaison Accreditation Network (PLAN) Quality Standards for Liaison Psychiatry Services.

The department had a five bedded resus area with an additional three cubicles in the majors area.

The service had six see and treat cubicles in the department, three cubicles in a designated area, two cubicles in the waiting area and one in the paediatric department. The areas were not always suitable as staff and patients could be overheard when treatment was being given.

The department had good links to Electrical and Biomedical Engineering (EBME). Staff told us that requests for replacements, additional equipment and repairs were responded to quickly.

The department was advertising to recruit a designated housekeeper who would oversee stores and stock. We undertook a sample of stock in SDEC and all items were in date.

We checked resuscitation equipment in the paediatric area and SDEC. They were stored in line with Resuscitation Council (UK) guidelines with the drawers sealed with a tamper evident tag. Following the inspection, the annual audit data provided for resus trolley audits showed the department passed in January 2022.

Staff disposed of clinical waste safely. Clinical waste bins were clearly marked and locked.

Assessing and responding to patient risk

Staff completed risk assessments for each patient. They removed or minimised risks and updated the assessments. Staff identified and quickly acted upon patients at risk of deterioration.

Staff used a nationally recognised tool to identify deteriorating patients. Staff used a tool in triage called NEWS2 to assess deteriorating patients at risk of sepsis.

Staff demonstrated understanding of the sepsis tool and followed the sepsis six. Sepsis is a life-threatening reaction to an infection. It happens when the immune system overreacts to an infection and starts to damage the body's own tissues and organs. The service incorporated sepsis inpatient screening tools within the patient records and we saw evidence of this being completed where required.

Urgent and emergency services

Walk in patients were seen by a streaming service operated externally. Patients were assessed upon arrival and triaged to either the emergency department, urgent treatment centre or SDEC. Staff told us the streaming process was not always effective. They reported that patients were on occasions directed incorrectly.

Handover between nursing staff took place daily. The nursing handover had all relevant information including psychosocial needs, allergies, treatment plan and nutrition and hydration. We observed daily nursing safety huddles where relevant information was shared.

We observed the nurse in charge handover which covered all of the relevant information and any organisational updates shared.

Handover between medical staff took place at shift change. The handover was comprehensive and covered all patients and key information.

We saw relevant risk assessments recorded in patient records including falls, delirium screening, and pressure care. Patient allergies were recorded in all records reviewed.

Staff were not always recording intentional rounding, we observed this in two out of five records.

Staff completed, or arranged, psycho-social assessments and risk assessments for patients thought to be at risk of self-harm or suicide. The service had 24-hour access to mental health liaison and specialist mental health support.

We observed pre-alerts were directed straight to resus from the ambulance. A suspected stroke patient was brought in by ambulance and onto a stroke pathway in resus. There was a prompt and efficient handover to two doctors and a nurse within four minutes of arrival and the ambulance crew were released.

Nurse staffing

The service did not always have enough nursing staff and support staff with the right qualifications, skills, training, and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix and gave bank and agency staff a full induction.

The service did not always have enough nursing and support staff to keep patients safe. The department had access to one triage nurse assigned 24 hours a day seven days a week. The department had a record of planned staffing figures for nurses and support workers which varied according to the shift. However, staff told us that an agreement had been reached previously to increase staffing levels to 13 nurses, two nursing assistants and six support workers on all shifts. However, this was not reflected in the documentation we saw. We were told recruitment to the additional roles was in progress. We were also told gaps in the rota were filled by regular agency staff to provide consistency and familiarity with practice in the department. Inconsistencies in staffing information meant we were unable to determine if the department was always safely staffed.

The department did not always deploy sufficient staff in resuscitation. The department had a five bedded resuscitation unit, with an additional three high dependency beds, and the establishment was three registered nurses. This is below the national standards for resus. The service was out to recruit to increase the establishment to four registered nurses which would then meet the national standards.

Urgent and emergency services

The department had a dedicated five bedded children's emergency department. The establishment was one band six paediatric nurse and one healthcare assistant between 07:30 and 20:00 and at night one band five adult nurse with relevant PILS training. The staffing establishment was not in line with the Royal College of Nursing guidance which states two paediatric nurses are required. Where this is not possible the service must ensure that registered adult nurses have the acquired knowledge, skills, and competencies.

Managers calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift. However, during our inspection, the department did not have the number of required nurses in accordance with national guidance on all shifts. Managers told us they had been unable to secure bank or agency staff.

The service regularly reviewed their staffing establishment and a new paper was due to be submitted to the executive team in September 2022, however priority posts were agreed to be recruited to. The service had also implemented the use of the Emergency Department Safer Nursing Care Tool. At the time of the inspection the results of using this tool were not available. The department was due to go through a building project which would see further adaptations to the staffing establishment.

The existing staffing establishment did not always meet the needs of the service. For example, the two Rapid Assessment and Treatment (RAT) cubicles did not have establishment for nurse staffing. However, recent funding had been agreed and the post was out to advert. The service had no establishment for the see and treat bays. The service would use nurse staffing from the emergency department roster.

The service did incorporate staffing establishment for a nurse to be allocated to the corridor for patients receiving care.

The department had recently implemented a RAG rating tool which looked at staffing, capacity, flow, and acuity. Therefore, the departmental manager could adjust staffing levels daily according to the needs of patients. Managers planned nurse staffing for each day based on a rota and could adjust this according to the acuity of patients and busyness of different areas of the department. However, we saw there were often gaps in this rota which managers were unable to fill with bank or agency staff. Managers escalated gaps in rotas, but these were not always filled.

The service had increasing turnover rates. Turnover data provided by the service showed nursing staff turnover had increased between February and July 2022.

The service had increasing sickness rates. In February 2022, the sickness absence rate for nursing staff was 6.84% it had risen every month to 10.04% in July 2022.

The department informed us they had a significant number of vacancies. However, they were actively recruiting into the posts and 15 new employees have been recruited and awaiting start dates.

The service recognised that they regularly used bank and agency nursing staff. Where possible, managers requested staff familiar with the service. Managers had approval to start block booking agency staff for up to four weeks in advance.

The SDEC was staffed by one consultant, two senior advanced practitioners, one registered nurse and two support workers. The service confirmed that if there was no nurse cover then the service would close. A business case has been submitted to increase the staffing to increase the capacity in the department.

Urgent and emergency services

Medical staffing

The service had enough medical staff with the right qualifications, skills, training, and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix and gave locum staff a full induction.

The service had enough medical staff to keep patients safe. Data for the whole trust in January 2022 showed the proportion of consultant staff was higher than the England average and the proportion of junior (foundation year 1-2) staff was lower than the England average. The service had a consultant on call during evenings and weekends. Managers made sure that all on call doctors were on the Specialist Register.

The service had low vacancy rates for medical staff. The service had vacancies at the time of our inspection. However, the service did not provide vacancy rates. Vacancy rates for medical staff across the whole care organisation were 7.28%.

The children's emergency department did not have paediatric consultant or doctor cover. The service would escalate any issue to emergency department consultants. However, the service had recently recruited a nurse consultant with a paediatric interest.

The service had fluctuating sickness rates. In February 2022, the sickness absence rate for medical staff was 2.05% it had fluctuated every month. However, the sickness rate was at the highest in July 2022 at 10.04%.

The service had increasing turnover rates for medical staff. Turnover data provided by the service showed medical staff turnover had increased between February and July 2022.

We requested information from the Trust regarding the employment of medical staff but we did not receive this. However, staff reported the number of medical staff matched the planned number on most shifts. Staff told us there were enough doctors available to keep patients safe.

Managers made sure locums had a full induction to the service before they started work. However, we observed that not all student doctors received an induction.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up to date and easily available to all staff providing care. However, records were not always stored securely.

Records were not always stored securely. Patient notes were comprehensive and paper records were stored in lockable trolleys. However, the trolleys were not always locked. We observed staff attempting to lock the trolley but were unable to do so. Staff were always in close proximity and the trolley was in their line of sight.

When patients were transferred to a new team or hospital, the records would be scanned into the electronic system. Electronic patient records could be accessed by all relevant staff and were available when the patient transferred out of the department.

When a patient was discharged the notes remained in the department prior to being scanned into the system. The patient records would be stored securely in department storage for three months before being archived.

The department was scheduled to implement fully electronic patient records.

Urgent and emergency services

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Pharmacy staff followed national practice to check patients' medicines, including medicines prescribed on discharge from the emergency department during the day, and provided advice to patients and carers.

Patient group directions (allowing named non prescribers to supply a prescription medicine in clearly defined circumstances) were in place. However, two PGDs were past their review by date.

Staff followed systems and processes to prescribe and administer medicines safely. They learned from safety alerts, incidents, and new guidance to improve practice. For example, a pathway for testing for monkeypox had been added to ED guidelines and 'grab boxes' had been introduced in triage to ensure PPE was available. Sepsis safety was monitored through the sepsis steering group. There were plans to use patient track data to take a view of sepsis care after the first 48hours. The sepsis steering group was engaged in early discussions about potential changes to trust guidelines in line with the recent (May 2022) Academy of Medical Royal College's sepsis guidance.

The hospital had submitted data to the North West Advancing Quality Alliance improving early detection and treatment of sepsis programme. Fairfield was performing above average for antibiotics administered within 1 hour of sepsis diagnosis [Fairfield Hospital 86% patients, Cohort 60% patients January to April 2022].

Staff stored and managed all medicines and prescribing documents safely. Medicines including controlled drugs were safely stored with the trust's monthly audits showing good compliance [between 95% and 100% Q1 2022].

The trust's 'Treatment of agitation in delirium' pathway helped to ensure people's behaviour was not controlled by inappropriate prescribing.

Medicines reconciliation was completed by pharmacy staff and records showed the trust target of 50% in 24 hours following admission had been achieved. However, this target was not compliant with the current guidance National Institute for health and Care Excellence (NICE) guidance which indicates 100% of patients' medicines should be reconciled within 24 hours or sooner if clinically necessary. This meant staff could not always be assured they had a complete understanding of the medicines each patient took and the potential impact on their diagnosis and treatment.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses 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. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff were able to describe the types of incidents they would report and how to report them on the online system.

Staff raised concerns and reported incidents and near misses in line with trust policy.

Staff we spoke with understood the duty of candour and were able to describe how they would be open and transparent and give patients and families a full explanation if things went wrong.

Urgent and emergency services

Staff received feedback from investigation of incidents. Incidents were reviewed by senior managers and immediate feedback given to staff. Managers conducted rapid reviews of any serious incidents identified.

Managers shared feedback and lessons learnt through the clinical governance meeting. Managers told us they would do specific learning reviews and the findings would be shared in the organisation's themes of the week.

Lessons learnt and common themes from incidents and complaints were shared with staff. We observed posters with this information displayed in staff common areas for their review.

Managers told us that they debriefed and supported staff after any serious incident.

Managers investigated incidents thoroughly and could demonstrate actions and changes made.

Is the service effective?

Requires Improvement 

Since we last carried out a comprehensive inspection of this service, they have become part of a newly formed NHS trust. As such we cannot compare previous ratings with this one. We rated it as requires improvement.

Evidence-based care and treatment

The service provided care and treatment based on relevant guidance and evidence-based practice. However, this was not consistently applied across the trust. Staff protected the rights of patients subject to the Mental Health Act 1983.

The trust operated a central online policy hub. However, during our inspection of the core services, we found that some services were using legacy policies from the previous trusts or accessing a suite of policies separate to the central Northern Care Alliance hub. As part of our ongoing monitoring of the trust, and throughout the inspection, we found there was a need to align some legacy Salford and Pennine policies to ensure there were trust-wide versions that reflected national or best practice guidance where appropriate.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. Staff contacted the mental health liaison team to arrange mental health assessments of patients including assessments under the Mental Health Act, where necessary.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients. We saw discussion of patients with mental health needs at daily huddle and at nursing and doctors' handovers.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural, and other needs.

The service did not always have the facilities to ensure patients in the waiting area had appropriate nutrition and hydration. The vending machine in the waiting area was out of order. Patients reported that they were not offered nutrition and hydration and had to request this from staff whilst in the waiting area.

Once in the department, staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. We observed comfort rounds in SDEC where patients were being offered nutrition and hydration.

The department used volunteers to support staff with supplying food and drink to patients.

We carried out a group observation using the Short Observational Framework for Inspection (SOFI) method on 10 August 2022. We observed patients been given food and drink. Fluid and nutrition charts where usually completed fully and accurately. However, we observed one fluid balance chart not completed in full out of seven records reviewed.

Pain relief

Staff did not always assess and monitor patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool and we observed pain assessment carried out by staff at triage. Staff gave pain relief in line with individual needs and best practice.

Patients received pain relief soon after it was identified they needed it, or they requested it. We observed patients in the department being offered pain relief. We observed one patient request pain relief, staff provided this in a timely manner.

However, patients in the waiting area were not offered pain relief in a timely manner. During our inspection, members of the inspection team were approached by a patient who was in pain and who had not been offered pain relief. We alerted staff to this, who immediately acted to address this.

Patient outcomes

Staff did not always monitor the effectiveness of care and treatment. Findings were not used to make improvements and achieve good outcomes for patients.

We requested local and clinical audit programmes for the service. However, this information was not provided. Therefore, we could not find evidence of the service monitoring improvements.

The service did monitor the patient experience on a daily basis. The department carried out local quality audits which included nursing documents being completed in full, NEWS2 charts completed, completion of the sepsis screening tool and pain scores being recorded. Therefore, the department had oversight of these areas and changes could be made to improve patient experience.

The service had a lower than expected risk of re-attendance than the England average. The rate in June 2022 was 4.74%.

Competent staff

The service mostly made sure staff were competent for their roles. Managers appraised staff's work performance. However, they did not consistently hold supervision meetings with them to provide support and development.

Managers gave all new staff a full induction tailored to their role before they started work. Staff we spoke with confirmed they had received an appropriate induction which equipped them to work within the department and were able to complete a supernumerary period.

Managers did not always support staff to develop through yearly, constructive appraisals of their work. From information provided by the trust, overall compliance with annual appraisals was 63.7% of nursing staff and 0% of medical staff.

Managers supported nursing staff to develop through regular, constructive clinical supervision of their work. Nursing staff we spoke with told us they received supervision and support from local managers. However, managers did not always support medical staff to develop through regular, constructive clinical supervision of their work.

There were clinical educators who supported the learning and development needs of staff. The department employed a part time practice educator. The department was recruiting to fill the role permanently.

The children's emergency department did not have a clinical or practice educator.

Managers identified any training needs their staff had. However, due to pressures in the department and gaps in staffing rotas staff and managers acknowledged it was difficult to give staff the time and opportunity to develop their skills and knowledge. This was evident in low compliance with life support training which was delivered face to face.

Multidisciplinary working

Doctors, nurses, and other healthcare professionals worked together as a team to benefit patients. They supported each other on a day to day basis to provide good care. However; staff did not hold regular and effective multidisciplinary meetings to discuss patients and improve care.

Nursing and doctor handovers took place separately. However, we saw positive working relationships between nursing and medical staff during our inspection, with staff sharing information relevant to providing care and treatment to patients.

Staff worked across health care disciplines and with other agencies when required to care for patients. Staff told us they had good working relationships with mental health teams, physiotherapists, and occupational therapists.

Staff referred patients for mental health assessments by the mental health liaison team when they showed signs of mental ill health or depression.

Seven-day services

Key services were available seven days a week to support timely patient care.

Staff could call for support from doctors and other disciplines and diagnostic services, including mental health services, 24 hours a day, seven days a week.

Staff reported there were no delays in accessing diagnostics tests and the department had some x-ray services located within it.

Health Promotion

Staff did not always give patients practical support and advice to lead healthier lives.

Urgent and emergency services

The service did not have relevant information promoting healthy lifestyles and support displayed within the department.

Staff assessed each patient's health when they presented through triage and rapid assessment.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff did not consistently support patients to make informed decisions about their care and treatment. They did not consistently follow national guidance to gain patients' consent as this was not always recorded in patient notes. Not all staff knew how to support patients who lacked capacity to make their own decisions or who were experiencing mental ill health.

Most staff understood how and when to assess whether a patient had the capacity to make decisions about their care. However, staff training rates were low. Therefore, we cannot be assured about staff's awareness.

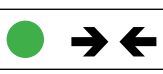
Staff did not consistently clearly record consent in the patients' records. We reviewed seven patient records and did not find evidence of consent recorded in six. However, we observed one patient requesting to leave the department and not be admitted against medical advice. Both the medical and nursing staff discussions were recorded within the patient records.

Staff did not always consistently record and sign DNACPR records when put in place. We observed one DNACPR being agreed within the department. However, this has not been signed by a second doctor.

Staff received but did not always keep up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. The service told us that training in these subjects was covered within level three safeguarding adults and children training. However, evidence provided on site showed only 35% of staff had completed level three safeguarding adults training and 65% of staff had completed level three safeguarding children and young people training.

Some staff could describe and knew how to access policy and get accurate advice on the Mental Capacity Act.

Is the service caring?

Good 

Since we last carried out a comprehensive inspection of this service, they have become part of a newly formed NHS trust. As such we cannot compare previous ratings with this one. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were not always able to be discreet and responsive when caring for patients due to the environment. However, staff took the time to interact with patients and those close to them in a respectful and considerate way.

We carried out a group observation using the Short Observational Framework for Inspection (SOFI) method on 10 August 2022. The SOFI tool is used to review services for people who have conditions that mean they cannot reliably give their

verbal opinions on the services they receive. We continually observed what happened to patients over a chosen observation period, making recordings at set intervals. In each time period, we recorded the general mood of the service users, the type of activity or non-activity they were engaged with and the style and number of staff interactions with service users. In each time frame there may be more than one type of engagement and multiple interactions with staff. Interactions with staff are categorised as positive, neutral, or poor.

The group observation took place on a corridor within the emergency department where three patients waited on trolleys and two on chairs. The observation started at 6:25 pm and lasted 20 minutes. We observed five patients and four members of staff. Data was collected in five-minute time frames.

- The general mood state for patients throughout the observation was neutral for 75% of the period and for 25% of the time it was negative.
- In 81% of the time frames the patients were passive and not engaged in any task. In 44% of the time frames there was engagement between patients and staff.
- 80% of staff interactions were neutral, 20% were positive and none were poor.

During the observation we saw staff engage with patients and their relatives in a warm, friendly yet respectful way.

Patients said staff treated them well and with kindness. The service provided feedback received from patients since February 2022 which included comments such as staff were ‘really kind’, ‘went above and beyond’, ’professional, calm, informative and cheerful’, ‘attentive and amazing’ and ‘informed and involved’.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

Staff were aware of the need to respect patients’ rights to privacy and dignity and did everything possible to ensure those rights were protected. For example, we saw staff moving patients into cubicles to discuss care. However, due to capacity issues within the department it was not always possible for staff to do this. When staff had to provide care and treatment in corridors, they took time to ensure patients were informed and completed tasks as discreetly as they could.

Emotional support

Staff provided emotional support to patients, families, and carers to minimise their distress. They understood patients' personal, cultural, and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity.

Staff understood the emotional and social impact that a person’s care, treatment, or condition had on their wellbeing and on those close to them. However, some staff expressed frustration that they were unable to give the level of care and emotional support they wanted to due to pressures and lack of staffing in the department.

Staff did not undertake training on breaking bad news.

Urgent and emergency services

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families, and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. We listened to conversations between staff and patients and heard staff answer questions and where necessary explain things in different ways to those who did not understand any elements of their treatment plan.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. We saw patient experience feedback cards available in the children's emergency department. We observed patient feedback displayed on notice boards within the department detailing changes implemented as a result of patient feedback.

Patients were invited to take part in the family and friend's test. We requested the survey results. We saw that 72.91% of patients would recommend the department.

We saw feedback provided to staff was reported on the online reporting system.

The department was seeking out ways to improve patient experience. We were informed the SDEC had invited the patient experience lead to come in and observe and give feedback on patient experience within the department.

Is the service responsive?

Requires Improvement 

Since we last carried out a comprehensive inspection of this service, they have become part of a newly formed NHS trust. As such we cannot compare previous ratings with this one. We rated it as requires improvement.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the needs of the local population. Managers worked with a local primary care streaming service to direct patients onto the most appropriate care pathway.

The facilities and premises were not always appropriate for the services being delivered. The department was overcrowded, with patients being cared for in the corridor. During our inspection, we observed an adult receiving treatment within the children's emergency department. However, work was in progress to build and expand the department, which would include a new waiting area, a new ambulance off load area and Rapid Assessment and Treatment (RAT) area and other expansion.

The department had a relative's room in the ambulance arrival corridor. The room had appropriate facilities including soft furnishings and drink making facilities.

Urgent and emergency services

Staff could access emergency mental health support 24 hours a day, 7 days a week for patients with mental health problems, learning disabilities and dementia. Staff described positive working relationships with the mental health liaison team and told us they were proactive in responding to requests for support and managers held regular meetings with the team.

The service relieved pressure on other departments when they could treat patients in a day through the use of the Same Day Emergency Care unit (SDEC). In addition, the SDEC ran services such as Deep Vein Thrombosis diagnostics and same day doppler, to aid discharge, prevent admissions into Hospital and prevent attendances in the emergency department.

The department did not have their own security staff. The hospital security staff would visit as part of the hospital walk rounds. We observed security within the department assisting with a patient that was becoming agitated. Staff told us they could call security and they would respond to the request.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff did not always make sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. However, staff referred patients to the mental health liaison team where appropriate.

The department was not designed to meet the needs of patients living with dementia. We did not see any adjustments to the environment to make it 'dementia friendly'.

We did not find evidence that staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Staff were able to describe how they would access interpretation and translation services.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. We saw patients' communication needs including the use of interpreters was discussed at nursing handovers.

Patients were given a choice of food and drink to meet their cultural and religious preferences. This included hot food which the service can request out of hours.

Staff had access to communication aids to help patients become partners in their care and treatment.

Access and flow

People could not consistently access the service when they needed it and did not always receive the right care promptly. Waiting times from attendance to treatment and arrangements to admit, treat and discharge patients were not consistently in line with national standards.

Managers monitored waiting times. During our inspection the longest attendance in the emergency department was 22 hours and six minutes.

Urgent and emergency services

Patients could not always access emergency services when needed, nor receive treatment within agreed timeframes and national targets. The average waiting time for treatment in June 2022 was 82 minutes against a standard of 60 minutes. The average waiting time, to decision to admit or discharge, in the department was 496 minutes in June 2022, this had risen from 239 minutes in May 2021.

In June 2022 the average waiting time for triage was 14 minutes. This was better than the national target of 15 minutes. This had risen from an average of 11 minutes in May 2021. In this period the department had only exceeded this target twice in October 2021 with an average of 17 minutes and in November 2021 with an average of 16 minutes.

Patients often stayed longer than they needed to in the department. Performance data supplied by the service showed increasing numbers of patients waiting on trolleys in the department, from one patient waiting on a trolley for 12 hours or more in May 2021 to 178 patients in June 2022. However, this was a reduction from previous months, in May 2022 the number of patients was 202. In the same month, 394 patients waited between four and 12 hours on a trolley.

Throughout our inspection, the service had large numbers of patients within the department waiting for beds following a decision to admit. For example, during inspection we noted that 16 patients were waiting for a hospital bed.

In April 2022 the service had 181 ambulances which waited over 60 minutes for handover into the department. This is a reduction from October 2021 when the number of ambulances waiting was 209. During our inspection, the maximum number of ambulances we saw outside was three. However, staff reported that previously this had been as many as 11. We spoke to ambulance crew on site who reported that the wait time had improved drastically.

The department reported a close working relationship with the local NHS ambulance service. A pathway has been developed between the ambulance service and the department to admit patients directly to SDEC and also to an Urgent Treatment Centre. Data provided by the department demonstrates that in June 2022 they had no ambulances waiting over 60 minutes. The service was monitoring waiting times and implemented changes to improve patient flow.

The service had expanded their admission criteria in the paediatric department and the urgent treatment centre to relieve pressure in the main department. The UTC had extended their criteria to cover minor injury and illness. This was being reviewed at the time of our inspection. The UTC discharged patients with a range of information. For example, they could discharge directly to a virtual fracture clinic where an orthopaedic consultant would review the x-ray and make a treatment decision. Staff told us they felt the UTC relieved pressure off the main emergency department.

The paediatric department had patient pathways to North Manchester. Staff informed us there could be delays in transfers due to ambulance availability. However, staff reported good links with community paediatric nurses who could offer same day appointments to facilitate discharge. These pathways were effective for patients and helped relieve pressure on the department.

The service had used the national Emergency Care Improvement Support Team (ECIST) to review patient attendance data. The service had 10% higher frailty admission rates than other local organisations. The service had recently undertaken a test for change within the department to recruit a physiotherapist and an occupational therapist permanently to the department. Managers reported this would allow the team to link into the community teams and prevent admissions to the department. At the time of the inspection this had received approval and recruitment was to be commenced.

Managers from the department attended hospital wide bed management meetings three times a day. These were held online and included discussion on patient moves, discharge plans and use of escalation areas. We saw managers prioritised support to the department in line with the pressures we observed.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives, and carers knew how to complain or raise concerns.

The service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them. The service had received 78 complaints between August 2021 and August 2022. The majority of complaints were about clinical treatment. This was further broken down into admission, discharge and transfers, communications, and patient care. Complaints were coordinated by the patient advice and liaison service (PALS) at the hospital.

Managers investigated complaints and identified themes from complaints and patient feedback. Cross divisional learning and themes were discussed in Band 7 meetings and consultant and general physician meetings.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. We reviewed three written responses to patient complaints and saw they were comprehensive, addressed the patients' concerns and offered an apology. Patients were signposted to the Parliamentary and Health Service Ombudsman (PHSO) if they remained dissatisfied with the outcome of the local resolution process.

Managers shared feedback from complaints with staff and learning was used to improve the service. Posters were displayed in the staff room sharing learning and themes.

Is the service well-led?

Requires Improvement 

Since we last carried out a comprehensive inspection of this service, they have become part of a newly formed NHS trust. As such we cannot compare previous ratings with this one. We rated it as requires improvement.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Local leaders had the experience, and integrity to ensure that the service could be run effectively and risks to performance addressed. Leaders in the department could clearly articulate the challenges the service faced.

Urgent and emergency services

Staff we spoke with told us local leaders were visible, approachable, and felt supported. Some staff reported senior leaders being visible within the department, such as divisional director of nursing. However, whilst on inspection we did not observe this.

The department leads and senior leaders were committed and passionate about the service and worked to ensure patients were kept safe.

The department was developing their own leaders to provide career progression. Managers told us they had development programmes in place through the department for all levels of nursing staff. For example, staff told us they were being supported to complete their emergency nurse practitioner course.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The trust and care organisation had a clear vision and strategy which aligned with local priorities and the needs of the communities served. We reviewed priority objectives for the division for 2022 to 2023, these were specific to the department. During our inspection we observed some of the objectives had already been achieved. For example, the development of the staff garden and the development of the SDEC pathways.

A major part of the future vision was the expansion of the service. Capital investment had been approved for the building project. Phase one of the building work was scheduled to be completed in April 2023.

Local leaders were focused on staff recruitment as a priority. The business case had been approved to recruit to the required establishment. Managers told us this included staffing for the new department once the building had been completed.

Culture

Staff felt respected, supported, and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff reported feeling respected, supported, and valued. Staff told us that local managers had an open-door approach and they felt they could raise concerns and ideas with them. For example, a member of staff suggested the department utilise the outdoor space next to the staff room and develop a staff wellbeing garden. The member of staff was supported to draft and submit a business case which was approved. Staff spoke very highly of the garden and we observed staff using this regularly on breaks.

Staff reported a positive culture within the department.

Staff told us they felt supported by local managers and there were good working relationships. However, some staff said there was little engagement with nor visibility of senior leaders from the trust.

The local leaders offered support to staff and teams following traumatic events. For example, staff were offered support following a cardiac arrest in the SDEC.

Staff were focused on the needs of patients, but some staff told us they were not able to meet these needs and provide care to an adequate standard. Staff told us they felt demoralised when providing corridor care.

Managers told us their main priority was staff wellbeing. In particular the expansion of the wellbeing garden and the improvement of their wellbeing check target which was currently 84% with a target of 90%. The service also provided staff with four hours paid time off annually as part of the Support, Caring, Assisting, Recognising our NCA Family (SCARF) trust-wide initiative.

Staff told us they could raise concerns without fear. Staff could access support from a Freedom to Speak Up Guardian. A Freedom to Speak Up Guardian works alongside the trust's senior leadership team to ensure staff have the capability to speak up effectively and are supported appropriately if they have concerns regarding patient care.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There were effective governance processes in place in the service. Leaders attended directorate, divisional and care organisation quality, and performance meetings. The divisional governance meetings took place monthly and led by an ED consultant and nursing and clinical teams attended these meetings.

The SDEC lead attended weekly meetings with the leadership team to monitor improvement projects and the ongoing site improvement work.

The department held monthly mortality and morbidity review meetings. The mortality and morbidity lead sat on the mortality oversight group and fed into the divisional group. Leaders told us they had confidence relevant information was provided to the care organisation and trust through this structure.

During our meeting with the senior leadership team we were assured they were fully sighted on the activity and performance of the emergency department.

Consultants from the acute medical unit and the department attended joint monthly patient safety meetings to discuss, share and identify learning.

Information such as learning from incidents was shared through daily huddles and shared within the staff areas.

Management of risk, issues, and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The service had nine risks rated 10 or above on the divisional risk register. Of these, lack of patient flow within the hospital and the wider system was the top risk and rated red. Nurse staffing was also rated one of the highest risks and rated red. This aligned with what staff and leaders told us about the main risks and what we saw whilst on inspection. Managers reviewed the risk register at monthly divisional quality performance meetings.

We reviewed the risk register and saw that it allocated a risk owner, dates for review, controls, gaps in controls and action plans. For example, one of the controls for patient flow within the department was to extend the urgent treatment centre criteria. During our inspection, we saw that the newly extended criteria has been implemented.

There was an emergency department improvement action plan with a focus on topics such as system capacity, patient flow and discharge processes.

Learning from the SDEC was shared across the trust through six weekly advanced clinical practitioner (ACP) and junior doctor training sessions.

Information Management

The service collected data and analysed it. However, some staff were not confident the data was always accurate. In addition, staff could not always find the data they needed in accessible formats to help them understand performance, make decisions and drive improvements. Data was not recorded or presented uniformly across the trust and some important data was not captured.

The information systems were secure. However, they were not always reliable or integrated well. On 18 May 2022 the trust experienced a major failure of some of its key information systems which affected Bury, Rochdale and Oldham care organisations. As a result, a critical IT incident was declared. The trust announced the issues were fully resolved on 20 June 2022. The failure disrupted diagnostic, pathology and pharmacy services, and referral pathways from GPs and primary care services.

Data was collected to measure performance. This included ambulance handover times, time from arrival to treatment, length of stay in the emergency department and time for referral to speciality.

The service had four information governance breaches within the last six months. All had a severity rating of no harm and actions were recorded.

We were not assured leaders and staff always received information to enable them to challenge and improve performance. This was because data we requested as part of the inspection process was not made available in formats which were easily accessible nor attributable to the service. For example, mandatory training data was difficult to analyse. Local leaders provided data onsite of the mandatory training figures.

The service submitted data regarding incidents to national reporting systems. However, this was not always assigned to the service within the systems and therefore did not allow external agencies, such as CQC clear oversight.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Local leaders actively and openly engaged with staff to plan and manage the service. Managers told us that staff forums are held with divisional directors, nursing colleagues and care organisation leaders.

Friends and family test information from June 2022 was displayed on notice boards in the emergency department. There were examples of implemented actions or changes for improvement, however there were no examples of positive and negative feedback.

The service did engage with external partners and other stakeholders to plan and manage services. For example, they worked with other local community partners to review frequent attenders in particular attenders from nursing homes.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The local leaders had developed a departmental RAG rating tool which looked at staffing, capacity, flow, and acuity. This meant that managers could adjust the service in order to meet the demands and improve the service within the department.

Staff were actively involved in improvement projects. For example, nursing staff were involved in the designing of the new intake criteria for the urgent treatment centre.

Leaders encouraged staff to put forward ideas to improve patient safety. For example, implementing a patient RAG review at 7pm in the urgent treatment centre. This should help flow and prevent admissions into the main department.

Staff identified areas of training that needed to be developed within the department. For example, they were developing lumbar puncture training for SDEC, ACPs and junior doctors.

Salford Royal Hospital

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Description of this hospital

Northern Care Alliance NHS Foundation Trust was formed on 1 October 2021 when Salford Royal Hospital NHS Foundation Trust legally acquired Pennine Acute Hospitals NHS Foundation Trust.

The trust has four hospitals – Salford Royal Hospital, Royal Oldham Hospital, Fairfield General Hospital and Rochdale Infirmary which provide a full range of acute services, including acute medicine, urgent and emergency care, acute frailty units, rehabilitation services, dental services and surgical services, to a population of approximately 1 million people. The trusts had been working in partnership from 2016 until the acquisition. This included a shared executive leadership team.

When a trust acquires another trust in order to improve the quality and safety of care, we do not aggregate ratings from the previously separate trust at trust level for up to two years. The ratings for the trust in this report are therefore based only on the ratings for Salford Royal Hospital and our rating of leadership at the trust level.

Our normal practice following an acquisition would be to inspect all services run by the enlarged trust. However, our usual inspection work has been curtailed by the COVID-19 pandemic.

At Northern Care Alliance we inspected only those services where we were aware of current risks. We did not rate the hospital overall.

In our ratings tables starting on page 30 we show all ratings for services run by the trust, including those from earlier inspections and from those hospitals we did not inspect this time.

Medical Care

The medical care division provided medical care, consisting of general medicine and care of the elderly as well as specialities such as cardiology, endoscopy and stroke are delivered from Salford Royal Hospital.

During our visit our inspection team spoke with patients' relatives and staff which included consultants, junior doctors, nurses, matrons, pharmacists, discharge coordinators, house keepers and nursing students. We also spoke with the associate director of nursing, the associate director of operations and the clinical director for the medicine care group.

Our findings

We inspected the service between 8 and 9 August 2022. Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity. As part of the inspection we reviewed information provided by the trust about staffing, training and monitoring of performance.

Since we last carried out a comprehensive inspection of this service, they have become part of a newly formed NHS trust. As such we cannot compare previous ratings.

We rated it as requires improvement because:

- The service did not have enough staff to care for patients and keep them safe. Staff did not always have training in key skills. The service was not meeting its mandatory training compliance target.
- The service did not always ensure that staff received appropriate support, training, professional development, supervision and appraisals. The service did not offer comprehensive training for staff to ensure they could support patients living with dementia, autism or a learning disability.
- People could not always access the service when they needed it or received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards.
- There was limited evidence that the medical division monitored the effectiveness of care and treatment and used the findings to make improvements and achieved good outcomes for patients. There were gaps in management and support arrangements for staff, such as staff appraisals.

However:

- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.
- The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.

Surgery

The division of surgery provides a range of general and specialist surgical services, including trauma and orthopaedic surgery, urology and complex elective and emergency surgery. The surgery division has seven wards, a pre-operative assessment clinic, two surgical admission lounges and a day surgery unit. It includes an intestinal failure unit (IFU) which holds national reference centre status for the treatment of complex intestinal failure.

Our findings

There are 20 operating theatres on two levels and a day case theatre; wards and departments are spread throughout the hospital, including different buildings and on different floors.

Between October 2021 and July 2022, the hospital had a monthly average of 766 emergency admissions, 1134 day case admissions, 358 elective admissions and 1291 operations performed.

During the inspection, we visited seven wards, theatres, surgical admissions lounge, recovery areas, the surgical triage unit, and the pre-operative assessment clinic. Due to COVID-19 restrictions we visited wards identified as not having an outbreak at the time of inspection. We observed staff interactions with patients, safety huddles and handovers.

The inspection team spoke with 26 staff, five patients and three carers and relatives who were using the service. Staff we spoke with included senior leaders, consultants, matrons, sisters, registered nurses, junior doctors, health care assistants, porters, and housekeepers. We reviewed ten patient records and ten complaint files.

Our rating of this service went down. We rated it as requires improvement because:

- The service did not always have enough nursing staff to keep patients safe. Staff did not always complete mandatory training in key skills. Compliance for some risk assessments did not always meet hospital targets. Not all staff had completed training on how to recognise and report abuse.
- Whilst staff monitored the effectiveness of care and treatment, they did not consistently use the findings to make improvements. The service had a higher than expected risk of readmission for elective admissions for urology and general surgery patients when compared to the England average. Managers did not always appraise staff's work performance or hold supervision meetings with them to provide support and development. Not all staff completed training in the Mental Capacity Act or Deprivation of Liberty Safeguards.
- The environment across the surgical wards and theatre areas was not always dementia friendly. People could not always access the service when they needed it or received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards. Complaints were not always responded to within the timescales specified in the trust complaints policy.
- Senior leaders were not always visible and approachable in the service for all staff. Not all staff felt there was an open culture where they could raise concerns without fear. Not all staff were clear about their roles and accountabilities. Staff could not always find the data they needed in accessible formats to help them understand performance, make decisions, and drive improvements. Data was not recorded or presented uniformly across the trust and some important data was not captured. Senior leaders were not always actively and openly engaged with staff.

However:

- Staff used equipment and control measures to protect patients, themselves, and others from infection. They kept equipment and the premises visibly clean. Staff managed clinical waste well. Staff identified and quickly acted upon patients at risk of deterioration. The service had enough medical staff and support staff to care for patients and provide the right care and treatment. Staff kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- The service provided care and treatment based on national guidance and evidence-based practice, gave patients enough food and drink, and gave them pain relief when they needed it. The service mainly achieved good outcomes for patients. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives and supported them to make decisions about their care. Most key services were available seven days a week to support timely patient care.

Our findings

- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families, and carers.
- The service planned and provided care in a way that met the needs of local people, took account of patients' individual needs and preferences, and made it easy for people to give feedback.
- Most staff spoke positively about the local leadership. Leaders had the skills and abilities to run the service, the service had a vision for what it wanted to achieve and a strategy to turn it into action. Leaders operated effective governance processes, throughout the service and with partner organisations. They identified and escalated relevant risks and issues and identified actions to reduce their impact. The service collected data and analysed it, leaders and staff actively and openly engaged with patients. Staff were committed to continually learning and improving services. Leaders encouraged innovation and participation in research.

Urgent and Emergency Care

Our rating of this location went down. We rated it as requires improvement because:

- The service did not have enough staff to care for patients and keep them safe. Staff did not always have training in key skills and did not always manage safety well. Patients with suspected sepsis were not always escalated appropriately or treated in a timely manner. Not all staff completed training on how to recognise and report abuse. The service did not consistently control infection risk well. Staff did not consistently assess risks to patients, nor act on them. The management of controlled drugs in the Majors area was not effective.
- Staff did not always give patients enough to eat and drink, nor always give them pain relief when they needed it. Managers did not always make sure staff were competent for their roles. Overall compliance with annual appraisals was 56%, and due to staffing pressures, staff were not always released to carry out face to face training such as immediate life support. Staff did not always support patients to make informed decisions about their care.
- Due to staff shortages and overcrowding in the department, staff were not able to respect the privacy and dignity of patients. They were not able to take account of their individual needs, nor help them understand their conditions. They were not able to provide emotional support to patients, families and carers.
- People could not access the service when they needed it and had to wait too long for treatment. The service did not always take account of patients' individual needs.
- Leaders did not consistently run services well and did not always use reliable information systems. Staff did not always understand the service's vision and values, and how to apply them in their work. Staff did not always feel respected, supported and valued. Though staff were committed to improving services we did to see evidence of ongoing quality improvement work or innovation.

However:

- The service had enough medical staff to care for patients and keep them safe. Staff mostly understood how to protect patients from abuse. Staff kept good care records. The service managed safety incidents well and learned lessons from them.
- Staff mainly provided good care and treatment. Managers monitored the effectiveness of the service. Staff mostly worked well together for the benefit of patients, advised them on how to lead healthier lives. Key services were available seven days a week.
- Staff treated patients with compassion and kindness.

Our findings

- The service planned care to meet the needs of local people and made it easy for people to give feedback.
- Leaders supported staff to develop their skills. Staff were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged with stakeholders to plan and manage services.

Surgery

Requires Improvement ↓

Is the service safe?

Requires Improvement ↓

Our rating of safe went down. We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills to all staff. However, they did not make sure everyone completed it.

Mandatory training topics were in line with national guidance and training was delivered through e-learning modules with some face-to-face training. Key topics included life support, fire safety, health and safety, infection prevention and control (IPC), information governance, data protection, equality and diversity, manual handling and adult and children's safeguarding training.

Sepsis training was included in essential job-related training and staff we spoke with told us they had completed it. The trust told us they did not record sepsis training against staff roles on their electronic staff record at Salford Royal Hospital. Therefore, they were unable to provide assurance about the number of staff who had completed it.

Divisional data showed poor compliance with some essential training topics such as adult basic life support (BLS) which had an average overall compliance rate of 64% for nursing staff and 43% for medical staff. Compliance rates for adult immediate life support training (ILS) was 56% for nursing staff and no data was provided for medical staff. This meant that less than half of medical staff were up to date with basic life support which could put patients at risk.

Completion rates for the surgical division were below the trust target of 90% in a number of areas. Overall compliance for mandatory training for nursing staff was 86% and for medical staff overall compliance was 73%.

For example, anaesthetics medical staff, urology medical staff and orthopaedic medical staff had not met the trust target of 90% for most modules, and compliance for BLS training ranged from 44% to 71%.

Nursing staff on the intestinal failure unit (IFU), orthopaedic surgery ward (B6), the pre-operative assessment unit, the emergency surgery unit (H4) and the surgical enhanced care unit (B2M) had also not met the trust target of 90% for most modules. Compliance ranged from 42% to 71% for BLS.

Nursing staff on the surgical triage unit, surgical admissions lounge, recovery unit, general surgery wards B1 and B2 and orthopaedic scrub and support had met the trust target for most modules. However, compliance for BLS and ILS ranged from 64% and 83% respectively.

Anaesthetics advanced practitioners, anaesthetic nursing support staff, anaesthetic additional support staff and nursing staff on the surgery scrub and clinical support team had also met the trust target for most modules. However, compliance for ILS training ranged from 33% to 40% and compliance for BLS training ranged from 55% to 83%.

Managers monitored mandatory training and alerted staff when they needed to update their training. However, managers did not always ensure staff were granted protected time away from normal duties to complete mandatory training within formal working hours. Most staff we spoke with told us that staff absence and the need to prioritise other duties made it difficult to use their protected time for training. Some staff told us they found the training system complicated and hard to navigate whilst others said they did not receive any protected time and completed the training at home.

From 1 July 2022, all registered health care providers were required to ensure their staff received training in learning disability and autism, including how to interact appropriately with autistic people and people who have a learning disability. This training should be at a level appropriate to their role. At the time of the inspection, the NCA had not made completion of this training mandatory, and staff had not completed the necessary programme of learning as required. This meant staff may not have had the skills and knowledge to communicate effectively and provide safe care to these patient groups.

Nursing and medical staff from the surgical division also completed additional role-specific training in addition to the core mandatory training. This included Malnutrition Universal Screening Tool (MUST) and specific IPC techniques. However, divisional data showed poor compliance rates for nursing staff that ranged from 25% to 50% and for medical staff overall compliance was 56%.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. However, not all staff had completed training on how to recognise and report abuse.

Staff received training specific for their role on how to recognise and report abuse. Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Staff gave examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. This included patients who were autistic or living with dementia.

Safeguarding training was mandatory to all staff but compliance fell below the trust target of 90% for higher level training. The compliance for level 1 adults safeguarding training within the surgical division was; 94% (nursing staff) and 81% (medical staff). Level 2 adults safeguarding training was 91% (nursing staff) and 79% (medical staff). Level 3 adults safeguarding was 68% (nursing staff) and 52% (medical staff).

The compliance for level 1 children's safeguarding training was 91% (nursing staff) and 74% (medical staff). Level 2 children's safeguarding was 90% (nursing staff) and 74% (medical staff). Level 3 children's safeguarding was 74% (nursing staff) and 54% (medical staff). This meant that not all staff had the required competencies to safeguard adults and children from harm or abuse. The safeguarding training included female genital mutilation (FGM) and staff we spoke with knew to report cases of FGM to the police as per trust policy.

Adult and children safeguarding policies were easily accessible on the hospital's intranet to support staff. The policies were comprehensive and outlined processes for staff to follow, this included contact details for the safeguarding team, referral form and incident reporting.

Surgery

The hospital had named nurses for safeguarding adults, safeguarding specialist nurses, a lead nurse for domestic abuse, a safeguarding adult's practitioner, and a safeguarding committee. Staff we spoke with were aware of who the safeguarding leads were and how to contact them.

Cleanliness, infection control and hygiene

The service controlled infection risk well. The service used systems to identify and prevent surgical site infections. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Ward areas were visibly clean and had suitable furnishings which appeared to be clean and well-maintained. Theatre environments were also visibly clean, in a good state of repair and most theatres had been refurbished. There were four laminar flow theatres used mainly for orthopaedic surgery or other surgery that required prosthetic implants. This was in line with the Royal College of Surgeons' recommendations.

Staff cleaned equipment after patient contact and disposable curtains on the wards we visited were dated to show they had been replaced within the last six months in line with national guidance.

Wards we visited completed their own checks which indicated they performed well for cleanliness, but cleaning schedules were not routinely displayed as required. Staff told us that toilets and bathrooms were cleaned three times a day. However, records were not always completed which meant it was difficult to establish if cleaning had been completed in accordance with the schedule and safe practice. For example, on ward B1 a bathroom had gaps in the cleaning schedule of two consecutive days during one week. Some wards had no cleaning schedule in the toilets and staff told us that housekeepers kept their own records and audits.

Staff followed infection control principles including the use of personal protective equipment (PPE) and followed safe-practice guidelines for putting on and removing it. All staff followed ‘bare below elbows’ guidance. There were sufficient supplies of gloves, aprons, and clinical masks available. Clinical sinks were in all areas, including additional temporary sinks, with hand-washing instructions, soap, and hand sanitisers. We observed staff, patients and visitors washing their hands when entering wards.

Staff completed IPC training as part of mandatory requirements with a trust target of 90%. For IPC level one, for the surgery division, there was 98% compliance for nursing staff and 90% for medical staff. For IPC level two, there was 89% compliance for nursing staff and 72% for medical staff.

Infection control audits dated July 2022 were provided for wards H4 and B6. Overall compliance was 91% and 90% respectively. Hand hygiene compliance was 86% across both wards. Other data from March 2022 to August 2022 included hand hygiene audit results for general surgery wards B1 and B2, surgical enhanced care unit (B2M), oral surgery, surgical triage unit, theatre recovery and pre-op assessment. Compliance was on average 100% across these wards apart from July 2022 when B2 scored 85%.

Infection control audits dated May 2022 for 14 theatres showed compliance scores over 90% apart from one theatre which was 88%. Hand hygiene scores ranged from 85% to 100%.

There was clear guidance displayed throughout the wards on how to minimise the risk of spreading COVID-19. We saw staff and patients adhere to this across the wards and theatre areas. Wards had notices on the entrance doors to remind patients and visitors how to adhere to IPC guidance. Staff adhered to social distancing and rooms had information on the doors displaying what PPE should be worn and the maximum number of people allowed.

'I am clean' stickers were used to indicate when equipment was last cleaned on the wards we visited.

Patients were tested for COVID-19 three days prior to elective surgery and tested again before a ward transfer. Those who were COVID-19 positive or had acquired other infections were cared for in alternative rooms separate from other patients with staff allocated to these areas. We did not visit any wards identified as 'red' where COVID-19 positive patients were being cared for.

The hospital reported an increase in COVID-19 infections in June 2022. Emerging themes were identified and managers revised their mask wearing guidance. This was reviewed on a weekly basis and managers held COVID-19 outbreak meetings when required to discuss what wards were affected and what actions were in place.

The hospital had policies in place that included COVID-19 outbreak control and management, pre-operative COVID-19 pathway for elective surgery, staff testing and isolation requirements for COVID-19.

Healthcare associated infections were monitored, and IPC performance was reported quarterly.

Data provided from February 2022 to July 2022 showed low rates of hospital acquired clostridium difficile (C.Diff). Six cases were reported on wards which included a general surgery ward and the surgical enhanced care unit (B2M). Each case was reviewed using a root cause analysis approach and highlighted learning points and areas of good practice. Any themes were identified, and judgements made to see if the infections had been avoidable.

We looked at the surgery division governance board meeting minutes dated April 2022. This showed that the surgery division had reported four cases of methicillin-resistant staphylococcus aureus (MRSA) acquisitions within the previous 12 months. A root cause analysis was performed for each case and any learning was shared with clinicians and staff through training, ward safety huddles, infection control reports and governance meetings. There had been no MRSA bloodstream infections reported within the previous 12 months.

Patients underwent MRSA screening and pre-admission checks for other infection risks, such as C.Diff, prior to admission for elective surgery. We saw evidence of this in the patient records we reviewed during the inspection, and we observed a patient being asked to self swab for MRSA in the pre-operative assessment clinic. Emergency patients were screened within 24 hours of admission and prior to any ward transfers.

Staff disposed of clinical waste safely and appropriately. Dirty utility areas were organised and clear from clutter. Sharps bins were dated and not overfilled.

Staff worked effectively to prevent, identify and treat surgical site infections (SSIs). The hospital conducted surveillance of SSIs for orthopaedic and general surgery during alternate quarters of the year. Due to COVID-19, the SSI service was intermittently suspended throughout 2020/21 and 2021/22, with staff redeployed to work in infection control. Full-time surveillance resumed in April 2022 for general surgery and July 2022 for orthopaedics.

There were policies for decontamination of reusable medical devices, waste management, IPC for seasonal respiratory infections and guidance for the completion of deep cleaning. However, the division provided a cleaning, disinfection and sterilisation policy which had an expiry date of July 2022. This meant that staff may not be following the most up to date guidance.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

Wards were a combination of bays and side rooms that were gender specific. Some wards had side rooms and bays which were not visible from the main nurse's station. However, on areas such as the orthopaedic surgery ward (B6) and the surgical enhanced care unit (B2M), nurses were based in the bays for increased observation of patients who may be at risk of falls or required a higher level of monitoring.

All inpatient wards we visited had sufficient shower and bathroom facilities within the bays. Toilets were clearly identified for different genders. The ward areas were free from clutter, and we saw that equipment and consumable items were stored appropriately.

Access to the theatres and surgical wards was secure and required key code access for entry.

The service had enough suitable equipment to help them safely care for patients and staff told us equipment was routinely checked and cleaned in between use. Equipment we looked at such as hoists and blood pressure monitoring machines were visibly clean. Single-use, sterile instruments and consumable items were stored appropriately and were within their expiry dates.

Staff carried out daily safety checks of specialist equipment and reported issues for resolution. We checked equipment on wards such as general surgery wards (B1 and B2), orthopaedic surgery ward (B6) and elective head and neck surgical ward (H6). Monitoring equipment, wheelchairs and hoists we sampled included stickers to indicate maintenance checks within the last 12 months. Each area we visited had resuscitation trolleys that were sealed for security. Checks of the top of the trolleys were completed daily with a monthly full check of the trolley's contents.

In theatres we observed resuscitation trolleys had been checked as per policy and equipment had stickers to show they had been serviced.

Patients could reach call bells and told us that staff responded quickly when called. We saw staff respond to the call bell alert system which identified that an emergency response had been raised.

We checked storage areas and found substances such as cleaning materials were stored safely in accordance with the relevant guidance. Staff disposed of clinical waste safely. Sharps disposal boxes were dated, signed, and not overfilled.

Wards had designated fire marshals who wore orange vests in the event of an evacuation. Patients were identified on a board in the staff office as green (non-assisted evacuation), amber (assisted evacuation) and red (bed evacuation). Staff gave an example of a recent successful fire evacuation of wards B1, B2 and B2M in a timely manner.

Assessing and responding to patient risk

Surgery

Staff identified and quickly acted upon patients at risk of deterioration. Staff completed and updated risk assessments for each patient and removed or minimised risks. However, compliance for some risk assessments did not always meet hospital targets.

Staff used the nationally recognised national early warning scores (NEWS2) tool to identify deteriorating patients and escalated them appropriately. This was evidenced in the patient records we reviewed. We reviewed 10 patient records and found that staff used this tool in line with the trust's policy relating to the deteriorating patient.

The hospital had policies in place that were compliant with both national safety standards for invasive procedures (NatSSIPS) and local safety standards for invasive procedures (LocSSIPS). The trust had a LocSSIPS library online that staff and the public could easily access. There was an extensive list of all currently approved LocSSIPs in use across the care organisations. Each care organisation had its own library due to slight differences due to local resources and infrastructure.

We observed robust patient assessments in the pre-operative clinic that included health, medical history, home circumstances and a mini mental state assessment.

Staff knew about and dealt with any specific risk issues. During our inspection we saw that staff assessed patients' conditions to identify any issues that may need to be escalated such as sepsis, venous thromboembolism (VTE – also known as blood clots), falls, nutrition, and pressure ulcers. Patients who had a NEWS score of six or above were automatically assessed for sepsis. Staff we spoke with were able to describe the signs of sepsis and knew how to escalate a patient's condition so they would receive treatment quickly. Wards had posters on the walls to alert staff of the sepsis screening tool and the urgency for antibiotics for patients who were showing signs of infection. Staff also completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide.

Staff shared key information to keep patients safe when handing over their care to others. We attended handover meetings on the wards and theatre briefings where we saw relevant and up to date information shared.

We observed shift changes and noted that handovers included all necessary key information to keep patients safe.

Boards above patients' beds provided oversight of their individual risks discreetly using symbols. There was information relating to nutrition and hydration, falls, one to one status and complex needs. For example, a butterfly symbol was used for patients living with dementia. Patients also wore different coloured wristbands to illustrate allergies, risk of falls, dementia, infection, and critical medication. Patients who were high risk of falls had a red circle on their board and those who were low risk of falls had a green circle.

Ward B6 had 32 beds for trauma and orthopaedic patients including those living with dementia. Staff told us that the falls management team gave feedback on any patterns from falls on the ward. This learning was shared among staff, they completed workshops and falls specific training. Patients who were high risk of falls requiring one to one support were in staffed bays to receive higher level of monitoring. During the inspection, staff told us that they had one of the lowest fall rates within the trust.

Surgery

Theatre staff completed the 'five steps to safer surgery' procedures, including the use of the World Health Organization (WHO) safer surgery checklist. Performance was audited monthly by the trust. Safety compliance data from January 2022 to June 2022 showed compliance was usually 100% for safety checks before, during and after surgery. However, the debrief step included rates of 70% compliance in March 2022 and 66% in June 2022. Reasons for debriefs not occurring included 'surgeon called to another unit', 'surgeons leaving theatre,' 'over running lists' and 'no reason attributed.'

Individual errors and concerns were identified as part of the audit process, they were reported appropriately, and action was taken in relation to these findings to improve patient safety.

Staff completed risk assessments for each patient after admission, using a recognised tool and reviewed this regularly, including after any incident.

However, divisional data showed that from November 2021 to July 2022 risk assessment completion for pressure ulcers within six hours of admission had not met the trust target of 95% during this time period. Compliance ranged from 88% to 94% and there had been an increase in grade two pressure ulcers between March 2022 and May 2022 when risk assessment compliance had been between 89% and 92%. There had been a decrease in reported pressure ulcers during the following months up to July 2022 and the division had met the target of 95% every month for risk assessments for pressure ulcers within 24 hours of admission.

Similarly, falls risk assessments completed within six hours of admission did not meet the trust target of 95% for the same time period and compliance ranged from 86% to 94%. However, they were completed within 24 hours consistently for these months with compliance ranging from 97% to 99%. Six falls with moderate harm had been reported during this time against their target of 0.

Staff also carried out intentional rounding observations (also known as care and comfort checks) every two hours through the night and every hour during the day. Observations included pain, position, personal care, falls risk and pressure ulcer prevention. However, on a number of wards we observed gaps in some patients intentional rounding records. Audit data showed that in May 2022 compliance for hourly checks varied across surgery wards from 67% to 100% against a target of 95%. In June 2022 compliance ranged from 70% to 100% and in July 2022 compliance ranged from 75% to 100%. This meant that identifying any changes to a patient's fundamental needs could be delayed and not escalated appropriately.

Nurse staffing

The service did not always have enough nursing staff to keep patients safe from avoidable harm and to provide the right care and treatment. However, there was enough support staff and managers regularly reviewed and adjusted staffing levels and skill mix.

The service did not always have enough nursing staff to keep patients safe. The number of nurses did not always match the planned numbers. We reviewed the fill rates for registered nursing staff from November 2021 to July 2022 against a target of 95%. Day shift fill rates ranged from 74% to 83%. The overall average was 79%. Night shift fill rates for registered nurses against a target of 95% ranged from 85% to 96%. The overall average was 91%.

We also looked at fill rates for registered nurses across six surgical wards from March 2022 to July 2022. General surgery wards B1 and B2 consistently had the lowest fill rates for day shifts with the average shift fill rate reported at 65% and 68% respectively. The surgical enhanced care unit (B2M) and the emergency surgery unit (H4) consistently had the lowest fill rates across night shifts with the average shift fill rate reported at 84% and 89%.

We saw evidence that non-registered staffing had been increased when nursing fill rates were low, and data showed that the division had enough support staff to keep patients safe. Day shift fill rates for care staff from November 2021 to July 2022 against a target of 95% ranged from 99% and 124%. The overall average was 111%. Night shift fill rates for care staff ranged from 121% to 159%. The overall average was 138%.

The division had high vacancy, turnover and sickness rates for nursing staff. Overall vacancy rates for the surgery division at the time of inspection was 13%.

The service had increasing sickness rates for nursing staff. Sickness data provided by the service showed nursing staff sickness had increased from 4% to 7% between March and July 2022. This was against a target of 3.6%.

However, the service had reducing turnover rates for nursing staff. Turnover data provided by the service showed nursing staff turnover had decreased from 12% to 10% between March and July 2022.

The division reported 70 incidents in the previous six months relating to staffing issues. Four incidents reported 'lack of or delayed medical review or escalation,' four related to 'movement of staff,' one reported 'no member of staff available to support one to one supervision of patients,' four incidents were related to staff skill mix and 45 incidents had been reported for low staffing levels.

Some staff we spoke with on the emergency surgery unit (H4) said that staffing levels were a concern. There were 24 beds and six escalation beds on the ward split across three bays and twelve side rooms. Managers often filled gaps in staffing by using staff from other wards.

We looked at six staffing related incidents that were reported on ward H4 in the last three months. Themes included low staffing levels (two registered nurses to 30 patients on a night shift), poor compliance with patient observation checks and insufficient skill mix.

Wards had staffing boards located at the entrance doors to show planned and actual staffing levels. For most wards we visited the number of actual registered nurses did not match the planned numbers.

Managers calculated and reviewed the number and grade of nurses and healthcare assistants needed for each shift in accordance with national guidance. The acuity of the ward patients was assessed to determine the required staff for that day and adjustments to numbers were made accordingly.

Staff we spoke with confirmed nurses were not always available in the numbers planned. They told us how gaps were usually filled by the re-deployment of nurses from other wards and the allocation of additional health care assistants. We saw evidence of this practice during the inspection.

The service had high rates of bank nurse usage. Data was provided for seven wards from March 2022 to August 2022 and showed monthly average bank fill rates ranged from 20% on the general surgery ward B2 and 89% on the surgical triage unit (C1). The intestinal failure unit (H8) had a monthly average bank fill rate of 70%. This meant that staff were not always familiar with the wards they were working on.

However, managers told us they used block booking of bank staff when possible, to try and cover longer term gaps. They limited their use of agency staff and we observed low rates of agency nurses. Managers told us that they made sure all

staff including bank and agency staff had a full induction and understood the service. During our inspection, we observed the theatre staffing consisted of one scrub nurse, one registered nurse, one or two healthcare assistants, one anaesthetist practitioner and one recovery practitioner. This was in line with the Association of Anaesthetists of Great Britain & Ireland (AAGBI) and the Association for Perioperative Practice (AFPP).

A number of actions had been undertaken to improve staffing. Senior leaders told us that staffing had been a challenge during and after the pandemic. They had undertaken rolling recruitment programmes and recruited more than 88 staff across the disciplines. This included an intake of trainee nurse associates in April 2022 and September 2022 and were currently on a third intake of apprenticeships. They told us that wards B1 and B2 currently had up to 30 vacancies of which 25 had been filled and new staff were due to commence employment in September and October 2022. The newly recruited staff would also support ward H4.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to provide the right care and treatment. However, the service had reported four incidents in the previous six months relating to lack of or delayed medical review or escalation.

Data for the whole trust in January 2022 showed the proportion of consultant staff was better than the England average. However, the proportion of junior (foundation year 1-2) staff was worse than the England average. For the surgical division there were currently five associate specialists, 145 consultants across all surgery specialities, 123 trainee doctors (grade FY1 and FY2), 5 speciality doctors and 53 trust grade doctors.

There were 25 substantive consultants in total for general surgery and staff could access locums when they needed additional medical staff. Managers made sure locums had a full induction to the service and were familiar with the hospital's policies and procedures before they started work.

The service had enough medical staff to keep patients safe. The wards and theatres we inspected had sufficient numbers of medical staff with a good skill mix on each shift to ensure that patients were safe.

The emergency surgery unit (H4) covered medical outliers, trauma and orthopaedics and there was an orthogeriatrician based on the ward to review these patients and they liaised with various teams.

There was a consultant of the week who did surgical ward rounds daily and provided cover for other consultants. The service always had a consultant on call during evenings and weekends.

In theatre there was a dedicated consultant called the 'starred anaesthetist' to assist with an emergency or difficult anaesthetic problems. The dedicated anaesthetist changed daily in line with best practice. Anaesthetists reviewed their patients after surgery and any issues handed over to the on-call consultant.

Staff told us there were enough doctors available to keep patients safe. The vacancy rates for medical staff across the Salford care organisation was 9%. We requested; however, the service did not provide information on the planned versus actual numbers of medical staff.

The service had low and reducing turnover rates for medical staff. Turnover data provided by the service showed medical staff turnover had decreased from 6% to 4% between March 2022 and July 2022.

Sickness rates for medical staff were low. The service provided information that showed sickness absence for doctors in the previous five months was 1%.

However, the division reported four incidents in the previous six months relating to 'lack of or delayed medical review or escalation,'

Doctors and nurses did their own daily ward rounds separately and feedback from staff was mixed about how effective this was. Some staff told us that it hindered communication and other staff including nurses told us they joined the doctors during ward rounds to remain heavily involved in their patients' care.

Records

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

Patient notes were comprehensive, and all staff could access them easily on computers located throughout the department. On the wards we visited, a mix of electronic and paper records were used.

During our inspection we looked at a total of 10 electronic patient records, and we found that records were completed comprehensively by staff.

When patients transferred to a new team, there were no delays in staff accessing their records. Electronic patient records could be accessed by all relevant staff and were available when the patient transferred out of the department.

The electronic system contained relevant risk assessments bundles such as falls, nutrition, pressure ulcers and sepsis. Risk assessments had been carried out when patients had been admitted to the wards and do not attempt cardiopulmonary resuscitation forms (DNACPR) and deprivation of liberty safeguard (DoLS) forms had been completed correctly if needed.

Care plan bundles on the electronic system were also comprehensive. This included medical, surgical, learning disability, autism, nutrition, stroke, and dementia care plans.

Electronic record systems were accessed through computers throughout the ward. These computers were username and password protected. Staff ensured that computers were locked when they were not attended, and paper records were stored securely in lockable drawers.

We did not witness any notes being left unattended and staff made a conscious effort to ensure records were locked away when not in use.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes to safely prescribe, administer, record and store medicines. The service had an integrated IT system for managing medicines that provided access to patients' GP records and community pharmacy, a plan was in place when IT issues meant records were not available.

Staff reviewed patients' medicines regularly, when admitted and during their stay. Medicines reconciliation was completed by pharmacy staff and records showed the trust target of 50% in 24 hours following admission had been achieved. However, this target was not compliant with the current National Institute for health and Care Excellence (NICE) guidance which indicates 100% of patients' medicines should be reconciled within 24 hours or sooner if clinically necessary. This meant staff could not always be assured they had a complete understanding of the medicines each patient took and the potential impact on their diagnosis and treatment.

The trust's monthly antimicrobial stewardship audit showed good compliance against audit standards (98% for Quarter 1 2022-23). The audit was completed monthly and any areas for improvement shared at ward and directorate level.

Specific advice was given to patients and carers about their medicines on discharge, usually by nursing staff on wards and in the discharge lounge. Pharmacists worked across directorates to ensure skills were maintained but were supervised by a trauma and orthopaedic specialist pharmacist. There was a difficulty recruiting pharmacy technicians, so the trust had employed medicines management assistants to support the management of workloads on the wards.

Staff followed current national practice to check patients had the correct medicines. All surgical patient records we checked, had appropriate monitoring in place.

Staff stored and managed all medicines and prescribing documents in line with the provider's policy, though we found a medicines procedure which was past the review date and not aligned across the Northern Care Alliance trust. Some wards had automated cabinets that sent requests to pharmacy for refills, however other wards relied on pharmacy staff checking order books when visiting the ward.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. 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. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff we spoke with were able to give examples of incidents they had reported on the electronic reporting system. For example, pressure ulcers, falls and staffing levels.

Staff raised concerns and reported incidents and near misses in line with trust policy. The service provided data on incidents reported for the previous six months. The data was for the Salford care organisation and not specific to the surgery division at the hospital. However, 87 incidents were theatre related, 67 were surgery related and 60 were anaesthetics related.

In accordance with the Serious Incident Framework 2015, the trust reported 26 serious incidents (SIs) in surgery which met the reporting criteria set by NHS England from June 2021 to May 2022. The most frequent type of incidents were surgical/invasive procedure (seven incidents), slips, trips, and falls (six incidents) and sub-optimal care of a deteriorating patient (six incidents).

We reviewed the service's never events. Never events are serious patient safety incidents that are entirely preventable. The division had reported one never event between June 2021 and May 2022 which occurred in theatre. Managers investigated the incident and shared lessons learned with the whole team and the wider service. There were no never events reported on any wards.

Surgery

Learning from incidents was shared with staff across the service and divisions through lead nurse, ward manager and governance meetings. Staff told us that incidents and learning were discussed during handovers, daily safety huddles and quarterly newsletters.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when they identified things that went wrong. 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 with were aware of the term and gave examples of when they had applied the process.

There was evidence that changes had been made because of feedback. Staff on ward B1 gave an example of how they had tried to reduce the number of falls. They used 'call don't fall' posters on the walls, gave patients gripped socks, used a falls sensor in a bathroom and staff provided a falls prevention video for patients to watch.

Is the service effective?

Requires Improvement ↓

Our rating of effective went down. We rated it as requires improvement.

Evidence-based care and treatment

Staff protected the rights of patients subject to the Mental Health Act 1983. The service provided care and treatment based on national guidance and evidence-based practice.

Compliance with NEWS2 and the safer surgery checklist was audited. Designated members of staff had the responsibility of completing the audits and did so in a timely manner.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. Staff contacted the mental health liaison team to arrange mental health assessments of patients including assessments under the Mental Health Act, where necessary.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients. We saw discussion of patients with mental health needs during nursing handovers.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. For example, National Institute for Health and Care Excellence (NICE), Royal College of Surgeons' guidelines, the Association of Anaesthetists of Great Britain & Ireland (AAGBI) and the Association for Perioperative Practice (AFPP). The trust operated a central online policy hub. However, during our inspection of the core services, we found that some services were using legacy policies from the previous trusts or accessing a suite of policies separate to the central Northern Care Alliance hub. As part of our ongoing monitoring of the trust, and throughout the inspection, we found there was a need to align some legacy Salford and Pennine policies to ensure there were trust-wide versions that reflected national or best practice guidance where appropriate.

The service had a standard operating procedure based on the 'stop before you block' (SBYB) guidance. The guidance aims to reduce incidences of wrong-sided nerve block during regional anaesthesia. This meant that theatre staff and anaesthetists had a second checker when administering an anaesthetic block. However, observations from the reported never event showed that this guidance was not always followed by staff.

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. Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods. The service made adjustments for patients' religious, cultural and other needs.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. We looked at 10 patient records which showed staff carried out an assessment of patients' nutritional requirements and used the malnutrition universal screening tool (MUST).

We saw that some patients had gaps in the fluid and nutrition charts on some wards we visited. Staff carried out an audit every month to measure whether patients had a MUST assessment completed within six hours and 24 hours of admission.

Divisional data showed that from November 2021 to July 2022 MUST assessments completed within six hours of admission had not met the trust target of 95% during this time period. Compliance ranged from 78% to 89%. However, the division had met the target of 95% every month for MUST assessments completed within 24 hours of admission.

Staff told us that recent audit results for monitoring and documenting patients' food and fluid intake had demonstrated a poor compliance. There was an action plan in place to improve performance. This started in May 2022 with a target completion date of August 2022. Actions included training and education for ward-based staff, new starters induction to include the importance of food chart and fluid balance completion and weekly audits of food and fluid charts. On ward B1 we saw a notice board dedicated to the topic of fluid balance that included informative posters on how to monitor fluids and the importance of doing so.

Patients with specific dietary needs were identified in their pre-operative assessment or within 24 hours if they were emergency patients. Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Drinks were readily available and were in easy reach of patients.

Patients told us that the food and drink available met their needs and that they had adequate choice. They were complimentary of the quality of the food. Staff across the wards described different options available for patients with specific requirements, such as vegan, vegetarian, halal, and kosher meals.

The service had protected meals times in place and patients who needed support eating their meals were identifiable to staff through the allocation of red trays. However, audit data showed that some wards had a low compliance rate of using the red tray system.

Specialist support from staff such as dietitians and speech and language therapists were available for patients who needed it.

Surgery

Patients waiting to have surgery were not left nil by mouth for long periods. Systems were in place that followed current best practice guidelines to identify patients that were required to fast before surgery.

Data from a patient survey taken the previous year showed that 100% of patients said they received help from staff when eating their meals.

Pain relief

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

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice.

There was an acute pain team available between Monday and Friday 8am until 6pm and weekends 8am until 2pm with out of hours support available.

Theatre and critical care had a post-operative pain management policy for staff to follow when patients were experiencing acute severe pain. Patients who did not respond to high dose opiates could be placed on a pain pathway by an anaesthetist or after consultation with a member of the acute pain team. Pain was assessed, during intentional rounding observations, every two hours through the night and every hour during the day. For patients who were experiencing high levels of pain they would be reviewed more often if needed.

We observed nurses administering pain medication, they had positive interactions with patients asking patient how their pain had been managed and asking patients for a pain score. Staff told us that they prioritised pain relief and regarded it as highly important.

We spoke with patients on the surgical wards who spoke positively about how their pain had been managed. Patients told us that if they had been in pain, staff had responded quickly and checked that the pain relief was effective. The patient survey showed that 100% of patients felt the staff did everything they could to help control their pain.

Staff used the Abbey Pain Scale (APS) for non-verbal patients. This scale uses pictures of faces to which patients could use to indicate levels of pain.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They mainly achieved good outcomes for patients. However, they did not consistently use the findings to make improvements. The service had a higher than expected risk of readmission for elective admissions for urology and general surgery patients when compared to the England average.

The service conducted local and national audits to monitor the effectiveness of care and treatment. Managers and staff had implemented changes and actions following some audit outcomes. However, we saw limited evidence that managers and staff consistently used the results and information from audits to improve patients' outcomes. Following our inspection, the trust provided clinical audit updates which showed several outstanding reports and significantly overdue action plans.

For example, the national joint registry audit outcomes had been published in September 2020 and a further report had been published in November 2021. At the time of inspection an action plan had not yet been completed.

The division currently had 53 on-going local audits registered with the clinical audit team and three audits registered in 2018/2019 and 2019/2020 were significantly overdue. The clinical audit reports documented that local audits should be completed in a timely manner and that results not within the expected assurance levels would be included onto risk registers until the appropriate assurance levels had been reached.

The care organisations' clinical audit programme included participation in the advancing quality (AQ) focus area programme related to hip and knee replacement. Monthly compliance with this AQ measure was an average 88.7% against a target of 92.5%. The care organisation was ranked 14th out of the 15 participating trusts.

From January 2021 to December 2021, all patients at Salford Royal Hospital had a lower than expected risk of readmission for elective admissions when compared to the England average.

However, urology and general surgery patients had a higher than expected risk of readmission for elective admissions when compared to the England average.

From January 2021 to December 2021, all patients at Salford Royal Hospital had a lower than expected risk of readmission for non-elective admissions when compared to the England average.

From January 2021 to December 2021, general surgery patients, urology patients and trauma and orthopaedics patients at Salford Royal Hospital had a lower than expected risk of readmission for non-elective admissions when compared to the England average.

The division participated in relevant national clinical audits. In the 2021 hip fracture audit, the hospital performed worse than the England average for ‘mental test score recorded on admission’ and ‘not delirious when tested post-op.’ However, the hospital met the best practice criteria and performed similar to or better than the England average for the other eight out of ten indicators.

Data for the national fracture liaison service database between January 2020 and December 2020 showed that the service scored lower than the national average on 9 out of 11 indicators.

The division participated in the national bowel cancer audit (NBOCAP) and performed within the expected range for each of the three indicators where there was a comparison to other hospitals. However, for ‘adjusted length of stay for patients undergoing major resection’ they were worse than the national average.

Data was provided for the number of patients readmitted from October 2021 to December 2021 due to infections. Performance for hip replacement, knee replacement and repair of the neck of femur (NoF) was better than the national average. However, performance for open reduction of fracture of long bone (3.9% readmission rate) was worse than the national average (0.7%). There was one post discharge infection recorded for one out of nine patients who had hip replacement surgery. Due to the suspension of surveillance, there was no other data available.

Outcomes from the national oesophago-gastric cancer audit (NOGCA) had most measures better than or close to the national average.

Surgery

The service participated in the nursing assessment and accreditation system (NAAS) audits. NAAS is the performance assessment framework to measure the quality of nursing care delivered by teams across the trust. NAAS is used to assure patients, visitors, and staff that patients are receiving safe, clean, and personal care every time (SCaPe).

NAAS audits covered topics such as; patient safety, environment safety, nutrition and hydration, safeguarding, pain management, medicines management, pressure ulcers, communication, and infection control. Wards are inspected on an unannounced basis and are assessed against the standards and scored red, amber, green or blue. All wards within the surgical division had been awarded blue which is SCaPe status and the highest level.

Competent staff

The service mostly made sure staff were competent for their roles. However, managers did not always appraise staff's work performance or hold supervision meetings with them to provide support and development.

There was a rotating staff training programme to improve skills across the surgery wards. This involved the general surgery wards (B1 and B2) and the emergency surgery unit (H4) into the surgical enhanced care unit (B2M). Managers gave all new staff a full induction tailored to their role before they started work. Theatres had induction packages and a 12 month plan to develop these for each discipline. This was being supported by practice trainers.

Staff we spoke with confirmed they had received an appropriate induction which equipped them to work within the department. Junior doctors and newly registered nurses spoke positively about the induction process and the extra support they had received.

Surgical wards had practice education leads who identified training requirements and signposted staff to learning and development resources.

Senior leaders told us that general surgery staff had three surgical study days a year and these were supported by the surgeons. Staff on wards B1, B2 and B2M were trained up to level two of critical care. Level two patients required more detailed observation or intervention and staff had the appropriate level of training to provide care and treatment.

The surgical division had numerous specialist nursing teams who specialised in nutrition, stoma care, urology, gynaecology, upper gastro, and lower gastrointestinal surgery.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. If staff members were not able to attend a team meeting the meeting minutes were shared via email. This allowed staff the opportunity to keep up to date with any changes or learning which had been highlighted.

However, managers did not always support staff to develop through yearly, constructive appraisals of their work. Trust data for the Salford care organisation showed that 77% of staff in the surgical division had completed an appraisal. Data for specific job roles showed that 60.7% of nursing staff and 81% of medical staff across the surgical division had received an appraisal in the last 12 months. This meant that not all staff had the opportunity to identify personal and professional development needs or receive support.

Staff were experienced but did not always have the right skills and knowledge to meet the needs of patients. This was because not all staff completed required mandatory or job-related training and managers did not have oversight of sepsis training compliance.

Multidisciplinary working

Doctors, nurses, and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

There was effective daily communication between multidisciplinary teams within the surgical wards and theatres. Staff handover meetings took place during shift changes and 'safety huddles' were carried out daily in the ward and theatres to ensure all staff had up-to-date information about risks and concerns.

Handovers were attended by staff of all levels including doctors, nurses, clinical support staff and allied health professionals including physiotherapists and occupational therapists.

Staff worked across health care disciplines and with other agencies when required to care for patients. For example, with adult social care teams to implement safe and effective discharges.

The ward staff told us they had a good relationship with consultants and ward-based doctors. We saw there was effective team working and communication between the theatre teams.

Staff worked with mental health colleagues when referring patients for a mental health assessment. Staff gave examples of when they had contacted the mental health team and told us patients were generally reviewed the same day or within 24 hours of a referral being made.

Staff worked closely with physiotherapists, occupational therapists, tissue viability nurses, dieticians and speech and language therapists. Patients spoke positively about the input and communication between the various professionals involved in their care.

Patients had their care pathway reviewed by relevant consultants.

Seven-day services

Most key services were available seven days a week to support timely patient care.

Most services within the division operated 24 hours a day for seven days, this included the surgical triage unit. Theatres operated 8am till 9pm seven days a week and out of hours operations could be carried out. Consultant cover was provided 24 hours a day seven days a week.

The pre-operative assessment and the assessment lounges for day case patients primarily operated between Mondays and Fridays. However, these services could operate weekend lists to manage patient waits at busy times.

Consultants led daily ward rounds on all wards, including weekends.

Patients were reviewed by consultants depending on the care pathway. There was sufficient out-of-hours medical cover provided to patients in the surgical wards by junior and middle grade doctors as well as on-site and on-call consultant cover. There was on-site consultant presence across most surgical specialties on weekends along with on-call cover and consultant-led ward rounds taking place seven days per week.

Staff told us they accessed the 'hospital at night team' after 5pm. This clinical team triaged all clinical calls and had advanced clinical practitioners to carry out assessments and treatments throughout the night.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week.

Microbiology, imaging (such as x-rays), physiotherapy, occupational therapy and pharmacy support was available on-call outside of normal working hours and at weekends.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

Staff assessed patient's health on admission and provided support for any individual who needed to live a healthier lifestyle. Patients identified as consuming high levels of alcohol, being overweight or smokers were given advice and support. This included information on how to access local support services.

Patients could access a weight management service within the hospital for treatment options and specialist advice in bariatric surgery. This was staffed by specialist doctors, dietitians, and psychologists.

The service had relevant information promoting healthy lifestyles and support on the surgical wards. The wards had a range of information leaflets to provide support and advice for patients around healthier living. We saw most wards had information leaflets about various health issues and how to manage them. These were also available in different languages.

There was a diabetic link nurse who could speak to patients about health concerns.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. However, not all staff completed training in the Mental Capacity Act or Deprivation of Liberty Safeguards.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.

The 'consent to examination or treatment' policy was accessible on the intranet under the whole trust section but was not applicable to the Salford care organisation. However, after the inspection a new trust wide policy was approved and was applicable to all care organisations.

Staff gained consent from patients for their care and treatment in line with legislation and guidance based on all the information available. Staff clearly recorded consent in the patients' records. During our inspection we reviewed 10 sets of patient records. Patient consent had been obtained and documented correctly where appropriate such as before treatment or a procedure was carried out.

When patients could not give consent, staff made decisions in their best interest, considering patients' wishes, culture and traditions.

Surgery

Managers monitored the use of Deprivation of Liberty Safeguards (DoLS) and made sure staff knew how to complete them. Staff completed DoLS appropriately and once a DoLS had been initiated a referral would be made to the safeguarding team to make them aware of that patient.

However, staff received but did not always keep up to date with training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards. The service told us that training in these subjects was covered within safeguarding adults level 3 training. However, not all staff were required to complete this level of training and evidence provided by the division showed only 68% of nursing staff and 52% of medical staff had completed it.

Results from the most recent mental capacity assessment audit identified some cause for concern in relation to compliance against five standards of care. Compliance for two standards were met but two standards were 69% and 79% against a target of 100%. As a result of the audit a number of recommendations had been agreed. This included an action plan from the care organisation and MCA training to be evaluated and made mandatory across all care organisations within the trust.

Is the service caring?

Good

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Staff explained to patients what they were doing when providing care and treatment.

We observed kind and caring interactions between patients and staff. For example, on the emergency admissions unit (H5), staff gave patients the time they required to communicate their needs and were reassuring.

Staff understood and respected the personal, cultural, social, and religious needs of patients and how they may relate to care needs. We observed patients who were living with dementia being cared for by staff in a calm and caring manner.

Staff followed policy to keep patient care and treatment confidential. Patients in individual rooms kept doors closed when necessary so their privacy could be maintained. We also saw staff spoke with patients in private to maintain confidentiality.

Patients said staff treated them well and with kindness. Patients we spoke with during the inspection told us staff were friendly, attentive, and caring. Patients spoke positively about the admission process, length of stay and transfers between wards. Comments included “the staff work really hard” “they are always ready to help” and “nothing was too much trouble” “staff have been lovely and friendly” “staff have checked on me and kept me updated on when I can go home” and “the care has been amazing.”

Surgery

The patient survey showed that 100% of patients felt fully informed about their care and treatment.

Staff followed policy to keep patient care and treatment confidential. The patient survey showed that 100% of patients felt they were treated with respect and dignity.

Emotional support

Staff provided emotional support to patients, families, and carers to minimise their distress. They understood patients' personal, cultural, and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. We observed a patient on ward B6 who was living with dementia and staff acted calmly with kindness to provide emotional support to reduce their distress.

Staff understood the emotional and social impact that a person's care, treatment, or condition had on their wellbeing and on those close to them. The service had a multi-faith chaplaincy team to provide emotional and religious support to patients and their visitors. The support was available 24 hours a day. Information relating to this was displayed on notice boards throughout the department.

Staff shared examples of how they had adapted their practice to accommodate individual needs and preferences. For example, staff had adapted the discharge plan for a patient who was autistic so they could remain on the inpatient ward instead of waiting in an unfamiliar discharge lounge.

There was support available for the bereaved from the hospital palliative care team and bereavement team. Information on these services was displayed within leaflets with contact numbers.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families, and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. We observed staff on wards communicating with patients in a clear verbal style.

Staff talked with patients, families, and carers in a way they could understand, using communication aids where necessary. Data from a patient survey taken the previous year showed that over 95% of patients felt that doctors had answered their questions in a way they could understand. There was 100% of patients who felt that nurses and other clinical staff answered their questions clearly.

Patients' family members we spoke with told us they had been kept updated if requested to do so.

Patients and their families could give feedback on the service and their treatment via patient surveys and staff supported them to do this. Wards had posters displayed on notice boards encouraging patients to share their experience of care and treatment to help them improve.

Staff mainly supported patients to make advanced decisions about their care. Data from a patient survey showed that between 83% and 86% of patients felt fully involved in the decisions about their care.

Surgery

Patient surveys and patients we spoke with during the inspection gave positive feedback about the service.

Is the service responsive?

Requires Improvement 

Our rating of responsive went down. We rated it as requires improvement

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

The hospital provided a range of elective and unplanned surgical services for the communities it served. This included general surgery, gynaecology, trauma and orthopaedic, urology and oral surgery.

Managers planned and organised services so that they met the needs of the local population.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. The areas we inspected were compliant with same-sex accommodation guidelines and we observed that male patients were cared for in separate areas to female patients.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia. Wards had posters to inform patients and families about a local mental health advocacy support service that could attend ward rounds, medication reviews, discharge meetings and help patients understand their rights under the Mental Health Act.

The service had systems to help care for patients in need of additional support or specialist intervention. Appropriate notification systems were in place to highlight patients who had specific or complex needs and open visiting times for patients who needed it.

The hospital had a successful dining companion scheme, which provided support to patients at mealtimes. Volunteers worked on various wards to support elderly, stroke, and trauma patients. They were trained to feed or support the feeding of patients, who may have cognitive impairment like dementia or have mobility, visual or communication difficulties.

From September 2021 to January 2022 there had been 51 volunteers who had provided 195 volunteer hours each month. It was reported that 976 patients had been supported by dining companions and 98% of patients had been visited for an hour or more.

It was also reported that 95% of patients said the volunteer had improved their mood and 100% of staff said that the support was helpful in allowing them to deliver good quality care and made them feel less stressed.

Meeting people's individual needs

Surgery

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers. However, the environment across the surgical wards and theatre areas was not always dementia friendly.

Staff made sure patients living with mental health problems, learning disabilities and dementia received the necessary care to meet all their needs. Staff could access emergency mental health support 24 hours a day seven days a week for patients living with mental health problems.

Staff could refer patients to the learning disability and autism service to help support them and their carers. Specialist learning disability nurses were available to help make reasonable adjustments and help co-ordinate care. For example, pre-admission planning, ward visits, communication advice and discharge planning.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. They had access to communication aids to help patients become partners in their care and treatment. Staff on B1 told us they used picture cards so patients could point to pictures to illustrate their feelings and needs. Staff on B2 shared an example of how they had made adjustments for a patient with learning disabilities and involved their parents to gain information regarding preferences.

The wards we visited used wristbands, sunflower lanyards, or a butterfly symbol to discreetly identify patients living with dementia or a learning disability. Staff told us that patients could have a side room and have fidget toys and their own communication cards.

The service had information leaflets available in languages spoken by the patients and local community.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff were able to describe situations when they had accessed interpretation and translation services for patients.

Patients were given a choice of food and drink to meet their cultural and religious preferences. Staff told us that they had various options to cater for different preferences such as kosher, halal and Jamaican food. Staff on B6 told us they had acquired an additional fridge so that patients of a certain faith could keep their food stocked separately.

Ward B6 had a quiet room for prayer and staff told us that porters escorted patients to the chapel to pray. The quiet room had various religious texts for patients to use. Chaplains would attend wards to visit and pray with patients at their bedsides if requested.

Most wards we visited had dementia activity boxes that included handknitted arm covers, memorabilia packs and games. In addition, ward B6 had a quiet room, memory boxes and used music to help calm patients when they were agitated. This meant patients living with dementia had access to items which could help them engage in activities that were therapeutic, mentally stimulating, and beneficial for their wellbeing.

We observed posters on noticeboards that signposted patients and families to dementia support services. The wards had signed up to John's Campaign which focused on the right of people living with dementia to be supported by their family or carers in health and social care settings.

Ward B6 had a dementia link nurse and adjustments had been made to the environment to make it dementia friendly. There were larger clocks, subtle lighting option, neutral and matt finish flooring, a board with the date and weather, pictures on bathroom and toilet doors and pictures of food instead of menus.

However, not all wards were designed to meet the needs of patients living with dementia. Most wards we visited did not have any adjustments to the environment to make it dementia friendly such as toilet or shower signage on doors.

We did not find evidence that staff supported patients living with dementia and learning disabilities by using 'this is me' documents or 'hospital passports'. Hospital passports record information such as anxieties, likes and dislikes, interests, and preferred ways to communicate. Staff we spoke with were aware of these communication aids but could not provide any evidence of them being actively used at the time of inspection.

Access and flow

People could not always access the service when they needed it or received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards.

Patients could be admitted for surgical treatments through a number of routes, such as pre-planned day surgery, through accident and emergency or through GP referral. Patient records showed that patients were assessed upon admission to the wards or prior to undergoing surgery.

Managers monitored waiting times; however, they did not always ensure that patients could access services when needed or receive treatment within agreed timeframes and national targets.

NHS England sets out that patients should wait no longer than 18 weeks from GP referral to treatment (RTT) with a national target of 92%. Trust data showed that the hospital overall treated 66.4% of patients within 18 weeks of referral in January 2022. This was better than the actual national 62.8% delivery against target. However, the hospital treated 55.7% of patients within 18 weeks in March 2022 and 58% in June 2022. This was worse than the actual national figures which ranged from 62.4% and 62.2% for the same time period.

Hospital data broken down by speciality for May 2022 showed that general surgery had treated 40% of patients within 18 weeks (actual national 58.3%), urology was 52.7% (actual national 60.4%), trauma and orthopaedic was 43% (actual national 57.9%), gynaecology was 48.8% (actual national 59.7%) and oral surgery was 34.7% (actual national 55.7%).

Hospital data for June 2022 showed that 43% of cancer patients had seen a consultant within two weeks of referral from their GP. This was significantly below the national target of 93% and worse than the actual national 77.7%. For the same time period around 92% of cancer patients received a treatment plan within 31 days of referral from their GP. This was slightly below the national target of 96%. Trust data also showed that showed that 58% of cancer patients received treatment within 62 days of referral from their GP. This was below the national target of 85%.

NHS England also set a standard that no patients should wait longer than 52 weeks for any referral to treatment. Data as of May 2022 showed the trust was in the bottom 25% of all trusts for this measure. For the trust, the percentage of patients waiting more than 52 weeks increased by 74.8% from December 2021 with 6,700 to 11,709 in May 2022.

In February 2022 NHS England set a target for hospitals to eliminate waits of over 104 weeks by July 2022. In August 2022, the hospital had 10 patients waiting 104 weeks and over. Senior leaders told us that for the surgical division they had reduced 104-week waiters from 600 patients to one patient who was deemed clinically complex. The service held clinical prioritisation meetings to focus on the waiting list targets.

Surgery

NHS England also set a target for hospitals to eliminate patient waits over 78 weeks by April 2023 and 52 week waits by March 2025. The hospital had an elective recovery plan that included proposed trajectories for reducing these waiting lists. For example, the trajectory showed that between September 2022 and February 2023 they had planned to reduce patients waiting over 78 weeks by 290 patients to zero.

Data for the trust showed that the waiting list had increased from 125,000 in October 2021 to 140,000 in May 2022 and the number of patients treated per month has remained consistent around 15,000 per month since December 2021.

From February 2021 to January 2022, the average length of stay for patients having elective and non-elective surgery at this hospital was worse than the England average across all surgical specialties except for non-elective urology.

The average length of stay for patients having elective surgery at this hospital was 6.8 days. The average for England was 3.8 days. The average length of stay for patients having non-elective surgery at this hospital was 7.4 days. The average for England was 4.3 days. Patients who have longer hospital stays are at risk of hospital acquired infection, falls, sleep deprivation and physical deconditioning.

Data for the same time period broken down by specialties showed that the average length of stay for patients having elective general surgery at this hospital was 11.8 days. The average for England was 4.1 days. Elective neurosurgery was 5.7 days against a national average of 5.4 days, elective urology surgery was 3.4 days against a national average of 2.4 days.

Non-elective general surgery was 4.3 days. The average for England was 3.3 days. Non-elective neurosurgery was 13.8 days against a national average of 12.3 days. Non-elective urology surgery was 2.4 days which was the same as the national average.

Senior leaders told us that length of stay was a challenge and they were looking at ways to improve this. They said there had been an improvement in the length of stay for neurology patients since introducing robotic surgery.

Staff told us that patients who did not meet the criteria to reside (patients who were medically fit for discharge) were monitored daily. There were also weekly meetings to review those patients who had a long length of stay. Trust data showed that in July 2022 there were 185 patients who were medically optimised to leave hospital. This data was for the Salford care organisation across all specialities.

When patients had their operations cancelled at the last minute, they were not always rearranged within national targets. Over the previous two years, the percentage of cancelled operations at the trust was worse than the England average. Data from quarter four in 2021/2022 showed that the trust cancelled 363 surgeries. Of these cancelled operations, 6% of patients were not treated within 28 days compared to the England average of 3%.

Trust data showed that between February 2022 and July 2022 the hospital had cancelled 528 operations for non-clinical reasons. The main reasons were administration error (128 operations), replaced by an emergency (110 operations), COVID-19 related (93 operations), no anaesthetist (54 operations) and no surgeon (47 operations). The hospital had cancelled 297 operations for clinical reasons for the same time period. The main reasons were related to patient not being fit (70 operations), not medically fit (58 operations) and cancelled at pre-operation stage due to fitness (43 operations).

Surgery

Staff did not always plan patients' discharge effectively. This was evident from the number of patient discharges between 5pm and midnight. Trust data showed that between March 2022 and July 2022, an average of 137 general surgery patients per month were discharged from the hospital after 5pm. For the same time period the figures were; an average of 72 trauma and orthopaedic patients, 79 urology patients, 28 neurology patients and 67 gynaecology patients.

Staff started planning each patient's discharge as early as possible and there was a discharge team to deal with complex discharges for patients with mental health and social care needs. Managers monitored the number of patients whose discharge was delayed, knew which wards had the most delays, and took action to reduce them.

However, staff told us that doctors would sometimes announce unplanned (same day) discharges during ward rounds. They said that planned discharges were quicker compared to unplanned discharges for reasons such as waiting for discharge medication or equipment.

Staff and patients told us that waiting for take home medication was a common reason for an unplanned discharge delay. One patient told us they had been informed in the morning that they would be discharged that day. However, at 5pm they were still waiting for their discharge medication. This meant that the bed was not available for another patient who would need it.

Staff told us that issues with discharge medications could be due to a delay in the prescriptions being written up or clinical errors. This delay prevented patients being sent to the discharge lounge. However, there were daily meetings with the patient flow team so movement could be monitored and maintained and to identify and resolve any issues relating to the admission or discharge of patients. Staff were aware of how to escalate key risks that could affect staffing and bed capacity constraints and there was daily involvement by the matrons and ward managers to address these risks.

Several actions had been undertaken to improve referral to treatment waiting time performance and theatre utilisation. Senior leaders told us they had recruited more theatre staff which had increased the capacity to run more theatres and that most of them were now fully staffed. They told us that bed availability was a daily challenge to ensure there was sufficient capacity for emergency and elective work and that patient flow was discussed daily. They said that cancellations due to bed availability did happen occasionally and that orthopaedic and surgical bed capacity was in the top three risks.

The hospital had an integrated discharge team who supported patients with their discharge from hospital when care and support needs had been identified.

Managers monitored and took action to minimise missed appointments. Managers ensured that patients who did not attend appointments were contacted, and a new appointment was made.

The service relieved pressure on other departments by treating patients for planned day case surgery and the surgical triage unit (STU) reduced unnecessary admissions to inpatient beds. This also helped capacity across the emergency department.

Staff we spoke with told us that many patients returned to the STU after theatre and remained there until discharge. The inclusion criteria for post-operative recovery from theatre was for patients with a maximum 48 hour expected length of stay. However, during the inspection, one patient had been in the STU for eight days.

Learning from complaints and concerns

Surgery

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. However, complaints were not always responded to within the timescales specified in the trust complaints policy.

Patients and relatives we spoke with knew how to complain or raise concerns.

The service clearly displayed information in patient areas about how to raise a concern. Wards had posters displayed to encourage patients and families to give feedback on the quality of care and treatment. This included information on the patient advice and liaison service (PALS), the friends and family test (FFT), how to give feedback online and how to contact the patient experience team. There were also 'help' cards given to patients that encouraged them to speak to staff if they had any concerns. The cards included a helpline phone number to call if they still had concerns after speaking to staff. The helpline was staffed 24 hours a day 365 days a year by a team of senior nurses who would review their concerns within an hour.

Senior leaders told us that they held monthly patient experience meetings and that feedback from the FFT was reported back up through the quality matron. The service used social media to share information and patients on the cancer improvement committee could share their experiences and provide feedback. Patient stories were also shared at the improvement board to learn what was going well and which areas required improvement.

Senior leaders told us that staff could also use a reporting system to share compliments and had received a lot for the surgery division.

Staff we spoke with understood the policy on complaints, knew how to handle them and could give examples of how they used patient feedback to improve daily practice. Staff on B6 told us that a common theme for complaints was related to discharges being delayed. Wards displayed patient feedback on notice boards describing 'you said we did' scenarios. One example was how staff had continued to plan for patients' discharges as early as possible to avoid delays with discharge summaries or medication.

Managers investigated complaints and identified themes. Hospital data showed that from February 2022 to July 2022 the surgical division at Salford Royal Hospital received 59 formal complaints and 275 enquiries via PALS. However, the divisions average compliance for responding to these complaints within the agreed period was 77%.

Managers shared feedback from complaints with staff and learning was used to improve the service. The nature of the complaints and the learning identified was recorded on a database and included actions to be taken. The outcomes from complaints were shared at the daily safety huddle meetings so that staff could learn and improve patient safety and experience.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Is the service well-led?

Requires Improvement ↓

Our rating of well-led went down. We rated it as requires improvement.

Surgery

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. Most staff spoke positively about the local leadership. They supported staff to develop their skills and take on more senior roles. However, most staff told us that senior leaders were not visible, and engagement was limited.

The trust managed its services through four place-based care organisations. Each care organisation was managed by a medical director, director of nursing, director of operations, HR director and finance director. Salford Royal Hospital was part of the Salford care organisation.

The division of surgery had a triumvirate leadership team with a chairperson of division, a divisional director of nursing and a managing director.

The division was split into anaesthetics, peri-operative care, trauma and orthopaedics/plastics, gynaecology, urology, and general and oral surgery. Each speciality had a senior manager and an assistant director of nursing services. However, not all specialities had a clinical director. At the time of inspection, general and oral surgery did not have this position filled.

The division had identified gaps in theatre and nursing staffing and plans to retain and increase staffing were in progress. They had successfully recruited more than 88 members of staff across the disciplines. Some had started in April 2022 and others were due to start in September 2022.

Most staff spoke positively about the local leadership and told us they had good working relationships. Staff in theatres told us they were actively encouraged to progress their career from healthcare assistants to operating department practitioners (ODP's) or nurse assistants. They told us that managers supported them with educational training days off site.

On the wards and units that we visited during the inspection we saw that there was strong clinical leadership from the ward managers and the lead nurses. Most nurses we spoke with told us that they felt valued and supported by the ward managers. Staff on the surgical wards told us they were proud of their professional development and felt appreciated.

Ward managers told us that service leaders were visible, approachable, supportive, and friendly. They worked closely with the lead nurse, quality matron and deputy lead of surgery and had regular meetings.

However, not all staff spoke positively about the senior leadership and organisation structure.

Most staff told us that senior leaders were not visible, and engagement was limited. Some staff felt that not having a clinical director of general and oral surgery was problematic. They did not feel supported or listened to when raising concerns with senior members of staff. They believed that clinical incidents were not always reported or acted on due to a defensive attitude from leaders.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The trust had developed a vision and strategy for 2021 called 'Vision 10: NCA 10 Year Strategy' with the vision to be the safest and most effective organisation in the NHS and the place where people want to work. This strategy focussed on improving population health, caring for and inspiring people, improving quality, improving performance, supporting social and economic development and financial sustainability.

Senior leaders told us the aims for the surgical division were to manage waiting lists, focus on cancer pathways, organisational development and succession planning, good outcomes for patients, safety, high staff satisfaction and efficient use of resource.

Other aims included the promotion of staff wellbeing with a better work/life balance, to improve understanding about job roles/responsibilities and more detailed work on job plans.

The trust had a 'people milestone plan' for 2022/2023 that incorporated aims and objectives related to staff. Actions focused on the need to recruit and train the right number of staff, with the right skills and abilities and to listen, invest, inspire, and care for staff to create a positive staff experience. Leaders recognised that this would improve patient care, experience, and outcomes.

Culture

Staff mostly felt respected, supported, and valued. They were focused on the needs of patients receiving care. The service promoted and provided opportunities for career development. However, not all staff felt there was an open culture where they could raise concerns without fear.

Most staff we spoke with were highly motivated, patient-focussed and spoke positively about working in the surgical services.

The trust had a support programme for staff called 'SCARF' (Support, Care, Assist, Recognise, Family). This helped staff look after their physical, emotional, and psychological wellbeing and to make it easier for staff to find access to practical resources and information.

Staff received four hours of wellbeing time a year and staff could be referred for counselling through the programme via occupational health. All staff we spoke with had heard of the SCARF programme and knew how to access it if they needed to.

Staff told us they were most proud of their team work especially through the pandemic and many staff described positive working relationships with colleagues of all levels. All staff we spoke with said that staffing was the main issue that impacted on their work.

Staff could access support from a freedom to speak up service (FTSU) and there was a system in place to enable staff to be able to speak up about any safety concerns. The hospital reported that their data showed a good awareness and consistent usage of the FTSU service. It was noted to be in preference to external services and there had been an annual improvement in staff perceptions of the speak up culture.

Most staff told us that morale was good and that the culture in the division was positive. We spoke with a junior doctor who told us that consultants were approachable, understanding, and friendly.

However, a small number of staff told us that they did not always feel respected or supported by senior managers. There was a reluctance to speak up without fear and they said this had been the culture for many years.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff had regular opportunities to meet, discuss and learn from the performance of the service. However, monitoring and reporting of local clinical audit activity was not always effective. Not all staff were clear about their roles and accountabilities.

The surgery division worked in partnership with the NCA's Manchester Centre of Clinical Neurosciences (MCCN). This division provided specialist surgical services, including ear, nose, and throat (ENT), neurosurgery and complex spinal surgery. The MCCN had five neurosurgery wards, a trauma assessment unit, and other services, including neuro rehabilitation. There were effective governance processes in place in the service. Senior leaders met regularly and held clinical prioritisation meetings in relation to waiting lists. They also discussed and monitored performance targets such as RTT, cancer waits, and theatre utilisation.

The triumvirate met once a week and told us they had regular close contact in other meetings such as operational board meetings and governance meetings. They attended directorate, divisional and care organisation quality, and performance meetings. The divisional governance meetings took place monthly and were chaired by the divisional director of nursing. We reviewed the minutes of a recent division governance meeting. These included key discussions around IPC, complaints, lessons learnt, policies, current risks, clinical effectiveness, and performance issues.

Team meetings were held on the wards and staff had the opportunity to add agenda items. Ward managers in the division met weekly and information from this meeting was communicated to staff. There was also regular senior nurse meetings and a quality away day booked for September 2022. Governance meetings took place every two months with general surgeons, junior doctors, senior nurses and senior managers.

Senior leaders had recently started an end of week email to share information with staff. They said it had had improved communication, reduced email traffic and that staff had been responsive to this new practice. They had an 'open door policy' once a week so staff could meet and discuss any issues arising.

The trust had developed a theatre excellence programme across the care organisations. The aims were to get waiting lists back to pre-pandemic levels by 2025, make the theatre departments a great place to work and to standardise best practice to improve patient safety and experience.

Staff told us that they were provided with information relating to learning and performance via emails, news bulletins, safety huddles and staff meetings.

The chairperson of division had regular scheduled meetings with the clinical directors across the specialities. They told us they had worked with the clinical directors from each speciality to bring more clarity on what they needed to focus on.

Senior leaders recognised there were issues affecting monitoring and reporting of local clinical audit activity. Recent board meeting minutes documented issues that included; the lack of an effective registration and monitoring database across the trust, not all local audit activity was registered with the clinical audit team (CAT) which was not in line with policy requirements, the CAT were not always sent audit reports after completion and local audits were not completed in a timely manner.

Nursing and support staff we spoke with understood what their individual roles and responsibilities were, what they were accountable for and to whom they were accountable. However, one member of staff within general and oral surgery told us that not all staff had job plans in place or a clinical director in post. They said there was a lack of clarity over the roles and accountabilities regarding on call duties.

Management of risk, issues and performance

Leaders and teams identified and escalated relevant risks and issues and identified actions to reduce their impact. However, they did not use systems to manage performance effectively. We identified poor performance in key processes such as mandatory training, accessibility of some policies, patient access and flow and patient outcomes. We were not assured the surgical services had implemented suitable remedial actions to demonstrate an improvement in key performance and compliance measures.

There was a divisional risk register with actions and due dates assigned to a named person or ward/directorate. Each risk had its own action plan. There were 120 live and approved risks, 10 new/unapproved risks and 57 overdue risks on the services register.

There was a surgery division risk committee who met quarterly and identified any missing risks associated with service delivery, reviewed existing risks, confirmed appropriate scoring, and escalated any score of 12 and above to the board assurance framework (BAF).

Senior leaders told us that risk registers were reviewed at least monthly and discussed weekly by the triumvirate team.

Senior leaders were able to verbalise their top risks which included non-elective orthopaedic bed capacity and surgery bed deficit. They recognised that not having enough non-elective beds and moving patients into elective beds was affecting the elective programme. They told us that staffing was still a high risk but had been downgraded due to recent onboarding and work around recruitment.

Ward managers were aware of the risks in their areas of work and were able to verbalise these and the plans in place to mitigate these risks. Whilst staffing was an issue for ward managers, they told us about their risks specific to their ward and had action plans in place to try to mitigate the risks.

We saw that routine audit and monitoring of key processes took place to monitor performance against objectives. Information relating to performance against key quality, safety and performance objectives was monitored and cascaded to staff through team meetings, safety huddles, performance dashboards and newsletters.

Whilst the service had risk management and audit processes in place, we were not assured the service managed performance and staff and patient risks effectively. This was because we identified poor performance in key processes such as mandatory training, accessibility of some policies, patient access and flow, patient outcomes and monitoring/ reporting of local clinical audit activity during the inspection.

Surgery

Information Management

The service collected data and analysed it. However, some staff were not confident the data was always accurate. In addition, staff could not always find the data they needed in accessible formats to help them understand performance, make decisions, and drive improvements. Data was not recorded or presented uniformly across the trust and some important data was not captured.

The information systems were secure. However, they were not always reliable or integrated well. On 18 May 2022, the trust experienced a major failure of some of its key information systems which affected Bury, Rochdale and Oldham care organisations. As a result, a critical IT incident was declared. The trust announced the issues were fully resolved on 20 June 2022. The failure disrupted diagnostic, pathology and pharmacy services, and referral pathways from GPs and primary care services.

The division had clear and robust service performance measures, which were reported and monitored through monthly governance scorecards to measure the performance of the division and individual wards.

The division had a comprehensive information governance policy that outlined robust arrangements to ensure the availability, integrity and confidentiality of identifiable data, records, and data management systems, in line with data security standards.

Any data security breaches were incident reported and lessons shared with staff via meetings and emails. We asked the trust to provide details of any information governance breaches in the previous six months. However, they did not provide data specific to Salford care organisation. Staff received training on information governance as part of their mandatory training, and the compliance rate across the surgical division was 91%.

There was a holistic understanding of performance that included data about people's views (complaints and feedback), finance (the cost and productivity impact of staff absence) and quality (number of falls, pressure ulcers and infection rates). This was evident in board meeting minutes that we observed.

The trust had recently reported an improvement in the retention rate of staff with less than two years' service and planned to add qualitative data to the report to highlight the most successful initiatives.

The ward and theatre areas had notice boards in place displaying information such as guidance and performance for staff and patients. Information on performance, patient safety and staffing was routinely collated, and dashboards were used to review this information and analyse trends.

Staff told us they could access patient information and up to date national best practice guidelines and prescribing formularies when needed. The division had effective arrangements to ensure that data or notifications were submitted to external bodies such as Care Quality Commission (CQC), Medicines and Healthcare products Regulatory Agency (MHRA) and Health and Safety Executive (HSE).

Information technology systems were used effectively to monitor and improve the quality of care. For example, to monitor compliance with the WHO checklist, risk assessments and fluid balance sheets. Action plans were in place for any areas that needed improvement.

Staff could access policies, procedures, and clinical guidelines through the trust intranet site.

However, not all policies we reviewed on the trust's intranet were easily accessible. Some policies were not saved under the Salford care organisation section. This meant if staff searched for some policies, they would not have access unless they searched for it across the NCA trust. After the inspection, the hospital provided a learning disabilities and autism policy that was applicable to the Salford care organisation. However, there was no issue date, approval date or review date recorded on the policy.

Engagement

The service routinely engaged with patients to gain feedback to plan and manage services. They collaborated with partner organisations to help improve services for patients. However, senior leaders were not always actively and openly engaged with staff.

Patients were asked to give feedback about their stay on the ward and staff across the surgical services told us they routinely engaged with patients to gain feedback from them. This was done informally and formally through participation in the friends and family survey. Feedback from the friends and family survey was mostly positive across the surgical wards.

The Salford care organisation had some positive and collaborative relationships with external partners to build a shared understanding of challenges within the system and the needs of the relevant population, and to deliver services to meet those needs. For example, the leadership team worked with the Health Watch partnership board to keep up-to-date on local developments.

The service had employed 'pathway navigators' to help address issues of patient inequalities in accessing health services. The issues were identified by local evidence. Senior leaders told us that their pathway navigators had supported patients with attending appointments and offered taxis for those who did not have access to transport.

The surgical division had networked with stakeholders, patients, and staff at a recent carer's event. Senior leaders told us that the division had a 'task and finish group' which met monthly and had focused on carers and information sharing. A carer's lead from a local charity attended the hospital two days a week to support wards and staff. Board meeting minutes from the last six months showed transparency and openness with stakeholders about performance.

The trust had a health and wellbeing agenda in place across all care organisations. This included the development of a women's wellbeing strategy, a reviewed well-being and attendance policy, SCARF support sessions, and a programme of micro-briefing sessions to support and enable leaders.

Most staff told us they received good support and regular communication from their line managers. Staff routinely participated in team meetings across the areas we inspected. Staff told us they used social media as an additional way to praise staff, highlight good practice and share information.

The NHS staff survey results 2021 showed staff in the surgical division scored higher than the overall trust score on making a difference, feeling valued, strong team attachment, personal development and recommending the service to others.

However, the NHS staff survey results 2021 showed staff in the surgical division scored lower than the overall trust score on completed appraisals, fair career progression, violence and bullying/harassment from patients and managers, work/life balance, working together and feeling respected.

The surgical division had a staff survey action plan with actions assigned to senior leaders. Improvement actions focused on flexible working and morale. They included the need to embed the importance of 'my time conversations' being done in a robust and meaningful way with training and support to be offered to all line managers. Other actions included: divisional leaders to develop quarterly surveys to give adequate feedback, rolling recruitment programme to ensure there are no gaps within staffing groups, team coaching, listening/engagement sessions, away days for teams and a focus on theatre conduct and etiquette.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The hospital participated in the nursing assessment and accreditation system (NAAS) to measure the quality of nursing care delivered by teams across the trust. All wards within the surgical division had been awarded blue status which was the highest level.

There was a culture of learning in the division, and we saw that staff at all levels wanted to improve services for patients and their relatives.

We saw that there were quality improvement projects taking place across the division and that staff were participating in these projects. Theatres used their own staff to take on the role of a 'mystery shopper' each month to observe and report on their own teams' compliance with the World Health Organization (WHO) safer surgery checklist. Staff spoke positively of this approach and told us it had provided opportunities for learning and improvement.

Senior leaders told us that the surgical robotic programme had been successful with neurology patients, and they were planning to expand this further into other specialities.

The intestinal failure unit (IFU) held national reference centre status for the treatment of complex intestinal failure. There was only one other hospital in England that held this status.

The service had a theatre excellence programme that was focused on culture and behaviours, and they had seen improvements with recovery outflow. Senior leaders told us that it was driven by clinicians, and they had recruited a senior nurse to support the wards and improve flow. In May 2022 and June 2022 they had an average of 30 incidents being reported due to patient delays in theatre. This significantly reduced to six incidents following this pilot.

The service was also involved in the data excellence programme which was trust wide and focused on staff well-being, saving lives, and theatre conduct and etiquette.

Medical care (including older people's care)

Requires Improvement ↓

Is the service safe?

Requires Improvement ↓

Our rating of safe went down. We rated it as requires improvement.

Mandatory Training

The service provided mandatory training in key skills to all staff and but did not always make sure everyone completed it.

Nursing staff did not always receive and keep up-to-date with their mandatory training. The medical divisions overall compliance for mandatory training for nursing staff was 78% against a target of 90%. For medical staff overall compliance was 73% against a target of 90%.

Staff we spoke with told us that mandatory training was delivered through a mix of e-learning and face to face sessions. Managers had commented that it had been difficult to book face to face sessions due to restrictions during the pandemic.

Mandatory training was comprehensive and covered topics such as information governance; infection prevention control; conflict resolution; equality, diversity and human rights and; health and safety.

Managers were able to review mandatory training compliance through an online platform and would alert staff when they needed to update or refresh their training. Managers told us that they would try to allow staff time away from clinical duties to complete mandatory training however they did say that this could not always be achieved due to staff shortages.

Staff we spoke with had told us that it had been difficult to complete mandatory training during clinical hours due to staff shortages.

From 1 July 2022, all registered health care providers were required to ensure their staff received training in learning disability and autism, including how to interact appropriately with autistic people and people who have a learning disability. This training should be at a level appropriate to their role. At the time of the inspection, the NCA had not made completion of this training mandatory, and staff had not completed the necessary programme of learning as required. This meant staff may not have had the skills and knowledge to communicate effectively and provide safe care to these patient groups.

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 received both level two and three safeguarding training for both adults and children, compliance for nursing staff within the medical division for safeguarding adults level 1 and 2 was 91%. Compliance for medical staff for safeguarding adults level 1 and 2 was 81%.

The trust had policies in place for the safeguarding of both adults and children. Medical wards had safeguarding information displayed which gave staff information and guidance on how to make a safeguarding referral and how to complete a mental capacity assessment.

Medical wards had safeguarding folders which included flowcharts on how to make a referral and the key safeguarding contacts in the local authority.

Staff we spoke with knew how to recognise abuse and understood their responsibility to report. Staff gave examples of recent safeguarding referrals which had been made, they told us that if they had a concern, they would alert the nurse in charge or ward manager. The ward manager would then liaise with the safeguarding team and relevant bodies to ensure the individual was protected.

Patients had risk assessments completed when they were admitted to a medical ward, staff assessed a patients mental capacity through a mental capacity assessment, if it was felt a patient lacked capacity then staff would alert the safeguarding team so that a more in depth assessment could be carried out.

Staff we spoke with said that the safeguarding team were supportive and would offer guidance to staff to help protect patients. Staff were able to recognise patients who lacked capacity and worked with the safeguarding team to highlight patients who may need a Deprivation of Liberty Safeguard (DoLS),the Deprivation of Liberty Safeguard is the procedure prescribed in law when it is necessary to deprive of their liberty a resident or patient who lacks capacity to consent to their care and treatment in order to keep them safe from harm.

We observed a nursing handover on a medical ward which discussed patients who had a DoLS in place.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Medical wards were visibly clean and had suitable furnishings which were clean and well maintained. However, the completion of cleaning record and checklists varied between wards.

Medical wards used isolation nursing for patients who were being treated for a transferrable infection such as Covid-19 or C-difficile. There was clear signage to indicate the risk of infection and the need to wear appropriate personal protective equipment at the entrance to side rooms and medical bays.

Staff followed infection control principles including the use of personal protective equipment (PPE). There was adequate supply of masks, aprons and latex gloves. We observed staff wearing the correct PPE, and donning and doffing before entering and on leaving a patient's room.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We observed staff cleaning using disinfect wipes. The hospital used 'I am clean' stickers once an area had been cleaned with the date of cleaning written on them.

Staff we observed adhered to the hospital's bare below the elbow policy. There was a suitable number of hand wash sinks on the medical wards and the hospital had posters which displayed the correct hand wash technique. The hand wash sinks had elbow taps and there were adequate supplies of soap and paper towels.

There were sanitising gel dispensers at the entrance and throughout each medical ward. We observed staff washing and sanitising their hands between patient interactions.

The hospital had an infection prevention control champion who undertook audits such as hand hygiene, uniform, and commode cleanliness. The three wards we visited had achieved 100% compliance on their weekly hand hygiene audits. The IPC champion also carried a weekly ward walk around to inspect the areas and answer any concerns or issues.

The wards had disposable curtains however these were not always dated, therefore it was difficult for staff to determine when they needed to be changed.

Staff completed infection prevention control as part of their mandatory training, for level 1 and 2 training there was a 84% compliance for medical staff and 92.5% for nursing staff.

Sharps bins were clean, not overfilled and were partially closed when not in use. However not all sharps bins we observed had been dated from the date they had first been used.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The medical wards were suitable, and the staff looked after them well, the areas we observed were clean and tidy. Medical wards were made up of a mix of side room and same sex bays. A number of medical wards had side rooms and bays which were not visible from the nurse’s station. Staff had told us that bay nursing was used as this allowed for increased observation of patients who may be at risk of falls.

At the entrance to each ward there was a notice board, which displayed staffing numbers for that day, it also gave the names of the staff on duty. There was also a safety thermometer on the board which highlighted the wards had not had any falls or pressure ulcers in the last 12 months.

Staff carried out daily safety checks of specialist equipment. There were resuscitation trolleys on all the medical wards we visited, each trolley was clean and secured. Each trolley had a defibrillator and suction unit which had been serviced within the last 12 months. There was an oxygen cylinder on each trolley which were full. Emergency trolleys were also securely tagged so that staff knew when the trolley had been last opened and if it had been replenished correctly.

We checked a sample of medical equipment on each medical ward we inspected such as blood pressure monitors, ECGs, and patient monitors. All the equipment we checked had been serviced within the last 12 months.

Staff told us that the hospital's engineering department carried out the servicing of medical equipment, when a service had been completed a sticker was place on that piece of equipment to alert staff when the next service was due.

There was a checklist for both daily and monthly checks of equipment, these had been completed appropriately by staff on the medical wards.

Patients could reach call bells and staff responded quickly when called. There was a call bell in each toilet and the cords were in suitable place for a patient to reach if they needed to alert staff if they had a fall or became unwell.

The service had enough suitable equipment to help them to safely care for patients. The hospital had bariatric equipment available such as hoists, beds and weighing scales.

Staff disposed of clinical waste safely. There were clinical waste bins in all the wards which were not overflowing, there was posters directing staff how to dispose of clinical waste appropriately.

We observed that electronic testing had been carried out in October 2021 on medical devices such as blood pressure monitors and electrocardiograms. Repeat testing was scheduled for and was to be renewed in October 2022.

There was clearly signposted fire exits on all the wards we inspected, the ward has evacuation slides and chairs to move patients in an emergency. Each ward had fire extinguishers which had been serviced in the last 12 months.

Each medical ward had a clean and dirty utility room. The clean utility rooms were used to store medicines and medical equipment and had a lockable door which had a pass code. The dirty utility was used for the disposal of clinical waste, each ward dirty utility was clean and well organised.

On wards such as the hyper acute stroke unit there was specialist monitoring equipment for individual patients. Readings from this were displayed at a nurse's station to allow for remote monitoring of a number of patients.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

All patients admitted to a medical ward had electronic risk assessments completed by a registered nurse on admission, risk assessments were repeated every seven days and staff were alerted when a risk assessment was due or if it had been missed. Risk assessments included falls risk, nutrition and pressure ulcers.

Staff received training in sepsis awareness and in National Early Warning Scores (NEWS2). Staff were able to recognise a deteriorating patient and could describe the process of escalation. The appropriate completion of NEWS was checked through monthly matron audits.

Patients who scored a NEWS of six or above were automatically assessed for sepsis, staff understood the importance of recognising the signs of sepsis early and knew how to escalate a patient so that they would receive treatment quickly.

Medical wards displayed information and guidance for staff on the signs of sepsis and how to correctly manage a patient.

Medical ward had a mix of electronic dashboards and marker boards which were used to display in real time what a patient's NEWS was. Boards also displayed when a patient's next set of observations were due and highlighted to staff if a set of observations was overdue and how long for.

We observed a nursing handover which included all the necessary key information to keep patients safe including DoLs, dementia and learning disabilities, allergies, care and discharge plans and patients who had specific nutritional requirements.

One to one nursing was used for patients who were at risk of falls but were being cared for inside rooms, however due to staffing issues one to one nursing could not always be carried out.

Staff told us that if they had concern that a patient was at risk of suicide or self harm they could make a referral to the mental health team, the team would review the patient and update their care plan for future care and discharge.

There was a system for highlighting patients with specific needs; for patients living with dementia or a learning disability patients had a different coloured ID band which highlighted them to staff.

Medical staff told us that if a patient deteriorated rapidly, they could escalate this to the critical care department, staff told us that the critical care team were supportive and worked quickly to facilitate appropriate and timely handovers to the intensive care unit.

Nurse staffing

The service did not always have enough substantive registered and unregistered nursing staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. However, bank and agency staff were utilised to fill gaps whenever possible. Managers regularly reviewed and adjusted staffing levels and skill mix.

The service did not always have enough nursing and support staff to keep patients safe. Medical wards had safety thermometers at the entrance to each ward which displayed the expected number and actual number of staff for that day's shift. During our inspection nurse staffing levels were consistently lower than the expected staffing target.

Staff told us that the medical division had three staffing calls each day, staff would raise staffing issues to lead nurses who would determine if nursing staff from a different medical ward could be used to supplement numbers.

The service had a hyperacute stroke unit which was used to care for patients for the first 72 hours following a stroke. During and after our inspection the trust told us the unit was staffed by a 1:4 nurse to patient ratio. This staffing was not in accordance with national guidance. However, the trust told us any patients who required a higher level of care were transferred to the high dependency unit and regularly reviewed.

Staff we spoke with told us that there had been instances when their ward was fully staffed that they would be asked to help on other medical wards, staff said that this was sometimes difficult as they felt they were asked to work on wards which they did not have the correct experience or skills for.

Matrons and ward managers calculated the number and grade of nurses needed using a recognised electronic rostering system, this system took into account the acuity and number of patients.

Matrons and ward managers we spoke with told us they worked on the clinical floor when there had been staffing pressures due to annual leave or sickness.

Medical care (including older people's care)

Data from the trust indicated planned rotas for the last three months for both registered and unregistered staff was below 70% for registered staff on day shifts and below 90% for night shifts. For unregistered staff rotas provided showed that 92% of unregistered day shifts were filled and 109% of night shifts.

Managers told us that the trust did use bank staffing but had said that they rarely used agency staff. Ward managers would use staff who already worked for the trust for bank shifts, staff were made aware of available bank shifts through staff messaging groups and work emails. Staff had commented that they were sometimes reluctant to take up bank shifts as they knew they would sometimes have to work on understaffed wards which they felt they sometimes did not have the experience for.

Over the last six months staff had raised 77 incidents relating to staff shortages and 15 were one to one nursing could not be achieved due to staffing issues.

Nurse staff sickness was on average 7.3% for the six months prior to the inspection, however July had seen a slightly higher sickness rate of 9.8%.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

Senior leaders for the medical division did raise that it had been difficult to appoint to certain specialties due to the national shortage of doctors. The trust had a number of medical vacancies which it could not fill.

Senior leaders had said that the trust medical staffing was adequate to meet the demand of patients however it had recognised gaps in its junior doctor workforce. The staff turnover rate across the division was 15%.

The service had a consultant on call at night and on the weekends. The medical division senior leaders told us they reviewed medical staffing daily and had recently employed a medical rota coordinator who managed medical rotas. The coordinator escalated staffing issues which were due to sickness or annual leave.

The medical division used agency and locum doctors to supplement staffing levels, locum doctors we spoke with said they had been well supported by senior doctors.

Junior doctors we spoke with had positive feedback about the support and training they had received. Junior doctors felt well supported and said they felt comfortable raising any issues or concerns to senior consultants.

Medical staff sickness was on average 0.8% for the six months prior to the inspection.

Records

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

Patient notes were comprehensive, and all staff could access them easily. Staff assessed patient notes electronically, while patients' medical notes were in paper form. Medical notes were stored in lockable cabinets on the medical wards.

Nursing staff updated patients' notes through an electronic patient record (EPR). Staff we spoke with said they found the system easy to use. Training in the EPR system was included in staff induction and during student nurse training.

The EPR system was username and password protected, staff ensured they locked computers when they were not in use.

We reviewed 10 sets of patient records during our inspection, records were completed appropriately and included the relevant assessments and observations. Risk assessments included falls risk, MUST (nutritional risk assessment) dementia and manual handling. Staff documented risk assessments when patients were admitted to a ward, the EPR system alerted staff when weekly risk assessments needed to be repeated.

We reviewed eight records which included a do not attempt cardiopulmonary resuscitation (DNACPR), these were found to be completed appropriately. A reason had been given why the DNACPR had been put in place, a discussion had been had between the patient and clinician, and the document had been signed and dated.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

The service used systems and processes to safely prescribe, administer, record and store medicines. The service had an integrated IT system for managing medicines that provided access to patients' GP records and community pharmacy, a plan was in place when IT issues meant records were not available.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Procedures were in place to manage medicines safely, though one procedure we checked was not aligned across the trust and had passed its review date. Nursing staff we spoke with did not know how to access medicines guidance online. Approximately 16% of discharge medicines were prepared on the wards, which helped to reduce waiting times.

Staff reviewed patient's medicines regularly and provided specific advice to patients and carers about their medicines. Medicines reconciliation was completed by pharmacy staff and records showed the trust target of 50% in 24 hours following admission had been achieved. However, this target was not compliant with the current National Institute for health and Care Excellence (NICE) guidance which indicates 100% of patients' medicines should be reconciled within 24 hours or sooner if clinically necessary. This meant staff could not always be assured they had a complete understanding of the medicines each patient took and the potential impact on their diagnosis and treatment.

Specific advice was given to patients and carers about their medicines on discharge, usually by nursing staff on wards and discharge lounge.

Staff mainly stored and managed all medicines and prescribing documents in line with the provider's policy. Most medicines and emergency trolleys we checked on wards were within the manufacturers expiry and stored safely.

Staff followed current national practice to check patients had the correct medicines. We checked 14 patients' records and found records had sufficient details for appropriate prescribing and monitoring. However, we found some administration gaps due to no stock being available on wards. Some wards had automated cabinets that sent requests to pharmacy for refills, however other wards relied on pharmacy staff checking order books when visiting the ward.

Incidents

Medical care (including older people's care)

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. 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. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. The service had an incident reporting policy which was up to date at the time of inspection.

The medical division had reported 62 incidents which were rated moderate harm or above in the last 12 months.

Staff raised concerns and reported incidents and near misses in line with trust policy. Staff we spoke to could tell us the process for reporting incidents and told us about a recent incident on the medical wards and what learning had been gained from this.

The medical division had reported no never events in the last 12 months. Never Events are serious incidents that are entirely preventable because guidance or safety recommendations providing strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.

Staff were able to explain what duty of candour was and what their responsibilities were. There were posters on the medical wards explaining the importance of duty of candour. Staff said they were open and transparent and gave patients and families a full explanation if and when things went wrong. While on inspection we reviewed an incident where a patient had been given incorrect medicines, there was no harm to the patient. The patient's consultant had apologised and discussed the incident with the patient following duty of candour guidelines.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff told us that they were made aware of incidents and learning from incidents that had happened in the hospital in team huddles and meetings.

The medical division held a monthly clinical governance meeting where incidents were discussed.

Is the service effective?

Good 

Our rating of effective stayed the same. We rated it as good because:

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The trust operated a central online policy hub. However, during our inspection of the core services, we found that some

services were using legacy policies from the previous trusts or accessing a suite of policies separate to the central Northern Care Alliance hub. As part of our ongoing monitoring of the trust, and throughout the inspection, we found there was a need to align some legacy Salford and Pennine policies to ensure there were trust-wide versions that reflected national or best practice guidance where appropriate.

We were told the hospital's endoscopy service was Joint Advisory Group (JAG) accredited for gastrointestinal endoscopy. The JAG accreditation scheme was established to support endoscopy services across the UK to focus on standards and identify areas for development.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. The hospital displayed guidance on the Mental Health Act and how to carry out a capacity assessment. Staff were able to explain who they would escalate to if they felt a patient lacked capacity.

Patients who were thought to have had or be having a stroke were assessed by specialist stroke nurses in the emergency department. Stroke nurses had training in National Institute of Health Stroke Score (NIHSS), this is an assessment tool used to evaluate and document the neurological status of an acute stroke patient.

The hospital provided hyperacute stroke care for patients who presented with stroke symptoms. The service was able to provide both time critical procedures for stroke patients which included thrombolysis and thrombectomy. Thrombolysis uses a medication to break down blood clots to improve blood flow and prevent damage to healthy tissue and organs. A thrombectomy is treatment that physically removes a clot from the brain.

Patients who had received as acute stroke procedure were monitored and cared for on the hyper acute stoke unit for 72 hours. The unit had specialist monitoring equipment which allowed for patients to be closely monitored by specialist trained nurses.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Patients we spoke with confirmed this, they told us that staff ensured they had enough food and drink.

Staff fully and accurately completed patients' fluid and nutrition charts where needed.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Staff completed the Malnutrition University Screen Tool (MUST) for each patient, this screening tool is used to identify patients who are malnourished or at risk of malnutrition. The tool includes management guidelines which can be used to develop a care plan. If a patient scored high on the assessment, then staff would request input from the dietetics team.

Specialist support from staff such as dietitians and speech and language therapists were available for patients who needed it. Nurses on the stroke ward had been trained by the speech and language team on how to carry out swallowing assessments on acute stroke patients, this meant that patients could be assessed in a timely manner if a member of the speech and language team (SALT) was not available.

Patients had choice of food they were given and there were optional menus for patients who had specific dietetic or religious requirements. The ward we visited had protected mealtimes, which allowed nurses and clinical support workers to be available to support patients who may need it.

Patients who had specific dietary requirements or who needed assistance at mealtimes were discussed during nurse handover. A patient we spoke with told us that staff assisted them during mealtimes as they had difficulty eating and drinking.

The hospital had a volunteer group known as dining companions, who assisted patients during mealtimes.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. We observed nurses doing pain medication rounds; they had positive interactions with patients, asking patient how their pain had been managed and asking patients for a pain score. Where patients felt their pain was not been managed adequately, then a discussion was held with both the patient and nurses to rectify this.

We spoke to patients on the medical wards who all said they felt their pain had been managed well and when they had told nurses that they were in pain that pain relief was administered soon after requesting it.

Patient outcomes

The service mostly achieved good outcomes for patients. Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The service participated in relevant national clinical audits. Audits included The Sentinel Stroke National Audit Programme (SSNAP), myocardial ischemia, heart failure, chronic obstructive pulmonary disease (COPD) and lung cancer. The trust shared action plans which had been developed following the results of these audits.

The most recent SSNAP data for Salford Royal Hospital showed they had received grade A between January 2022 and March 2022. SSNAP data is scored from a range of A (Best) to E (Worst). The SSNAP audit looks at key performance indicators such as the time it takes for a patient to be scanned following a stroke, the time taken to be admitted to a stroke unit, the percentage of patients given thrombolysis who were eligible and the time it took, the percentage of patients assessed by a stroke consultant within 24 hours and the percentage of patients who had a swallow screening test within four hours.

Data produced by the trust for the Chronic Obstructive Pulmonary Disease audit from April 2021 to September 2021 showed the hospital performed better than the national average in the audits six key performance indicators.

The hospital performance for the Myocardial Ischaemia National Audit Project was varied. The trust performed better than the national average for the key performance indicators of having an angioplasty before discharge, received secondary prevention medication for which was eligible and was referred to cardiac rehabilitation. However, the hospital was worse than national average for admittance to cardiac ward and review by cardiologist.

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 development.

Managers we spoke with told us they supported staff to develop through yearly, constructive appraisals of their work, however they did say that due to staffing pressures it had been difficult to meet their target for appraisal. From the data provided 88% of staff on medical wards had received an appraisal in the last 12 months, against a trust target of 90%.

Managers identified poor staff performance promptly and supported staff to improve. Ward managers were able to give us examples, such as when they needed to highlight poor performance in regards to not filling out patient notes correctly and in a timely manner.

Managers gave all new staff a full induction tailored to their role before they started work. Nursing staff were provided with an induction workbook, which outlined their induction processes and what they would be expected to achieve. The induction process highlighted to the member of staff who their preceptor would be and also outlined that they would have regular check ins throughout their induction to check the progress they had made.

Managers supported medical and nursing staff to develop through regular, constructive clinical supervision of their work. We spoke with newly qualified nurses and junior doctors who said they were well supported and spoke highly of the clinical and educational support they received.

Managers we spoke with told us that due to staff shortages it was sometimes difficult to ensure all staff attended team meeting, they did however say that meeting minutes would be shared with the team through group email and staff would be made aware of updates at nurse handover and safety huddles.

The clinical educators supported the learning and development needs of staff. The hospital had clinical educators who assisted with the development and assessment of international recruits.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. The stroke ward held multidisciplinary meetings weekly which included doctors, nurses, physiotherapists, occupational therapists and speech and language therapists.

Staff worked across health care disciplines and with other agencies when required to care for patients. Senior leaders we spoke with told us that wards worked closely which local authorities and adult social care originations to plan patient discharges.

Staff referred patients for mental health assessments when they showed signs of mental ill health. We reviewed patient notes which had records of staff referring patients to the mental health team for psychological assessments.

Patients had their care pathway reviewed by relevant consultants. We observed a multidisciplinary ward round which included specialist consultants, nurses and allied health professionals.

Seven-day services

Key services were available seven days a week to support timely patient care.

Consultants led daily ward rounds on all wards, including weekends. Patients were reviewed by consultants depending on the care pathway.

There was a consultant on call 24 hours a day, the consultant on call worked between 8am and 8pm seven days a week, care was then handed over to a consultant who covered the night shift seven days a week.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards/units.

Staff assessed each patient’s health when admitted and provided support for any individual needs to live a healthier lifestyle. Patients were assessed for smoking cessation and alcohol dependency as part of their assessments.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity or were experiencing mental ill health. They used measures that limit patients' liberty appropriately.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff risk assessed each patient individually with regards to mental capacity and DoLS. If a member of staff felt a patient lacked capacity then a referral was made to the safeguarding team who would carry out a comprehensive mental capacity assessment.

The trust carried out a Mental Capacity Act audit to determine if standards of documentation were being met which included if a diagnostic and functional test had been carried out and recorded if a patient could or could not retain information. The hospital achieved an overall compliance of 85%, recommendations had been made following the audit which included an update to training packages.

Medical care (including older people's care)

Staff gained consent from patients for their care and treatment in line with legislation and guidance. We observed staff interacting with patients during our visit, staff explained procedures and why they were doing them to the patient, they confirmed if the patient had understood and was happy to continue.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS).

The service provided mandatory training for staff which covered consent, the Mental Capacity Act and Deprivation of Liberty Safeguards according to the trust's safeguarding training framework.

We reviewed eight do not attempt cardiopulmonary resuscitation (DNACPR) forms during our inspection, the forms were all completed correctly. The forms included information on a reason why the DNACPR had been put in place, if a discussion had been had with the patient and their clinician and where the patient lacked capacity a discussion was documented with a family member.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. Staff we spoke with showed good understanding of the process of best interests decision making in relation to the specific decision and patients with fluctuating capacity to consent.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good because:

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Patients told us, and we saw during inspection, staff always introduced themselves, explaining who they were and what would happen.

Staff ensured curtains and doors were closed during consultations to ensure privacy for patients. We observed staff interacting with patients in a respectful and positive way. We observed staff explaining to patients when changes had been made to their care plan and asked if they had any questions.

Patients said staff treated them well and with kindness. Patients told us that communication was good and that staff knew a lot of information about their care and treatment which was shared with them.

Staff followed policy to keep patient care and treatment confidential. Staff made a conscious effort to ensure records were locked away when not in use.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. There were posters on the ward that directed patients to the multi faith chaplaincy centre and when services were held.

The trust collected data for the NHS Friends and Family test. The data was collected for all in-patients, and not specifically for medical patients. For the 12 months prior to inspection, the average satisfaction scores were 92.6% positive and 3.9% negative with an average response rate of 21%.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. We observed nurses assisting patients.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. We observed positive examples of staff dealing sensitively with distressed patients in the area.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. Medical wards used the Swan model (sign, words, actions, needs) of end of life and bereavement care and was used to support and guide the care of patients and their loved ones where they were being cared for at the end of life and after the patient has passed away. Staff understood the emotional and social impact that a person’s care, treatment or condition had on their wellbeing and on those close to them.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment.

Patients gave positive feedback about the service. All patients we spoke with praised the hospital and the care they had received.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. The contact telephone number for the ward was given to all patients in their discharge information. We saw feedback leaflets throughout the service for patients and carers to complete. There was communication support for patients who had a learning disability. Patients with a learning disability were allowed a family member or carer to stay with them on the ward.

The trust supported John’s campaign, which supports the rights of people living with dementia to have a carer to advocate for them and be with them whenever they most need it.

Medical care (including older people's care)

Is the service responsive?

Requires Improvement ↓↓

Our rating of responsive went down. We rated it as requires improvement.

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

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services so they met the changing needs of the local population.

There were challenges for the provision of care in the community across the region, which impacted on staff ability to discharge patients. Each ward we visited had a discharge coordinator whose role was to plan discharges and liaise with other bodies to ensure support for patients and ensure safe discharge.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. Staff had told us that if breaches occurred due to the need to move patients when there had been an outbreak of a communicable disease such as COVID-19, then this would be incident reported.

The service had systems to help care for patients in need of additional support or specialist intervention. Appropriate notification systems were in place to 'flag' patients who had specific or complex needs.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia.

Speech and language therapists worked weekends. In addition, specialist stroke nurses could assess whether a patient who had suffered a stroke could swallow well enough to eat and drink safely.

Specialist stroke nurses provided a seven-day service to provide support and advice to staff and patients on wards or awaiting admission in the emergency department.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

For patients using wheelchairs the service's entrances and exits had automatic doors, there were lifts to all medical areas and toilets and wash areas were wheelchair accessible.

The service had a dementia nurse who carried out in-depth assessments and a palliative care team who gave guidance and support with end of life care, which consultants believed helped guide staff in carrying out that patient's care.

The complex needs passport also highlighted to staff reasonable adjustments that should be made and highlighted to staff if patients had any impairments and how to best support them. Patients living with dementia were given blue hospital name bands and a butterfly magnet was placed on the 'what matters to me' board so that they could be identified by staff as having a cognitive impairment.

Staff could access emergency mental health support 24 hours a day, seven days a week for patients living with mental health problems. There was support for patient with learning disabilities, autism and dementia, however this was not a 24 hour service. Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports.

Managers told us they ensured staff, patients, loved ones and carers could get help from interpreters or sign language interpreters when needed.

Patients were given a choice of food and drink to meet their cultural and religious preferences. There were daily menus that patients could choose from.

The wards had signed up to John's Campaign. This is a campaign to promote the rights of carers to be welcomed and work in partnership with health and social care settings and professionals.

Access and flow

People could not always access the service when they needed it or received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards.

Managers monitored waiting times, however not all patients could access services when needed and did not always receive treatment within agreed timeframes and national targets. For cancer patients only 58% of patients were treated within 62 days of referral from their GP, this was below the national target of 85%, the trusts performance was below the England average.

In August 2022, only 59.5% of patients of both admitted and non-admitted were treated within 18 weeks against a national target of 92%. For admitted patients only 57.2% of patients were treated within 18 weeks, the trust was not meeting the national target of 92%.

From March 2021 to February 2022, the average length of stay for medical elective patients at Salford Royal Hospital was 6.4 days, which was the same as the England average of 6.4 days. For medical non-elective patients, the average length of stay was 6.8 days, which was higher than England average of 5.8 days.

The service had an emergency assessment unit which had an average stay over the past three months of 1.5 days.

Managers made sure they had arrangements for medical staff to review any medical patients on non-medical wards.

Physiotherapy and occupational therapy staff planned discharge for patients with more complex needs and liaised with social care to ensure appropriate equipment was in place.

Staff said they tried to keep moving patients at night to a minimum however this was sometimes needed due to a lack of capacity, they told us if a patient was moved at night they would incident report this. There had been 663 bed moves in the medical care division after 8pm in the 6 months prior to the inspection.

At the time of inspection, we were told that there were 35 patients in the hospital, that did not meet the criteria to reside (patients who were medically fit for discharge).

The senior leadership team told us the biggest challenges to discharging patients were those who required ongoing care in a nursing home or who needed complex packages of care.

Staff worked to make sure they started discharge planning as early as possible and we were told that on some wards a specific member of nursing staff took responsibility to gather all the relevant history to aid a patient's discharge more quickly.

The service had implemented a hospital at home team called home first which had helped people with care in their own home. This was implemented to try and increase the number of carers in the community to improve discharge rates for patients who were medically fit to be discharged but who did not have the care in the community they needed.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns. The medical division had received 74 formal complaints and 293 enquiries raised through patient advice and liaison service (PALS) in the last six months. The division's compliance for responding to these complaints within the agreed time frame was 70%.

The service provided evidence of learning from complaints and action plans which had been put in place, themes from complaints included falls, communication and training.

The service clearly displayed information about how to raise a concern in patient areas. The service had PALs and displayed information to direct patients how to make a complaint if they needed to. Patients we spoke with knew how to raise a complaint if they needed to.

Wards displayed complaints and compliments on display boards at entrances to each ward. The boards had a section for "you said, we did" where staff had shown how they had actioned suggestions from patients.

Staff understood the policy on complaints and knew how to handle them. Staff told us they would try to resolve complaints at the point of care, however if it could not be resolved they would give the patient and family their ward manager's details and PALS information.

Ward managers dealt with complaints or concerns which had not been resolved at the point of care and told us they would speak with patients and their families directly. For formal complaints they investigated these and completed a report which was sent back to the patient relations team. Following this process and interactions with the patient and their families, lessons learnt would then be shared with staff.

Medical care (including older people's care)

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service. Learning from complaints and concerns was shared at team meetings and daily huddles.

Staff could give examples of how they used patient feedback to improve daily practice. Staff gave an example of lessons learnt from a complaint. We observed a nursing handover where learning from a complaint was shared with staff.

Is the service well-led?

Good 

Our rating of well-led stayed the same. We rated it as good because:

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The medical care service was covered by a triumvirate which consisted of a medical director, director of operations and a divisional director of nursing. The triumvirate were supported by business partners for governance. The team held weekly senior operations meetings and attended weekly trust management governance meetings.

Wards were managed by matrons who were supported by lead nurses. Staff commented that matrons and lead nurses were visible and supportive.

On the wards we visited, matrons had an open-door policy so that staff could speak with them and raise any concerns at any point. Matrons were visible on the wards and supported staff when needed.

The division had identified gaps in medical staffing and were looking at ways to retain and increase staffing. They commented that it had become increasingly difficult to recruit to senior medical posts and commented that there was a national shortage of specialist consultants.

The trust had a talent and organisational development team whose role was to deliver a number of leadership development programmes. The leadership development programme included a senior leader programme for trust leaders at a senior level, a mid-level programme and a leadership induction programme.

Vision and Strategy

The trust had a vision for what it wanted to achieve and a strategy to turn it into action. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. However, it was unclear how this related to medical division at this service.

Medical care (including older people's care)

The trust vision was to be the safest and most effective organisation in the NHS and the place where people want to work. The trust was passionate about tackling inequalities and improving health outcomes and experiences in all their sites.

Over the next decade, the trust had the ambition to become the safest and most effective organisation in the NHS.

The trust had a 10 year clinical strategy dated from 2021 to 2031, this strategy focused on improving population health in all its places by working with partners, improving quality in safety, experience and outcomes, improving performance by meeting and exceeding standards, and having financial sustainability.

The medical division aligned with the trust strategy. The division's own vision was to ensure there was a focus on both patient and staff satisfaction, there was no specific strategy to achieve this. The division had put an emphasis on having a happy and healthy workforce and understood the positive effect this had on patient care. Senior leaders understood the pressures the medical division workforce was under and had placed an emphasis on staff wellbeing.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Senior leaders for the care division said that one of the division's biggest successes was the workforce's resilience through the pandemic. Managers we spoke with were sighted on the impact of the pandemic on staff morale as the workload had increased.

Staff could access support from a Freedom to Speak Up Guardian and we saw posters about this through the service. There was a system and process in place to enable staff to be able to speak up about any safety concerns. There was a freedom to speak up policy and a freedom to speak up team.

Some staff we spoke with described the workforce morale as low and felt under pressure due to staffing shortages and the effects of the COVID-19 pandemic, staff understood that medical and nursing shortages were also a national problem.

Staff we spoke with said that teamwork on the medical wards was good and that they supported each other when the division was under high levels of pressure. Nursing staff we spoke with reported good relationships between nursing, medical and non-clinical staff.

The trust had produced targeted resources for black, Asian and minority ethnic (BAME), Disabled and lesbian, gay, bisexual, transgender, and questioning (LGBTQ+) staff, who were signposted to resources and support with a particular focus around wellbeing.

The service launched a BAME Staff Network Facebook page which provided a safe and supportive space for staff to have open conversations during home and virtual working which increased during the pandemic.

The service created a Black, Asian & Minority Ethnic leadership council to ensure senior leaders were taking into account the decisions of BAME colleagues in strategic decision making.

Medical care (including older people's care)

Governance

Leaders operated effective governance processes, throughout the service. There was limited assurance that processes, policies and procedures were routinely shared across the trust. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The medicine care group held monthly governance meetings where they reviewed serious incidents, mandatory training compliance and risks. We reviewed the minutes of a recent medical care group governance and assurance meeting. These included key discussions around workforce, current risks, clinical effectiveness and performance issues in relation to each speciality area.

Each division had their own weekly clinical governance meetings, where any potential serious incidents or concise incidents were reviewed. They invited staff to present the feedback and RCA reports for serious incidents. The meetings also reviewed ongoing risks and looked at any outstanding risks that had not been approved. They were also looking at a process to ensure policies are up to date.

Medical wards carried out a number of audits and there were designated audit leads so that staff knew their roles and responsibilities.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The medicines care group had a risk register which was reviewed regularly. Senior leaders told us the service's top three risks were staffing, patient flow and a lack of provision in the community.

The medical care division had a risk register where risks were graded and summarised the action plans which had been developed. At the time of the inspection the division had 165 approved live risks and 27 new risks which were waiting to be approved. The division held monthly meetings to go through the risk register, these meeting would be used to discuss new risks and review progress on action plans on approved risks.

The medical division had implemented the trusts' Service Accreditation System (SAS), this system was used to embed and monitor the same high standards. The SAS allowed the service to monitor and ensure that minimum core service standards and key performance indicators were being met. It also allowed the service to identify high performing services and highlight good and innovative practice.

The care organisation had a mortality oversight group which held meetings to review the organisations mortality performance. The medical care division presented its mortality and morbidity performance to the group, the information provided gave an overview of the number of deaths, the reasons for death, and the learning and actions which had been identified.

When we spoke with senior leaders for the division they highlighted key risks such as recruitment and retention, maintaining staff health and wellbeing and delivery of key performance standards particularly for urgent care and cancer pathways.

Information Management

The service collected data and analysed it. However, some staff were not confident the data was always accurate. In addition, staff could not always find the data they needed in accessible formats to help them understand performance, make decisions and drive improvements. Data was not recorded or presented uniformly across the trust and some important data was not captured.

The information systems were secure. However, they were not always reliable or integrated well. On 18 May 2022 the trust experienced a major failure of some of its key information systems which affected Bury, Rochdale and Oldham care organisations. As a result, a critical IT incident was declared. The trust announced the issues were fully resolved on 20 June 2022. The failure disrupted diagnostic, pathology and pharmacy services, and referral pathways from GPs and primary care services.

Staff could access policies, procedures and clinical guidelines through the trust intranet site. Staff told us they could access patient information and up to date national best practice guidelines and prescribing formularies when needed.The service had carried out an audit to assess compliance with the safe and secure storage of patient records of the medicines care group. The audit highlighted overall good practice and attitude towards patient confidentially.

Staff received training on information governance as part of their mandatory training. Compliance for training was 93% for nursing staff and 96% for medical staff.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The trust and division worked with the ICS to support the COVID-19 recovery plan. This was an integrated systemwide plan to support the recovery of services provided by health and social care providers after the pandemic.

The service was part of the wellbeing programme called SCARF, which was a wrap-around programme of support to look after the physical, emotional and mental wellbeing of staff, and to made it easier to find and access the practical resources and information for individual’s need.

Leaders were invited to attend the monthly trust team brief receiving a briefing on key issues and developments, from which messages and information were then cascaded outwards to their wider teams.

The trust produced a weekly e-newsletter which staff could access on the trust’s intranet, the newsletter covered organisation updates and changes.

The service had created a medical staff engagement forum which was established to allow communication between consultant clinicians.

Senior leaders told us that they spend time with their colleagues on the frontline, providing the opportunity to find out more about the issues that mattered most to their people.

Leaflets about the friends and family test, and the patient advice and liaison service (PALS) were available on all wards. Internet feedback was gathered along with complaint trends and outcomes. We saw thank you cards, and letters displayed at the entrances to wards.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. Leaders encouraged innovation.

In response to the COVID-19 pandemic, there had been a number of reconfigurations of patient pathways and ward locations to improve patient care and safety. There had also been a number of trust wide improvement initiatives including 'Letters for loved ones' which commenced in April 2020 as a direct response to the impact on the COVID-19 pandemic on patients and their carers to promote effective communication. The trust had also launched improvement projects such as coaching support to clinicians to improve the reliability of the procedure room process on the endoscopy unit.

Salford Royal had a well-established Nursing Assessment and Accreditation system (NAAS) across all wards. The system measured the quality of care delivered by individuals and teams, supporting a culture of continuous improvement. It was backed by robust governance and accountability arrangements from Board to Ward. The NAAS ensured leaders were focused on the key risks to the delivery of excellent care.

Urgent and emergency services

Requires Improvement ↓

Is the service safe?

Inadequate ↓↓

Our rating of safe went down. We rated it as inadequate.

Mandatory training

The service provided mandatory training in key skills including the highest level of life support training to staff. However, they did not make sure everyone completed it.

Staff did not always receive or keep up to date with their mandatory training. The service provided information that showed overall mandatory training compliance was below target for all groups of staff except managers. For medical staff, 68% had completed mandatory training and 80% of nursing staff had completed all mandatory training requirements. In the children's emergency department (PANDA unit) 78% of staff had completed mandatory training.

The service had low levels of compliance with life support training. For example, compliance with immediate life support (ILS) training was 38% for medical staff and 56% for nursing staff. Staff told us there were trainers in the department who could deliver ILS training, but the wider hospital had not supported them to do this. Compliance with basic life support training was 44% for medical staff and 52% for nursing staff.

The service also had low compliance rates for paediatric basic life support training, with 20% of nursing and 30% of medical staff having completed it. In the PANDA unit, 40% of nurses had completed paediatric immediate life support training. Following our inspection, the service told us all advanced clinical practitioners on the unit had completed paediatric immediate life support and advanced life support and were trainers for this.

The department employed a part time practice educator. However, they were often taken from the role to fill gaps in nurse staffing and we observed this during our inspection. The PANDA unit did not have a dedicated practice educator.

The mandatory training was comprehensive and met the needs of patients and staff. The mandatory training policy broke down mandatory into NHS core mandatory training, essential job-related mandatory training and speciality specific mandatory training. Staff received core trust mandatory training and additional department specific training such as emergency tracheostomy, tongue splint and rapid infuser training. All new nurses received an initial training day.

Staff completed mandatory equality, diversity and human rights training and compliance was 90%. However, clinical staff did not complete specific training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. Following our inspection, the service provided information that showed only one member of staff working in the PANDA unit had completed training on learning disabilities and autism.

Managers monitored mandatory training and alerted staff when they needed to update their training. However, managers told us the electronic system did not accurately reflect the actual mandatory training compliance figures and they kept additional local registers. This meant we could not be assured managers accurately tracked compliance and alerted staff when necessary.

Urgent and emergency services

From 1 July 2022, all registered health care providers were required to ensure their staff received training in learning disability and autism, including how to interact appropriately with autistic people and people who have a learning disability. This training should be at a level appropriate to their role. At the time of the inspection, the NCA had not made completion of this training mandatory, and staff had not completed the necessary programme of learning as required. This meant staff may not have had the skills and knowledge to communicate effectively and provide safe care to these patient groups.

Safeguarding

Staff mostly understood how to protect patients from abuse and the service worked well with other agencies to do so. However, not all staff had training on how to recognise and report abuse.

Nursing staff received training specific for their role on how to recognise and report abuse. We saw 72% of nursing staff had completed level three safeguarding children training and 85% safeguarding adults level three training.

However, not all medical staff received training specific for their role on how to recognise and report abuse. We saw 43% of medical staff had completed level three safeguarding children and 53% had completed safeguarding adults' level three training.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. The department had a number of link roles to provide additional support to staff including for mental health and learning disability.

Staff knew how to identify adults and children at risk of, or suffering, significant harm. The children's emergency department (PANDA unit) had a safeguarding nurse, who provided advice and support to staff and staff knew how to escalate concerns to them.

Staff mainly knew how to make a safeguarding referral and who to inform if they had concerns. Staff we spoke with knew how to make a direct referral to the local authority and there was information available in staff areas regarding safeguarding. However, some staff were not aware of the referral process internally if there was a concern about a child and they wanted advice before making a safeguarding referral externally.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. Staff did not consistently use equipment and control measures to protect patients, themselves and others from infection. They did not always keep equipment and the premises visibly clean.

Not all areas were clean nor had suitable furnishings which were clean and well-maintained. We saw floors and equipment which were visibly unclean with dust, stains or rubbish not in bins. Bins with used linen were overflowing.

Cleaning records were up-to-date and demonstrated that some areas were cleaned regularly. For example, staff completed cubicle checklists for every cubicle daily and in between patients. There was a sign on each door following cleaning.

Staff did not always follow infection control principles including the use of personal protective equipment (PPE). Throughout our inspection, we saw staff who did not wear a face mask or wore it incorrectly. Staff did not wear gloves or aprons when serving food.

Staff did not consistently wash their hands when moving between patients to provide care. There were not enough handwashing facilities readily available for staff across the whole department. All staff followed 'bare below elbows' guidance. The service provided evidence of hand hygiene audits for the service which showed compliance at 100%, however the information did not identify a date or timescale for the audit.

Signs around the department asked patients and visitors to wear face masks. However, this was not monitored or promoted by staff. The waiting area had previously been split for suspected COVID positive patients; however, this was not being adhered to. We saw examples where patients were not asked if they would like to wear a face mask, though they told us they would be happy to. Following our inspection, the service told us they screened patients for suspected COVID-19 and had separate pathways for these patients.

However, in the PANDA unit (children's department) we observed staff changing PPE between rooms and when touching items.

Staff did not consistently clean equipment after patient contact. In the main emergency department staff did not label equipment to show when it was last cleaned. However, in PANDA unit staff used green 'I am clean' stickers to indicate equipment had been cleaned. We saw staff did not clean equipment between each patient in the triage area.

The service had no cases of clostridium difficile between February and July 2022.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff were trained to use them. Staff did not always manage clinical waste well.

Patients could not always reach call bells. Patients cared for on the corridor did not have access to call bells. Not all patients were placed in direct line of sight of a nurse or staff member.

The design of the environment did not always follow national guidance. The room used as a mental health assessment room in the PANDA unit (children's emergency department) did not meet national guidance for such spaces and was unsafe. This was because there were ligature points, light weight chairs that could be lifted, a drawer unit with screws loose that could be pulled out and a glass mirror. There was a shutter which covered the cables including oxygen and emergency call bell. The bed was not fit for purpose and had cables on which could be used to self-harm and there was only one door. We told managers about this during our inspection and they took immediate action to take the room out of use until necessary alterations were made.

We spoke with managers following our inspection, who explained the room was mainly used as a medical observation room and very rarely as a mental health assessment room. If it was used for patients with mental health issues, this was risk assessed on an individual basis at the point of use, there was rapid access to specialist mental health assessment and appropriate inpatient beds were found quickly.

The department was cluttered and overcrowded. There were two seated booths on one corridor the area around which was frequently overcrowded. In the PANDA unit we saw a cubicle, used by a patient and parent without staff present, which was cluttered with blood pressure machines, equipment left out and draw units with items in.

The equipment storeroom was left unlocked and boxes of intravenous fluids, including potassium, were stored on the floor. In the PANDA unit we found opened bottles of antiseptic solution on a shelf in the emergency room. This meant there was risk they could be accessed by patients or families and cause harm if used or ingested.

In the PANDA unit we saw a metal chain attached to door frame outside of baby change bathroom. The chain had a sharp key on the end and was hanging at the level of a small child. Staff could not explain what it was for. We alerted managers to the risk of injury to a child and they took immediate action.

Managers carried out audits of the environment. However, two areas of the department had last been audited in December 2021, when they scored below the required standard, and were overdue a re-audit which should have taken place in June 2022.

Staff did not always carry out daily safety checks of specialist equipment. We reviewed resuscitation trolley audits for all areas of the department and saw no annual audit had been completed of the trolley on PANDA unit between January and December 2021. The audit conducted in majors in February and March 2021 was failed due to gaps in daily and weekly checklists. The audit was repeated in April 2021 and passed. In March 2021, the audit for trolleys in minors failed due to gaps in daily and weekly checklists. This was repeated in April 2021 and passed. However, we could find no evidence of audits since April 2021 and during our inspection we found gaps in the daily and weekly checklists for resuscitation equipment in the main department and PANDA unit.

The service had some facilities to meet the needs of patients' families. There was relatives' room for families to wait whilst the patient waited for treatment. The waiting area had power banks available for patients and families to charge mobile devices. The department had marked out spaces on corridors which could be used to place patients in line with a fire risk assessment. There were 15 spaces and three seated booths for patients who could sit or who needed closer observation due to risks such as falls or dementia. However, these spaces became crowded if families waited with patients.

The service did not always have enough suitable equipment to help them to safely care for patients. Staff and managers reported missing items of equipment such as blood gas machines and dopplers. Not all relevant equipment in the resuscitation and majors area had been portable appliance tested. Not all equipment was in date. The baby scales within the PANDA unit were overdue for calibration and we also found out of date sampling syringes in a room in the unit.

Staff did not always dispose of clinical waste safely. In some areas we found sharps disposal boxes used which were not dated or signed.

Assessing and responding to patient risk

Staff did not always identify nor quickly act upon patients at risk of deterioration. Staff completed risk assessments for each patient, however there were delays in completing initial risk assessments. Staff did not always remove or minimise risks.

Staff used a nationally recognised tool to identify deteriorating patients. Staff used a tool in triage called qSOFA (Quick Sequential Organ Failure Assessment) to assess patients at risk of sepsis. Sepsis is a life-threatening reaction to an infection. It happens when the immune system overreacts to an infection and starts to damage the body's own tissues and organs.

However, this tool is not in line with most up to date national guidance. National guidance recommends the use of National Early Warning Scores (NEWS2). The service did not use this but used qSOFA instead.

The service provided information which acknowledged that screening for sepsis in the department had not been updated in line with national guidance and following our onsite activity took action to update the sepsis policy. They conducted a retrospective audit of 150 patients identified as 'red flag' for sepsis between June and October 2021. The audit identified 24 patients where if NEWS2 was used care or management may have been impacted. The service reviewed these patients and identified no harm had occurred, there was no evidence of increased mortality or adverse outcomes.

Staff used different tools at different parts of the patient pathway and could not clearly describe the pathway to follow if they suspected sepsis. Staff did not complete mandatory training on sepsis. Sepsis training was included in essential job-related training, but the service was not able to provide figures on how many staff had completed this training. This meant staff may not know how to recognise and escalate deteriorating patients appropriately.

During our inspection, we saw two patients who did not receive antibiotics within one hour of being identified as having suspected sepsis. This is important because delays in giving antibiotics in sepsis are associated with a significant increase in mortality.

The service provided audit data that showed between June 2021 and July 2022 of 539 patients were identified with suspected sepsis, 409 did not receive antibiotics within an hour. In addition, of these 409 patients, 338 did not flag as suspected sepsis using the qSOFA tool.

We escalated our concerns to leaders immediately following our inspection. They took prompt action to ensure staff used the most up to date tools and to communicate the changes to staff.

Staff did not always know about nor deal with any specific risk issues. The service did not have individualised risk assessment for patients placed on the corridor.

Staff mostly completed risk assessments for each patient on arrival, using a recognised tool called the Manchester Triage System (MTS). However, during our inspection we saw patients waiting for a long time from initial triage. For example, we recorded waiting times for initial triage on one day, of one hour 30 minutes in the major’s area and four hours in the minor’s area. This meant there was a risk patients would not have all risks assessed in a timely manner and may become more unwell whilst waiting. We observed the triage of four patients and saw two occasions where not all risks were appropriately assessed as staff did not carry out an assessment of the patient’s abdomen or assess reported numbness in a limb.

Staff did not always complete all risk assessments nor remove or minimise risks. We reviewed four patient notes and saw falls, pressure ulcer and VTE assessments were not completed in two. VTE stands for venous thromboembolism and is a condition where a blood clot forms in a vein.

Staff told us they used two seated booths near the nursing station for patients who may be at risk of falls. However, if full then patients would be placed elsewhere in the department and may be out of line of sight. We saw information which showed that though falls had decreased to eight in June 2022 from 15 in May 2022, most falls were unwitnessed whilst patients were in cubicles.

Patients on corridors did not have access to call bells, posters in the corridor told patients to alert staff if they needed to move or get up. However, throughout our inspection there were times when patients asked the inspection team to help as they unable to attract the attention of staff or were not in the line of sight of staff.

The service reported no hospital acquired pressure ulcers in June 2022.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. The service had 24-hour access to mental health liaison and specialist mental health support, through a neighbouring trust psychiatric liaison team who were based close to the department.

Staff shared key information to keep patients safe when handing over their care to others. We observed doctor and nurse handovers and saw key information was shared and plans made for each patient.

Shift changes and handovers included all necessary key information to keep patients safe. The doctor handover on the PANDA unit (children's emergency department) was comprehensive and covered all the patients and key information. There were only two patients on the department during our observation, this allowed for additional review at handover.

Staff reported they completed specific risk assessments for children and in particular, risk assessed the use of the mental health assessment room.

Nurse staffing

The service did not always have enough nursing staff and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix, and gave bank and agency staff a full induction.

The service did not always have enough nursing and support staff to keep patients safe.

One nurse was allocated to triage patients every shift. However, during our inspection there were long waits for triage and nurse managers were required to work as triage nurses to address these waits. The service did not have specific establishment for a nurse to look after patients cared for on the corridor. This meant there was not always a corridor nurse assigned even when patients were being placed in the corridor. Managers told us they had a business case approved to recruit for an additional nurse.

The department did not always deploy sufficient staff in resuscitation. For example, we saw 11 patients placed in the eight bedded resuscitation area, but the planned staffing for this area was only for four nurses. The service had placed a supernumerary nurse in the area to take the staffing to five registered nurses. However, this did not meet national guidelines for the ratio of nursing staff to patients in resuscitation areas.

Managers calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift. However, during our inspection, the department did not have the number of required nurses in accordance with national guidance on all shifts. Managers told us they had been unable to secure bank or agency staff.

Urgent and emergency services

The service had not conducted an establishment review for over two years due to the COVID-19 pandemic. This was because managers told us they were unable to map capacity and demand due to the absence of acuity data. We were unable to establish why acuity data was not available during this period. However, decisions relating to staffing were undertaken by experienced senior staff using professional judgement and reviewed multiple times each day.

The children's emergency department (PANDA unit) had enough nursing and support staff to keep children safe. Nurse staffing was planned at a ratio of one registered children's nurse to four patients in line with agreed Greater Manchester standards, this included one triage nurse during the day.

The department manager could adjust staffing levels daily according to the needs of patients. Managers planned nurse staffing for each day based on a rota and could adjust this according to the acuity of patients and busyness of different areas of the department. However, we saw there were often gaps in this rota which managers were unable to fill with bank or agency staff. Managers escalated gaps in rotas, but these were not always filled by nursing staff from other areas of the hospital.

The number of nurses and healthcare assistants did not always match the planned numbers. We reviewed written staffing rotas for the emergency department for three weeks prior to the inspection. The service told us these showed staffing for the whole department not where staff were actually allocated. We saw gaps where actual numbers did not match planned on all of the day and night shift rotas.

Following our inspection, the service provided actual fill rates for nurse staff for the emergency village as a whole. This included services which are reported under medical care such as the discharge lounge. This meant we could not be assured that service always deployed the actual required number of nursing staff in line with planned numbers.

We escalated our concerns regarding staffing whilst on site and leaders took immediate action. Following our inspection, leaders told us they were allowing the department to block book agency staff to address the gaps in nursing rotas.

The service did not provide vacancy rates. However, vacancy rates for nursing staff across the whole care organisation were 18%.

The service had increasing turnover rates. Turnover data provided by the service showed nursing staff turnover had increased between February and July 2022.

The service had increasing sickness rates. In February 2022, the sickness absence rate for nursing staff was 4.63% it had risen every month to 8.22% in July 2022. However, we were given information on site which showed sickness absence at 20% in June 2022, with 16% of staff absent due to COVID-19.

The service regularly used bank and agency nurses. Where possible, managers requested staff familiar with the service. However, staff told us the service struggled to get enough bank or agency staff to fill all the gaps in rotas.

Managers made sure all bank and agency staff had a full induction and understood the service.

Medical staffing

Urgent and emergency services

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and gave locum staff a full induction.

The service had enough medical staff to keep patients safe. Data for the whole trust in January 2022 showed the proportion of consultant staff was higher than as the England average and the proportion of junior (foundation year 1-2) staff was lower than the England average.

The service did not provide vacancy rates for medical staffing specifically for urgent and emergency services. However, vacancy rates for medical staff across the whole care organisation were 7.28%. There were no vacancies for consultants in the department at the time of our inspection. The service had advanced clinical practitioners (ACP) who worked as part of the medical staff rota and ACP cover was available 24 hours a day.

The children's emergency department had paediatric consultant cover on site during the day and on call out of hours. The consultant workforce included two paediatric emergency medicine consultants.

Sickness rates for medical staff were low. The service provided information that showed sickness absence for doctors in June and July 2022 was 0%, having reduced from 2.65% in February 2022

The service always had a consultant on call during evenings and weekends. This included the children's emergency department.

The service had increasing turnover rates for medical staff. Turnover data provided by the service showed medical staff turnover had increased between February and July 2022.

We requested; however, the service did not provide, information on the planned versus actual numbers of medical staff. Staff reported the number of medical staff matched the planned number on most shifts. Staff told us there were enough doctors available to keep patients safe.

The service did not provide rates of bank and locum staff, as requested. However, managers told us they could access locums when they needed additional medical staff.

Managers made sure locums had a full induction to the service before they started work. Locum and trainee medical staff we spoke with told us they had received a full induction to the service.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, and easily available to all staff providing care. However, records were not always stored securely

Patient notes were comprehensive, and all staff could access them easily on computers located throughout the department. In the children's emergency department, a mix of electronic and paper records were used.

However, we found gaps in some patient records we reviewed. For example, in all patient records we reviewed no time of arrival at the department was recorded. We saw a child's record where the consultant review had been completed but not recorded in the notes.

When patients transferred to a new team, there were no delays in staff accessing their records. Electronic patient records could be accessed by all relevant staff and were available when the patient transferred out of the department.

Records were not always stored securely. Staff completed patient records on an electronic patient record system. During our inspection we saw records displayed on computer screens which had been left open and unattended by staff. This meant there was a risk confidential patient information could be accessed by a member of the public or someone who was not authorised to view them.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes to prescribe and administer medicines safely. They learnt from safety alerts and incidents to improve practice. Themes from medicines audit and incident reporting were shared for learning at the department governance meetings.

Staff completed medicines records accurately and kept them up to date. Doctors used the Greater Manchester Care Record to access health care information including about patients' medicines. However, not all staff had access to Summary Care Record to access information for patients attending the hospital from outside Greater Manchester. This meant they had to seek pharmacist support from outside the department to clerk in patients' medicines.

Staff generally stored and managed all medicines and prescribing documents safely. Controlled drugs were safely stored however, the trust's quarterly controlled drugs audit identified that controlled drugs record keeping as an area for improvement in 'majors' where compliance was 71% for Q1 2022/23. Staff explained that measures were taken to remove and store patients' medicines for them when needed, but there was no formal risk assessment for this.

Staff followed national practice to check patients' current medicines when clerking patients. However, with people staying longer in ED the benefit of having dedicated pharmacy support to the department had been identified, to ensure patients had the correct medicines when they were admitted (medicines reconciliation). A business case was underway for pharmacy support to both ED and the admissions area of the new trauma building.

Medicines reconciliation was completed by pharmacy staff and records showed the trust target of 50% in 24 hours following admission had been achieved. However, this target was not compliant with the current National Institute for health and Care Excellence (NICE) guidance which indicates 100% of patients' medicines should be reconciled within 24 hours or sooner if clinically necessary. This meant staff could not always be assured they had a complete understanding of the medicines each patient took and the potential impact on their diagnosis and treatment.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses 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 knew what incidents to report and how to report them. Staff were able to describe the types of incidents they would report and how to report them on the online system.

Urgent and emergency services

Staff raised concerns and reported incidents and near misses in line with trust policy. We saw an example during our inspection where an incident involving a patient was reported appropriately.

The department reported 4 serious incidents between April and August 2022. Managers reviewed all incidents which had been reported more than two weeks earlier and not closed at divisional level and at the serious incident review summit.

Staff we spoke with understood the duty of candour and were able to describe how they would be open and transparent and give patients and families a full explanation if and when things went wrong.

Staff received feedback from investigation of incidents, both internal and external to the service. Incidents were reviewed by senior managers at a weekly meeting and immediate feedback given to staff. Managers conducted rapid reviews of any serious incidents identified.

Staff met to discuss the feedback and look at improvements to patient care. Managers shared feedback and lessons learnt through the weekly clinical management team meeting and monthly clinical governance meeting.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. The service had a clinical governance lead consultant who investigated all incidents involving medical staff.

However, there was limited evidence that changes had been made as a result of feedback. Staff told us the main contributory factor identified in incidents related to overcrowding in the department and the inability to admit patients who required it to inpatients beds in a timely way. Staff expressed frustration that suggestions made to improve this had not been actioned at trust level.

Is the service effective?

Requires Improvement 

Our rating of effective went down. We rated it as requires improvement.

Evidence-based care and treatment

The service did not always provide care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff did not always follow up-to-date policies to plan and deliver high quality care according to best practice and national guidance. For example, NHS England recommends using National Early Warning Scores (NEWS2) to standardise the identification of sepsis and reduce the number of patients who deteriorate in hospital. However, staff used a different tool, qSOFA, in line with the care organisation policy. This meant they were not following the most up-to date guidance.

The trust operated a central online policy hub. However, during our inspection of the core services, we found that some services were using legacy policies from the previous trusts or accessing a suite of policies separate to the central Northern Care Alliance hub. As part of our ongoing monitoring of the trust, and throughout the inspection, we found there was a need to align some legacy Salford and Pennine policies to ensure there were trust-wide versions that reflected national or best practice guidance where appropriate.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. Staff contacted the mental health liaison team to arrange mental health assessments of patients including assessments under the Mental Health Act, where necessary.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients. We saw discussion of patients with mental health needs at daily huddle and at nursing and doctors' handovers.

Nutrition and hydration

Staff did not always give patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Staff did not always make sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. We reviewed nine patient records and there was no record of food or drink being offered in eight of the records. There was only evidence of assessment of nutrition and hydration needs in four records. Members of the inspection team were asked by patients to get them drinks on several occasions throughout the inspection.

However, during our inspection we saw patients waiting a long time in the department being offered drinks and snacks, including a hot food trolley at lunch time.

Staff did not always fully and accurately complete patients' fluid and nutrition charts where needed. Fluid balance and food intake was not recorded in the patient records we reviewed.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. However, this was not completed in two patient records we reviewed.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain but did not always give pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool and we observed pain assessment carried out by staff at triage. Staff gave pain relief in line with individual needs and best practice.

However, patients did not always receive pain relief soon after it was identified they needed it, or they requested it. In one patient record reviewed there was no record of pain relief being administered after it was prescribed. We observed the triage of four patients and saw one occasion where a pain assessment was completed but pain relief was not offered and another where no pain assessment was completed.

Urgent and emergency services

During our inspection, members of the inspection team were approached by patients asking if they could have pain relief. Each time we alerted staff to this, who immediately acted to address this. We were told by a patient they had been taking their own pain relief medicines as they have not had their pain assessed.

Staff in children's emergency department used pain assessment tools suitable for use with young children.

Patient outcomes

Staff monitored the effectiveness of care and treatment. However, they did not consistently use the findings to make improvements. They mainly achieved good outcomes for patients.

The service participated in relevant national clinical audits. The clinical audit programme for 2022 to 2023 aligned with NHS England's Quality Accounts List and covered clinical and patient outcome audits.

We asked the service to provide outcomes of relevant clinical audits. However, the audit reports provided did not include actual outcomes.

We saw limited evidence that managers and staff used the results and information from audits to improve patients' outcomes. This was because clinical audit update reports provided by the trust following our inspection showed a number of local audits which were significantly overdue. Action plans associated to national audit outcomes reported in January 2021 were reported as outstanding in June 2021. Therefore, improvement was not consistently checked and monitored.

Managers and staff carried out a programme of repeated audits to check improvement over time. The service registered six different local clinical audits with the trust clinical audit team for 2021 to 2022.

The service had a similar risk of unplanned re-attendance as the England average. The rate in July 2022 was 8.8%.

Competent staff

The service mostly made sure staff were competent for their roles. Managers appraised staff's work performance. However, they did not consistently hold supervision meetings with them to provide support and development.

Staff were experienced and qualified but did not always have right skills and knowledge to meet the needs of patients. This was because not all staff completed required mandatory and job-related training.

Managers gave all new staff a full induction tailored to their role before they started work. Staff we spoke with confirmed they had received an appropriate induction which equipped them to work within the department and were able to complete a supernumerary period.

Managers supported staff to develop through yearly, constructive appraisals of their work. Overall compliance with annual appraisals was 56% in the main department with 71% of nursing and 76% of medical staff having completed their appraisal. In the children's emergency department, 100% of nursing staff had completed their appraisal and overall compliance across all staff was 75%.

Managers supported nursing staff to develop through regular, constructive clinical supervision of their work. Nursing staff we spoke with told us they received supervision and support for local managers.

However, managers did not always support medical staff to develop through regular, constructive clinical supervision of their work. Some medical staff we spoke with stated they did not receive supervision.

The clinical educators supported the learning and development needs of staff. The department employed a part time practice educator. However, due to staffing pressures, they were often called away from the role to make up gaps in staffing rotas.

The children's emergency department did not have a clinical or practice educator. However, we were given examples of staff development opportunities. For example, the service had four staff undertaking advanced clinical practitioner training.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Nursing staff attended daily 'huddles' which took before handover and notes from the meetings were available in a folder in the staff area.

Managers identified any training needs their staff had. However, due to pressures in the department and gaps in staffing rotas staff and managers acknowledged it was difficult to give staff the time and opportunity to develop their skills and knowledge. This was evident in low compliance with life support training which was delivered face to face.

Managers made sure staff received any specialist training for their role, through department specific training such as emergency tracheostomy, tongue splint and rapid infuser training. Staff had recently completed an emergency simulation exercise and all completed one day major incident training.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff did not hold regular and effective multidisciplinary meetings to discuss patients and improve their care. Nursing and doctor handovers took place separately. However, we saw positive working relationships between nursing and medical staff during our inspection, with staff sharing information relevant to providing care and treatment to patients.

Staff worked across health care disciplines and with other agencies when required to care for patients. We saw staff working closely with the mental health liaison team to arrange assessments and care for a patient in the department in mental health crisis.

Staff referred patients for mental health assessments to the co-located mental health liaison team when they showed signs of mental ill health or depression.

Seven-day services

Key services were available seven days a week to support timely patient care.

Staff could call for support from doctors and other disciplines and diagnostic services, including mental health services, 24 hours a day, seven days a week.

Staff reported there were no delays in accessing diagnostics tests and the department had some x-ray services located within it.

However, staff told us that the response from medical staff for patients who required review by a specialist differed across different specialities within the hospital, with closer working relationships and quicker response times from some specialities.

Health Promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards/units. For example, in the children's emergency department we saw posters signposting parents and children to mental health support available in Greater Manchester.

Staff assessed each patient's health when they presented through triage and rapid assessment.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff did not consistently support patients to make informed decisions about their care and treatment. They did not consistently follow national guidance to gain patients' consent as this was not always recorded in patient notes. Not all staff knew how to support patients who lacked capacity to make their own decisions or who were experiencing mental ill health.

Most staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Some staff we spoke with were able to describe how they would consider a patient's capacity when delivering care and treatment. However, other staff told us they did not feel they had appropriate training to carry out mental capacity assessments.

Staff did not consistently gain consent from patients for their care and treatment in line with legislation and guidance. We saw an example where a patient was deemed not to have capacity to consent to treatment but was given tranquilising medicines before a capacity assessment was completed. However, a review of five patients who had received rapid tranquilisation in the previous 24 hours showed staff had followed relevant policy to gain consent.

Staff did not consistently clearly record consent in the patients' records. We reviewed nine patient records, including three children, and did not find evidence of consent recorded in seven.

Not all staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. We saw two patients where a brief nursing note was made with regards to capacity to consent, but a capacity assessment was not carried out.

Staff received but did not always keep up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. The service told us that training in these subjects was covered within level three safeguarding adults and children training. However, evidence provided on site showed only 53% of medical staff had completed level three safeguarding adults training.

Urgent and emergency services

Some staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act.

Is the service caring?

Requires Improvement 

Our rating of caring went down. We rated it as requires improvement.

Compassionate care

Staff treated patients with compassion and kindness. However, staff did not always respect their privacy and dignity nor take account of their individual needs.

Staff were not always discreet and responsive when caring for patients. Staff were not always able to take time to interact with patients and those close to them in a respectful and considerate way.

We carried out a group observation using the Short Observational Framework for Inspection (SOFI) method on 8 August 2022. The SOFI tool is used to review services for people who have conditions that mean they cannot reliably give their verbal opinions on the services they receive. We continually observed what happened to patients over a chosen observation period, making recordings at set intervals. In each time period, we recorded the general mood of the service users, the type of activity or non-activity they were engaged with and the style and number of staff interactions with service users. In each time frame there may be more than one type of engagement and multiple interactions with staff. Interactions with staff are categorised as positive, neutral or poor.

The group observation took place on a corridor within the emergency department for 25 minutes, where five patients were on trolleys or chairs. During this period, we saw only one interaction with staff when transferring a patient to a cubicle. Staff did not interact with any other patient even though one patient was loudly complaining about their wait.

However, patients said staff treated them well and with kindness. The service provided feedback received from patients since February 2022 which included comments such as staff were ‘kind and open’, ‘went the extra step’, ’helpful and polite’, ‘had an excellent manner’ and ‘showed patience’.

Staff could not always keep patient care and treatment confidential. This was due to the overcrowding and pressures in the department. We saw conversations about care and treatment take place in areas where they could be overheard by other patients and relatives. We saw doctors carrying out dementia assessments on the corridor which could be overheard and therapists providing treatment on the corridor raising their voice to be heard.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. During our inspection, we saw staff deal with a very sensitive and non-judgment manner with a patient in mental health crisis. They showed understanding and support to the patient and their family.

Staff did not always protect the privacy and dignity of patients receiving care on the corridor. Managers told us patients were moved off the corridor for care and treatment. However, we observed staff taking blood from a seated patient on the corridor, doctors taking a medical history on the corridor which could be overheard by nearby patients and relatives and nursing staff doing observations on the corridor.

We saw several examples of the environment having a detrimental impact on the privacy and dignity of patients. We saw patients in night clothes and hospital gowns, with areas of their body exposed, and they were not given a blanket or covering. We saw staff unable to find a space for a patient to use a bed pan in privacy, so the patient had to use it in the corridor with only a screen between them and another patient.

Emotional support

Staff did not consistently provide emotional support to patients, families and carers to minimise their distress.

Staff did not always give patients and those close to them help, emotional support and advice when they needed it. During our inspection, we were approached twice by relatives who had been told to come to the department because their relative was there but could not find any staff to ask for further information or support. We alerted staff to this whilst on site. Relatives of patients expressed concern to members of the inspection team regarding a patient's falls risk whilst on the corridor.

Staff did not always support patients who became distressed in an open environment, nor help them maintain their privacy and dignity. For example, we saw a patient left vomiting on the corridor in front of other patients which upset them and the patient. We saw confused patients calling out to staff, who did not always answer. Members of the inspection team had to request help from staff multiple times, when patients asked them for help or told them they were in pain.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. However, some staff expressed frustration that they were unable to give the level of care and emotional support they wanted to due to pressures and lack of staffing in the department.

Newly recruited staff undertook training on organ donation and bereavement training as part of bereavement study days.

Understanding and involvement of patients and those close to them

Staff did not consistently support and involve patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff did not consistently make sure patients and those close to them understood their care and treatment. During our inspection, members of the team were approached by patients and families with questions about their care and treatment, requests for assistance and who were unclear about next steps. Some of these patients were visibly upset.

Staff talked to patients in a way they could understand, using communication aids where necessary. Staff in the children's emergency department used specialist assessment tools, for example pain assessments, to help them communicate with children. They had adapted face masks and personal protective equipment to be child friendly to facilitate communication and ensure children remained calm.

Urgent and emergency services

Patients and their families could give feedback on the service and their treatment. We saw feedback provided to staff was recorded on the online reporting system. Patients were invited to take part in the family and friends test and the service had restarted the patient survey which had been suspended during the COVID-19 pandemic. The service provided family and friends test data for February to July 2022. This showed low response rates for urgent and emergency care at Salford between 19.9 and 21%. The number pf patients who would recommend the department ranged between 66.2 and 73%. No data was received for April and June 2022. Managers were working with the patient experience team to explore ways of gaining patient feedback.

Is the service responsive?

Requires Improvement 

Our rating of responsive went down. We rated it as requires improvement.

Service delivery to meet the needs of local people

The service planned and provided care in a way that mostly met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services so they met the needs of the local population. Managers worked with local primary care services to ensure patients self-presenting to the emergency department were seen by a 'streaming nurse' and directed to the most appropriate care pathway. Managers described work with local commissioners to provide treatment within community diagnostic hubs.

However, facilities and premises were not always appropriate for the services being delivered. The department was overcrowded, with patients being cared for in the corridor. The waiting area was overcrowded with insufficient seating for the numbers of patients. During our inspection, we saw the children's waiting area used by adults due to lack of space in their waiting area. However, work was in progress to build a new trauma centre, which would house a trauma emergency department and ease overcrowding in the department.

Staff could access emergency mental health support 24 hours a day, 7 days a week for patients with mental health problems, learning disabilities and dementia. Staff described positive working relationships with the mental health liaison team and told us they were proactive in responding to requests for support. We saw the mental health liaison team conduct assessments in the department during our inspection.

The service had systems to help care for patients in need of additional support or specialist intervention. Staff could access support from link nurses in the department and the children's emergency department had a safeguarding lead nurse.

The service did not always relieve pressure on other departments when they could treat patients in a day. The service did not have a same day emergency care centre (SDEC).

Managers told us there was a tannoy system which gave key messages to patients in the waiting room about waiting times and mask wearing. However, we did not hear this in operation throughout our inspection.

Urgent and emergency services

Meeting people's individual needs

The service did not always take account of patients' individual needs and preferences. Staff made some reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Staff referred patients to the mental health liaison team where appropriate.

The department was not designed to meet the needs of patients living with dementia. We did not see any adjustments to the environment to make it 'dementia friendly'.

We did not find evidence that staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Staff were able to describe how they would access interpretation and translation services.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. We saw patients' communication needs including the use of interpreters were discussed and planned at handovers.

Patients were given a choice of food and drink to meet their cultural and religious preferences. This included hot food which was served at lunchtime from a trolley.

Staff had access to communication aids to help patients become partners in their care and treatment.

Access and flow

People could not consistently access the service when they needed it and did not always receive the right care promptly. Waiting times from arrival to treatment and arrangements to admit, treat and discharge patients were not consistently in line with national standards.

Managers monitored waiting times. The service performed well for ambulance turnaround times and handover delays.

However, patients could not always access emergency services when needed, nor receive treatment within agreed timeframes and national targets. In June 2022 the average waiting time for triage was 36 minutes against the national standard of 15 minutes. This had risen from an average of 19 minutes in June 2021. The average waiting time for treatment in June 2022 was 134 minutes against the national standard of 60 minutes. The average waiting time in the department was 364 minutes in June 2022, this had risen from 243 minutes in June 2021.

Patients often stayed longer than they needed to in the department. Performance data supplied by the service showed increasing numbers of patients waiting on trolleys in the department, from no patients waiting on a trolley for 12 hours or more in June 2021 to 175 patients in June 2022. In the same month, 1026 patients waited between four and 12 hours on a trolley.

Urgent and emergency services

During our inspection, patients were 'boarded' within the department including in resuscitation. Boarding is where patients are held in a borrowed bed in a department or ward which is not the speciality they are admitted to. Staff told us patients were waiting admission to surgical beds.

Throughout our inspection, the service had large numbers of patients within the department waiting for beds following a decision to admit. For example, on one day 21 patients were waiting for a hospital bed.

Patients were assessed by a 'streaming nurse' when they presented to the department reception. This service was ran by the local primary care team who then directed patients into the department or primary care, community services and other services or specialities if they did not need to be seen in an emergency department. Managers told us they streamed around 50 to 60 patients each day to the GP service.

Managers from the department attended hospital wide bed management meetings three times a day. These were held online and included discussion on patient moves, discharge plans and use of escalation areas. We saw managers prioritised support to the department in line with the pressures we observed.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns.

The service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them. The service had received 119 complaints between July 2021 and August 2022. The majority of complaints were about clinical treatment. This was further broken down into wrong diagnosis or treatment, delays in treatment and coordination of treatment. Complaints were coordinated by the patient advice and liaison service (PALS) at the hospital.

Managers investigated complaints and identified themes. A monthly complaints report was presented to senior leaders which outlined the number of complaints, any outstanding investigations and an overview of the complaints. We reviewed the report for July 2022 and saw themes related to poor staffing and wait to be seen in the emergency department.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. We reviewed three written responses to patient complaints and saw they were comprehensive, addressed the patients concerns and offered an apology. Patients were signposted to the Parliamentary and Health Service Ombudsman (PHSO) if they remained dissatisfied with the outcome of the local resolution process.

Managers shared feedback from complaints with staff and learning was used to improve the service. Managers met weekly with divisional directors and leads to review all complaints. Learning from complaints was shared at daily 'huddles'.

Urgent and emergency services

Is the service well-led?

Requires Improvement ↓

Our rating of well-led went down. We rated it as requires improvement.

Leadership

Leaders did not consistently demonstrate they had the skills and abilities to run the service. They mostly understood and managed the priorities and issues the service faced but did not take effective action to address these. However, senior care organisation leaders were not always visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Local leaders had the experience, and integrity to ensure that the service could be run effectively and risks to performance addressed. Leaders in the department had project management experience and could clearly articulate the challenges the service faced.

However, staff did not consistently know who their leaders were and how to access them. Some staff told us that though they felt supported by local leaders they did not see any leaders from the care organisation or wider trust in the department and would not know how to contact them. Some staff in the PANDA unit told us they felt local and care organisation leaders did not communicate effectively with them or take the needs of the PANDA unit into account.

The need to develop leaders was identified through a talent board which met regularly to identify staff who may be suitable for development and promotion. The service provided opportunities for internal promotion and development.

Vision and Strategy

The service did not have a clear vision for what it wanted to achieve nor a strategy to turn it into action, developed with all relevant stakeholders. The trust and divisional vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy, however these were not clearly understood or articulated at service level. Therefore, leaders and staff did to always understand and know how to apply them and monitor progress.

The trust and care organisation had a clear vision and strategy which aligned with local priorities and the needs of the communities served. We reviewed priority objectives for the integrated care division for 2022 to 2023 but saw these were not specific to the service.

A major part of the future vision was the building of a new trauma centre and building work was in progress at the time of our inspection, with clear target dates for completion. The service had a workstream in place to look at models of care; however, standard operating procedures and care pathways for the new trauma centre were still being developed at the time of our inspection. Following our inspection, the service told us these were completed and going through a governance process for approval.

Local leaders were focused on staff recruitment as a priority. However, they told us recruitment had not yet started for the new trauma emergency department and staffing plans were not in place.

Staff we spoke with were not aware of the vision and did not always understand how their role contributed to achieving the strategy. We did not see the trust vision or values displayed in the department.

Culture

Staff did not always feel respected, supported and valued. However, they were focused on the needs of patients receiving care. The service provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear, but staff did not always feel listened to.

Staff satisfaction was mixed. Throughout our inspection, members of the inspection team were approached by staff expressing concerns about the department. Some staff told us pressures in the department and staff shortages left them feeling undervalued, unsupported and unable to carry out their roles to the standard they would like.

The NHS staff survey report for 2021 showed only 23% of nursing and medical staff looked forward to going to work, 18% of medical and 16% of nursing staff said they were satisfied with the extent to which the organisation valued their work. This was relevant to the whole trust and information relating only to staff in urgent and emergency care at Salford was not available.

Staff told us they felt their well-being was not considered and we saw examples of staff exhausted and in tears as they had not been able to take breaks. However, the service did provide staff with four hours paid time off annually as part of the SCARF initiative. This stood for support, care, assist, recognise and family and was a trust wide initiative.

Some staff told us they felt supported by local managers and there were good working relationships between staff. However, staff said there was little engagement with nor visibility of senior leaders from the care organisation or trust.

Staff were focused on the needs of patients, but some staff told us they were not able to meet these needs and provide care to an adequate standard. Staff told us they felt demoralised when providing corridor care.

The service provided opportunities for career development. For example, in the children's emergency department (PANDA unit) four staff were supported to completed advanced clinical practitioner training.

Staff told us they could raise concerns without fear. Staff could access support from a Freedom to Speak Up Guardian. A Freedom to Speak Up Guardian works alongside the trust's senior leadership team to ensure staff have the capability to speak up effectively and are supported appropriately if they have concerns regarding patient care.

However, staff also said they did not always raise concerns as they felt no action would be taken.

Governance

Leaders did not consistently operate effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The arrangements for governance and performance management were clear but did not always operate effectively. Leaders attended directorate, divisional and care organisation quality and performance meetings. The divisional governance meeting was held weekly and the service had a consultant governance lead. Leaders told us they had confidence relevant information was provided to the care organisation and trust through this structure.

There was a consultant lead for mortality and morbidity in the department who sat on the mortality oversight group. Monthly divisional governance meetings rotated between clinical governance and mortality and morbidity reviews.

However, we were not assured the senior leadership were fully sighted on the activity and performance in the emergency department. This is because we found areas of concern such as management of suspected sepsis, where poor audit results and performance had not been addressed.

The children's emergency department (PANDA unit) did not have an executive lead, and the executive children's board was led by a divisional manager. This was not in line with Royal College of Paediatrics and Child Health guidance.

The governance and management of joint working arrangements were not always clearly set out. For example, the hospital did not have children's inpatient beds for the PANDA unit to admit children into but there was no formalised pathway with any neighbouring children's units or inpatient facilities. Staff told us children were transferred to where there was a bed.

Information such as learning from incidents was shared through daily huddles and through weekly communications emails.

Management of risk, issues and performance

Leaders and teams did not consistently use systems to manage performance effectively. They identified and escalated relevant risks and issues but did not always take actions to reduce their impact. Staff did not consistently contribute to decision-making to help avoid financial pressures compromising the quality of care. The service had plans to cope with unexpected events.

The service had 13 risks rated 10 or above on the divisional risk register. Of these, overcrowding in the emergency department was the top risk and rated red. This aligned with what staff and leaders told us about the main risks and what we saw whilst on inspection. Managers reviewed the risk register at monthly divisional quality performance meetings.

We reviewed the risk register and saw that it did not allocate a risk owner or dates for review or actions to be completed. Control measures were not always effective in mitigating the risks we saw on inspection. For example, a control measure for the risk of overcrowding in the emergency department was daily review of staffing numbers dependent on acuity. However, during our inspection we saw areas which had patients with high acuity, such as resuscitation, were understaffed, the department was overcrowded and there was no allocated nurse for patients cared for on corridors.

When performance issues were identified leaders took effective action to address them. For example, the service took immediate action to address concerns regarding the management of patients with suspected sepsis found during our inspection. They issued a new unified sepsis pathway but the new guidance for staff did not include guidance for children with suspected sepsis.

Staff and managers did not always have clear oversight of the patients in the department nor know where all patients were within the department. During our inspection, we saw examples where staff could not find patients within the department to deliver care and treatment, including one occasion where the patient had been discharged from the department and staff were unaware.

The service had plans to introduce a ward accreditation scheme to improve oversight of performance against key quality indicators. However, this was not in place at the time of our inspection.

Information Management

The service collected data and analysed it. However, some staff were not confident the data was always accurate. In addition, staff could not always find the data they needed in accessible formats to help them understand performance, make decisions and drive improvements. Data was not recorded or presented uniformly across the trust and some important data was not captured.

The information systems were secure. However, they were not always reliable or integrated well. On 18 May 2022 the trust experienced a major failure of some of its key information systems which affected Bury, Rochdale and Oldham care organisations. As a result, a critical IT incident was declared. The trust announced the issues were fully resolved on 20 June 2022. The failure disrupted diagnostic, pathology and pharmacy services, and referral pathways from GPs and primary care services.

Data was collected to measure performance. This included ambulance handover times, time from arrival to treatment, length of stay in the emergency department and time for referral to specialty.

There was a secure electronic incident reporting system in place that could be used to analyse themes and trends in reported incidents to enable reviews and appropriate mitigating actions to be taken.

The service did not have any information governance breaches in the last six months.

However, we were not assured that leaders and staff did not always receive information to enable them to challenge and improve performance. This was because data we requested as part of the inspection process was not made available in formats which were easily accessible nor attributable to the service. For example, mandatory training data was difficult to analyse, and a manager told us on inspection that the electronic staff record did not always assign the completed training to staff or roles.

The service submitted data regarding incidents to national reporting systems. However, this was not always assigned to the service within the systems and therefore did not allow external agencies, such as CQC clear oversight.

Engagement

Leaders and staff did not always actively and openly engage with patients and staff to plan and manage services. However, they did engage with local organisations and external stakeholders. They collaborated with partner organisations to help improve services for patients.

There was a limited approach to sharing information with and obtaining the views of staff. We did not see evidence of recent active engagement with people who used services. Feedback was not always reported or acted on in a timely way.

Staff gave examples of when they had made suggestions for improvement, and these had not been acknowledged or actioned. In the 2021 staff survey, nursing staff scored below the trust average for opportunities to show initiative and ability to make suggestions to improve their work or the department.

Urgent and emergency services

Staff in the children's emergency department told us they did not feel managers and care organisation leaders communicated effectively with them and were not visible on the unit.

However, the service did engage with external partners and other stakeholders to plan and manage services. For example, they worked with other NHS organisations to develop pathways for same day emergency care.

Learning, continuous improvement and innovation

Though staff were committed to continually learning and improving services, we saw limited examples of innovation and improvement projects.

Quality improvement initiatives described by managers and staff were limited to work within the hospital and focused on frailty and falls prevention.

Staff told us the last large quality improvement project was to improve ambulance turnaround time, this had resulted in a reduction in the time to clear ambulances form the department between January and June 2022.

Royal Oldham Hospital

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Description of this hospital

Northern Care Alliance NHS Foundation Trust was formed on 1 October 2021 when Salford Royal Hospital NHS Foundation Trust legally acquired Pennine Acute Hospitals NHS Foundation Trust.

The trust has four hospitals – Salford Royal Hospital, Royal Oldham Hospital, Fairfield General Hospital and Rochdale Infirmary which provide a full range of acute services, including acute medicine, urgent and emergency care, acute frailty units, rehabilitation services, dental services and surgical services, to a population of approximately 1 million people. The trusts had been working in partnership from 2016 until the acquisition. This included a shared executive leadership team.

When a trust acquires another trust in order to improve the quality and safety of care we do not aggregate ratings from the previously separate trust at trust level for up to two years. The ratings for the trust in this report are therefore based only on the ratings for Salford Royal Hospital and our rating of leadership at the trust level.

Our normal practice following an acquisition would be to inspect all services run by the enlarged trust. However, our usual inspection work has been curtailed by the COVID-19 pandemic.

At Northern Care Alliance we inspected only those services where we were aware of current risks. We did not rate the hospital overall.

In our ratings tables starting on page 30 we show all ratings for services run by the trust, including those from earlier inspections and from those hospitals we did not inspect this time.

Royal Oldham Medical Care

Medical care services at Royal Oldham Hospital are provided by The Northern Care Alliance NHS Foundation Trust. The Trust changed its name on 1 October 2021 when Salford Royal NHS Foundation Trust legally acquired Pennine Acute Hospitals NHS Trust.

We visited Royal Oldham Hospital as part of our unannounced inspection from 8 August to 10 August 2022. Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

Medical care services are part of the division of specialist medicine at Royal Oldham Hospital.

Our findings

During our inspection we visited and inspected the acute medical unit, respiratory (F7), cardiology (F8) including the coronary care unit, the general medical unit including the discharge lounge, gastroenterology (G2), three general medical wards (F9, F10 and T4) and endoscopy (G3), which is part of the surgery division.

We observed care and treatment of patients and looked at seven care records. We spoke with eight patients and two relatives, as well as staff members across the department. This included senior nurses, staff nurses, ward managers, consultants, healthcare assistants and the senior leadership team for the division.

We previously inspected the medical division when it was part of a different organisation so we cannot compare our new ratings directly with previous ratings. We rated it as requires improvement because:

- The service provided mandatory training but not all staff completed it on time. Nursing staff on some of the wards had low compliance rates for adult basic life support (resuscitation) level two training and did not always complete safeguarding training as required. The service did not always control infection risk well and did not always use equipment and control measures to protect patients, themselves and others from infection. Equipment on the wards was not always checked appropriately and could potentially cause harm to patients requiring assistance. Medicines were not always stored correctly. The service did not always have enough medical or nursing staff to keep patients safe.
- The service did not always provide treatment based on national guidance and evidence-based practice. There was limited access to some support services at weekends including speech and language therapy and dieticians.
- People could not always access the service when they needed it and receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not always in line with national standards.
- Leaders ran services well using reliable information systems and supported staff to develop their skills, but senior leaders were not often visible to staff. The service did not have a specific vision and strategy for what it wanted to achieve. The service did not always identify and escalate relevant risks and issues or actions to reduce their impact.

However:

- Staff completed risk assessments for patients and quickly acted upon patients at risk of deterioration. Records were clear, up to date, stored securely and available to staff when required. Staff were knowledgeable about incidents and reported them well. Managers investigated incidents and shared lessons to the team.
- Staff gave patients enough to eat and drink and gave patients pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers. Staff understood patients' personal, cultural and religious needs.
- The service planned care to meet the needs of local people. Staff made reasonable adjustments to help patients access services. Patients found it easy to give feedback and raise concerns about their care. The service managed complaints well and shared lessons learned with all staff.
- Staff mostly felt respected, supported and valued. The service was focused on the needs of patients receiving care. Leaders operated effective governance processes. Staff were clear about their roles and accountabilities.

Our findings

Royal Oldham Urgent and Emergency Care

We carried out an unannounced comprehensive inspection of Royal Oldham Hospital urgent and emergency care service between the dates of 08 and 10 August 2022.

The urgent and emergency care services had been inspected previously before the acquisition. However, the service had not been rated under the new Northern Care Alliance NHS Foundation Trust. We rated it as requires improvement because:

- The service did not have enough staff to care for patients and keep them safe. Staff did not always have training in key skills and did not always manage safety well. Not all staff completed training on how to recognise and report abuse.
- The service did not consistently control infection risk well. Staff did not consistently assess risks to patients, nor act on them.
- The design, maintenance and use of facilities, premises and equipment did not always keep people safe.
- The service did not always use systems and processes to safely record, prescribe, and administer medicines.
- Not all policies and procedures were ratified and in date. The service did not always provide care and treatment based on national guidance and evidence-based practice.
- People could not access the service when they needed it and had to wait too long for treatment.
- Leaders did not consistently run services well and did not always use reliable information systems. Staff did not always understand the service's vision and values, and how to apply them in their work. Staff did not always feel respected, supported, and valued.
- Managers did not always make sure staff were competent for their roles. Overall compliance with annual appraisals was 85% for nursing staff and 0% for medical staffing.
- Staff did not always feel respected, supported, and valued.

However:

- Staff gave patients enough to eat and drink and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent.
- Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families, and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback.
- Staff were committed to improving services we did see evidence of ongoing quality improvement work or innovation.

Royal Oldham Maternity

Maternity and midwifery services for the Northern Care Alliance were mainly at the Royal Oldham Hospital. There were antenatal services and community midwives based at Rochdale Infirmary.

Our findings

The women's and children's building opened in 2012. The service had about 5,000 births per year. Most maternity services were situated on the first floor with the exception of the postnatal ward on the second floor. Services included an antenatal clinic including sonography. There was a fetal medicine unit and antenatal day assessment unit (ANDU) with triage. The antenatal ward, of 22 beds, had a dedicated induction bay. The postnatal ward had 29 beds that were a combination of bays and side rooms. The labour ward had 11 private rooms, two of which were classed as high dependency and one was a bereavement suite. There were five beds in the birth centre including access to pools.

The obstetric theatres and level three neonatal unit, with 38 beds, were situated close to the labour ward.

There were community midwives available for home births as well as antenatal and postnatal care.

Specialist midwives supported across both locations. These included safeguarding, perinatal mental health, enhanced needs teams, continuity teams, governance, bereavement and smoking cessation.

We rated it as requires improvement because:

- The service had not ensured that staff had all required training in key skills including resuscitation, safeguarding and Practical Obstetric Multi-Professional Training (PROMPT).
- There was equipment, in all areas, that was past scheduled maintenance check dates. There was not always enough registered midwives or care staff to care for women and babies. There were some concerns about medicines management including oversight of medicines past their expiry dates. Care was recorded either electronically or on paper and not always clear to review the complete care record.
- The service was not accredited with the UNICEF baby friendly initiative. Compliance with staff appraisal completion was below the trust target. The service was an outlier for stillbirths and preterm babies.
- Staff we spoke with did not know the vision and strategy for the service. For community staff, there were no formal lone working arrangements.

However:

- Staff understood how to protect women from abuse, and managed safety well. The service controlled infection risk well. Midwives assessed risks to women and acted on them. The service managed safety incidents well.
- Staff provided good care and treatment, gave women enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service. Staff worked well together for the benefit of women, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff treated women with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to women, families and carers.
- The service planned care to meet the needs of local people, took account of women's individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.

Our findings

- Recent changes in senior leadership provided assurance of agreed plans to improve services including updated information systems and to support staff to develop their skills. Some staff had felt respected, supported and valued. Staff were focused on the needs of women receiving care and were clear about their roles and accountabilities. The service engaged well with women and the community to plan and manage services and all staff were committed to improving services continually.

Royal Oldham Surgery

Royal Oldham Hospital is situated in Oldham and is one of the four acute hospitals that form part of Northern Care Alliance NHS Foundation Trust which looks after a population of approximately 820,000 people. The trust was created on 01 October 2021 following a process of acquisition, in which Salford Royal NHS Foundation Trust acquired Pennine Acute NHS Foundation Trust. Royal Oldham Hospital was part of the Pennine Acute NHS Foundation Trust.

The division of surgery provides a range of general and specialist surgical services, including trauma and orthopaedic, vascular and colorectal surgery.

We observed care and treatment of patients and looked at care records. We spoke to patients, as well as staff members across the department. This included senior nurses, staff nurses, ward managers, consultants, healthcare assistants and the senior leadership team for the division.

We previously inspected the surgical division as part of a different organisation so we cannot compare our new ratings directly with previous ratings. We rated it as requires improvement because:

- Records were clear, up to date, stored securely and available to staff when required. Staff were knowledgeable about incidents and reported them well. Managers investigated incidents and shared lessons to the team.
- Staff provided good care and treatment based on national guidance and evidence-based practice. Staff gave patients enough to eat and drink and gave patients pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers. Staff understood patients' personal, cultural and religious needs.
- The service planned care to meet the needs of local people. Staff made reasonable adjustments to help patients access services. Patients found it easy to give feedback and raise concerns about their care. The service managed complaints well and shared lessons learned with all staff.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. The service had a vision and strategy for what it wanted to achieve. Staff understood the service's vision and values, and how to apply them in their work. Staff mostly felt respected, supported and valued. The service was focused on the needs of patients receiving care. Leaders operated effective governance processes. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However:

Our findings

- The service provided mandatory training but not all staff completed it on time. Medical staff did not always complete life support training in a timely manner.
- The service did not always have enough medical or nursing staff to keep patients safe.
- Staff did not always complete and review risk assessments for patients.
- The service did not always use systems and processes to safely store medicines.

Surgery

Requires Improvement ↓

Is the service safe?

Requires Improvement ↓

Since we last carried out a comprehensive inspection of this service, they have become part of a newly formed NHS trust. As such we cannot compare previous ratings with this one. We rated safe as requires improvement.

Mandatory Training

The mandatory training was comprehensive and met the needs of patients and staff. The service did not always make sure that staff completed mandatory training in key skills.

The mandatory training was comprehensive and met the needs of patients and staff. Staff undertook mandatory training courses on infection prevention and control; moving and handling; health, safety and welfare; equality, diversity and human rights; information governance and data security; fire safety, resuscitation and sepsis.

Training was a mix of online training and classroom based. Targets for all modules was 90% except for information governance with a target of 95%. At the time of our inspection, mandatory training compliance for nursing staff within the surgical division was 90%. Information governance was 96%. Sepsis training was 94%.

The nursing staff on the surgical division did not meet the mandatory training compliance rate for training on fire safety which was only 83% compliant.

Medical staff did not always complete their mandatory training on time. Medical staff from the division had not met the 95% compliance rate for training for information governance which was 89%, fire safety 64%, infection prevention control (both levels one and two) 83% and 75%, moving and handling level two 68% and basic life support 50%. Sepsis training was 82%.

Nurses from the division completed training specific to their roles and had high compliance rates for this training. They had 96% compliance for falls awareness and 92% for pressure ulcer training.

Managers and the division practice-based educators monitored mandatory training and alerted staff when they needed to update their training. However, managers did not always ensure staff were granted protected time away from normal duties to complete mandatory training within formal working hours.

The learning and development team recognised that there was a difficulty with staff attending mandatory training courses due to the demands placed on staff. Practice based educators were now offering some training on the wards for staff to attend.

From 1 July 2022, all registered health care providers were required to ensure their staff received training in learning disability and autism, including how to interact appropriately with autistic people and people who have a learning

disability. This training should be at a level appropriate to their role. At the time of the inspection, the NCA had not made completion of this training mandatory, and staff had not completed the necessary programme of learning as required. This meant staff may not have had the skills and knowledge to communicate effectively and provide safe care to these patient groups.

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. Medical staff did not always have good compliance rates for safeguarding training.

Safeguarding training was mandatory to all staff. Training compliance for both level one and two adults safeguarding was 94%. Compliance for level three adult safeguarding was 73%. Compliance for level three adult safeguarding amongst medical staff was only 59%. Training compliance for both level one and two children's safeguarding was 92%. Compliance for level three children's safeguarding was 85%. Compliance for level three children's safeguarding amongst medical staff was only 42%. This meant there was a risk of safeguarding concerns being missed by clinicians. Safeguarding training took the form of both online and face to face classroom-based training.

Safeguarding training covered the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). Training also included female genital mutilation (FGM) recognition, child sexual exploitation and training in the government PREVENT strategy to protect vulnerable people from the threat of terrorism radicalisation.

The trust had safeguarding policies in place for adults and children, in order to support staff to recognise and report abuse and neglect. These were available on the trust intranet.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff told us that they worked closely with the hospital safeguarding team who maintained a presence on the wards and were always available for advice.

Ward managers explained how safeguarding alerts were assessed and investigated appropriately and staff members raising safeguarding concerns received feedback.

Cleanliness, infection control and hygiene

The service kept equipment and the premises clean and controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Theatres we visited were visibly clean. Healthcare waste was disposed of in accordance with health technical memorandum (HTM 07/01). Clinical sinks and water safety were in accordance with HTM 04/01. The design and environment of the theatres were compliant with HTM 00/10. Theatres were IPC compliant in accordance with HTM 00/09.

Theatres had a dedicated cleaning staff that cleaned after theatre lists. Theatre staff cleaned between patients in accordance with best practice standards.

Ward areas were visibly clean, and we observed domestic staff cleaning during our inspection. All ward areas had suitable furnishings. The immediate environment was clean and dust free, floor space was clutter free, floors were covered in a wipeable material and chairs, couches and pressure relieving cushions were in a good state of repair.

We observed staff and visitors to ward and clinical areas being asked to wear masks and sanitise their hands prior to entering. Hand washing facilities and sterilising gel were sited at all ward entrances. Hand gel was sited at each side room and bays. Wards displayed posters that displayed the correct handwashing technique. Personal protective equipment (PPE) was available at the entrance of all wards and clinical areas we visited.

Overall infection prevention and control level one training compliance was 92%. Nursing staff compliance for level two infection prevention and control training was 91%. However, medical staff compliance was 75%.

PPE and hand hygiene compliance were monitored as part of monthly matron audits. From February to August 2022, PPE compliance across the surgical wards was around 91%. For the same time period hand hygiene compliance across the surgical wards was around 94%.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. We reviewed cleaning checklists against cleaning schedules, including those for high touch areas.

Following the inspection, we requested data of cleaning audits that had been carried out across the division of surgery. An audit completed in August 2022 showed that nursing staff across most of the wards scored 98% whilst domestic staff scored just below the compliance target of 95%.

We checked eight pieces of equipment across various surgical wards and theatres, and all had been labelled with “I am clean” stickers to show when they had been cleaned.

Cleaning documentation for clean and dirty utility rooms were complete. Clean and dirty laundry were segregated. Dirty utility areas were organised and clear from clutter.

Patients were screened for routine infections such as COVID-19 and MRSA when they arrived on the wards. Any patient that tested positive were provided with individual side rooms to reduce the chance or transmission to other patients.

The trust monitored incidences of healthcare acquired infections. We reviewed one of their recent audits which identified fifteen cases of Clostridium Difficile (a type of bacteria that can cause diarrhoea) on surgical wards between February and July 2022. The audit found that the trust had sustained low rates of Clostridium Difficile with only six of the fifteen identified across the surgical division.

All patient bed spaces on ward areas had privacy curtains which had been changed within the past six months.

We spoke with ten patients and sought their views on ward cleanliness and IPC. All ten provided positive feedback. They said that ward areas were clean, staff wore appropriate PPE when engaging in clinical activities, that they cleaned equipment before and after use and that staff always demonstrated good hand hygiene practices.

Environment and equipment

Surgery

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The design of the ward and theatre environments followed national guidance. Some of the wards had recently been reconfigured having previously been used as COVID-19 treatment areas. Wards T7 and T8 had recently undergone some minor building work to split them into two separate wards to improve patient flow. Each ward was configured with bays and side rooms and had enough bathroom and shower facilities. Ward bays were gender specific but could be reconfigured dependent on male/female patient ratios.

Access to wards and theatres was secure and needed key codes or electronic passes to gain entry. Theatre and ward areas including corridors were free of clutter. All items in storerooms were stored off the floor.

The service had enough suitable equipment and staff told us that there were enough items of equipment with which to provide safe and timely patient care.

Staff carried out daily checks of specialist equipment including anaesthetic machines in theatres, and we saw that equipment was stored safely when not in use. Staff received training on specialist medical equipment and compliance was monitored by the divisional practice-based educators.

We checked ten items of equipment, and all had been serviced and had in date inspection labels in place and had been portable appliance tested (PAT) tested by the estates department as required. Broken equipment was quarantined in locked storerooms and labelled not for use.

Resuscitation equipment and trolleys were checked daily by staff on all ward and theatre areas. We checked the contents of three resuscitation trolleys and all equipment was found to be in date and correctly stocked, defibrillators and other emergency equipment were in working order.

We saw evidence on all the wards inspected that those with fridges storing medicines that temperatures were correct and recorded accurately.

Notice boards were on the walls of each ward. They displayed names of staff who were on duty and the numbers of staff available for the shift. Other notice boards on the wards displayed the number of falls, pressure ulcers, healthcare associated infections and the number of days since the last incident.

Each ward had fire extinguishers which had been serviced in the last 12 months. Fire exits were signposted clearly, and the wards had chairs and slides to move patients in an emergency.

Patients could reach call bells from their beds and call bells in the toilets and wash areas were in suitable places for a patient to reach if they needed assistance. During our inspection we observed staff attending to patients promptly when a call bell had sounded.

Staff disposed of clinical waste safely and appropriately. Dirty utility areas were organised and clear from clutter. Sharps bins that were situated in these areas were dated correctly and were not overfilled. Cleaning materials and chemicals were stored securely.

Assessing and responding to patient risk

Surgery

Staff completed risk assessments for each patient but did not always update them in a timely manner to remove or minimise risks. Staff identified and quickly acted upon patients at risk of deterioration.

Staff used the nationally recognised national early warning scores (NEWS2) tool to identify deteriorating patients. NEWS scores were displayed on a screen at the nurses' station on each ward which also showed when they were due to be repeated. However, staff we spoke with said some patient observations were delayed occasionally due to staff shortages and patient acuity.

Patients who had a NEWS score of six or above were automatically assessed for sepsis. Staff we spoke with were able to describe the signs of sepsis and knew how to escalate a patient so they would receive treatment quickly. Wards had posters on the walls to alert staff of the sepsis screening tool and the urgency for antibiotics for patients who were showing signs of infection.

Staff were able to describe the process for escalation of a deteriorating patient. They would continue to monitor the patient and escalate to a doctor and the nurse in charge.

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. Updates to risk assessments due for each patient were detailed on the handover document for each patient. Risk assessments carried out included risk of pressure ulcers; malnutrition and falls. We reviewed eight falls risk assessments on ward T8. We saw 50% of the risk assessments were out of date including three for patients previously identified as being a high risk of falls and one had not been completed at all.

Staff were able to inform us of the patients on the ward with identified risks, such as vulnerability and existing pressure ulcers.

The service had 24-hour access to mental health liaison and specialist mental health support that they could access if they were concerned about a patient's mental health.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide.

Tissue viability nurses were available to support patients at risk of developing a pressure ulcer.

Staff completed handovers three times a day. They shared key information to keep patients safe when handing over their care to other members of staff.

Shift changes and handovers included all necessary key information to keep patients safe. We observed safety huddles and handovers where key information about patients on the wards was given to staff verbally and in written format including; patients at risk of falls or confusion, patients with pressure ulcers, nutrition and hydration and patients who had a 'do not attempt cardio-pulmonary resuscitation' (DNACPR) in place.

Theatre staff completed the 'five steps to safer surgery' procedures, including the use of the World Health Organisation (WHO) safer surgery checklist. We observed these taking place during our inspection and compliance was 100% for safety checks before, during and after surgery.

Staff completed training on sepsis, falls awareness, pressure ulcer prevention training, malnutrition screening tool (MUST) and venous thromboembolism (VTE). Compliance for nursing staff for all these training modules was over 90%. However, sepsis training for medical staff was 82%. This meant that not all medical staff were up to date, and this could be a potential risk to patient safety.

Nurse staffing

The service did not always have enough nursing and support staff to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service did not always have enough nursing and support staff to keep patients safe. The number of nurses and healthcare assistants did not always match the planned numbers. We reviewed the fill rates for registered nursing staff from January 2022 to July 2022 excluding May 2022 as this information was not provided by the trust due to an IT failure.

The average day shift fill rate for registered staff was 87% and the average night shift fill rate was 96%. Ward T6 consistently had the lowest fill rates across day shifts with the average shift fill rate reported at 78%. Ward T7 had the lowest fill rates across night shifts with the average shift fill rate reported at 92%. We saw evidence that non-registered staffing had been increased when qualified nursing fill rates were low with the average day shift fill rate for non-registered staff being 94% and the average night shift fill rate was 101%.

These figures included ward managers being counted as nursing staff, taking time away from their management duties. One ward manager told us that they often did not have time to review incident reports, complete audits or mandatory training as they were required to back fill staffing gaps in clinical roles.

Staff were frequently moved from areas of speciality to meet skill mix requirements and to support the wards with the highest acuity level of patients when required.

Managers calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. Senior leaders told us the service conducted nurse staffing establishment reviews annually.

Where there were no nurses available for a bay, managers tried to fill the shift from bank or agency in the first instance and the matter was escalated to the staffing on-call bleep holder. The ward manager also carried out clinical shifts where there were gaps in staffing.

Staff we spoke with told us that some surgical wards often felt unsafe due to staff shortages and the reliance on locum and bank staff to fill shifts.

We saw from the staffing on several of the wards that the planned numbers of registered nurses could not be met. We also saw occasions when there was one to one care required but the staffing numbers had not been elevated to accommodate this which meant that some areas fell below the staffing levels required to provide safe care.

Managers told us that they made sure all staff including bank and agency staff had a full induction and understood the service. Staff were classed as supernumerary during their induction period.

The leaders from the division told us that staff retention had been a challenge due to COVID-19. The service had a turnover rate of 1.3% nurses between February 2022 and July 2022.

Data from July for the trust for the surgical division showed that 9.6% of nurses were off sick in July 2022. The vacancy rate for nursing staff across the division was 1.6%.

We spoke with ten patients and relatives across the surgical division. All provided positive feedback, they acknowledged that staff were stretched but that they were able to meet their needs.

Medical staffing

The service had enough medical staff to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

We requested however, the service did not provide, information on the planned versus actual numbers of medical staff. However, staff told us there were enough doctors available to keep patients safe.

Sickness rates for medical staff were low. Data from the trust showed that 5.8% of doctors were off sick in July 2022.

Managers could access locums when they needed additional medical staff and managers ensured that locums had a full induction to the service before they started work.

Junior doctors on surgical wards rotated on a six-monthly basis and there was a new cohort of junior doctors on each ward at the time of our inspection who had started the previous week. Staff told us that this could be problematic with a lot of new medical staff on a ward who were unfamiliar with it. The new junior doctors said despite being new in post rotation they felt supported and could access middle grade or consultant support if required.

Consultants carried out ward rounds on weekdays. The service always had a consultant on call during evenings and weekends. A surgical registrar carried out daily ward rounds over the weekend. There was enough on-site and on-call consultant cover over a 24-hour period including cover outside of normal working hours and at weekends.

The leaders from the division told us that staff retention was a difficulty. The service had a turnover of 1.1% medics per month from February 2022.

Records

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

Patient notes were comprehensive, and all staff could access them easily. Records consisted of both electronic and paper notes. The electronic system contained relevant risk assessment bundles such as falls, nutrition, pressure ulcers and sepsis. Risk assessments had been carried out when patients had been admitted to the wards and do not attempt cardiopulmonary resuscitation forms (DNACPR) and deprivation of liberty safeguard (DoLS) forms had been completed correctly if needed.

The records reviewed were contemporaneous, legible and there was clear evidence of multidisciplinary working.

When patients transferred to a new team, there were no delays in staff accessing their records. Staff including locum staff told us that they could access all patient records easily.

Paper records were stored securely in trolleys with working keypads. We observed staff checking these were locked after returning patient notes to them.

Electronic record systems were accessed through computers throughout the ward. These computers were username and password protected. Staff ensured that computers were locked when they were not attended. Staff told us that they had sufficient computers to allow patient records to be completed contemporaneously.

We reviewed ten patient records. Nine out of ten records reviewed had risk assessments, care plans, observations and NEWS scores recorded though not all risk assessments had been reviewed in a timely manner.

Medicines

The service used systems and processes to safely prescribe, administer and record medicines. However, the service did not consistently use systems and processes to store medicines safely.

The service had an electronic system for managing medicines, a plan was in place when IT issues meant records were not available.

Medicines reconciliation was completed by pharmacy staff and records showed the trust target of 50% in 24 hours following admission had been achieved. However, this target was not compliant with the current guidance National Institute for health and Care Excellence (NICE) guidance which indicates 100% of patients' medicines should be reconciled within 24 hours or sooner if clinically necessary. This meant staff could not always be assured they had a complete understanding of the medicines each patient took and the potential impact on their diagnosis and treatment.

Staff stored and managed all medicines and prescribing documents securely. The pharmacy team visited wards to review stock levels and medicines expiry dates. However, pressures and vacancies within the technician and medicines management assistant roles meant capacity to complete these tasks was limited. We found some medicines were past their expiry date and several medicines with a reduced in use expiry, were not dated when opened. Therefore, there was a risk they would be used beyond their expiry dates. We reported this to the sister in charge before we left the ward who removed them from use.

Medicines including controlled drugs were generally safely stored with the trust's monthly audits showing improved overall compliance from December 2021 to July 2022. Any areas for improvement were shared with ward managers in order that action could be taken. Storage cupboards in one area did not meet with required standards. The trust was aware of this, and plans were in place for their replacement.

We found some records of emergency medicines and equipment checks were not completed. The wards had a sepsis box to support prompt treatment. On one ward we found there was no record of the contents of the box having been checked for three weeks.

Medicines management training for nursing staff across the division was 94%. However, medical staff compliance was 81% but this was due to the arrival of the new junior doctors who had started the week prior to our inspection.

The service had an electronic system for managing medicines, a plan was in place when IT issues meant records were not available. Staff generally followed systems and processes to prescribe and administer medicines safely. However, trust policy to support staff with the administration of time sensitive medicines at the correct times was not consistently followed. Of the eight medication records we reviewed, we found two people (25%) did not have their medicines administered within the correct timeframe. A delay in receiving time sensitive medicines may mean that patients do not receive the full benefit from their medicines.

We reviewed five electronic prescribing and medicines administration patient records. All the records were complete with allergy status recorded. The name of the prescriber was documented for each medicine and the appropriate assessments had been documented.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. 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. Managers ensured that actions from patient safety alerts were implemented and monitored.

Between February 2022 and July 2022, the trust told us that there were 9622 incidents for the hospital. Of these 181 (1.8%) were recorded as theatre incidents, 50 (0.5%) were surgery related, 29 (0.3%) were related to anaesthetics. There were no details about grading of incidents or level of harm provided to us.

Staff knew what incidents to report and how to report them. Staff we spoke with were able to give examples of incidents they had reported on the electronic reporting system. For example, pressure ulcers, falls, IT failures, medicines errors and staffing levels. Staff raised concerns and reported incidents and near misses in line with trust policy.

Staff understood the duty of candour. They were open and transparent and gave families a full explanation when things went wrong. Clinical meetings were held regularly to discuss incidents triggering duty of candour. We reviewed evidence of letters apologising for treatment that patients had received whilst in hospital.

Staff reported serious incidents clearly and in line with trust policy. Serious incidents were investigated jointly between medical and nursing staff. We reviewed two incident investigations. They were detailed, provided the root causes of the issues which had contributed to the incidents and actions were proposed with an action plan owner and action plan review date to ensure continuity. Staff involved in reporting were given feedback at the conclusion of any investigation.

Staff met to discuss the feedback and look at improvements to patient care. Incidents were discussed at a clinical leads meeting and learning from incidents was fed back to staff in safety huddles and via a staff newsletter.

Staff told us that they felt informed about incidents that had happened on their ward and serious incidents elsewhere and that learning from incidents was shared well.

Staff were able to give examples of incidents where learning had been shared in theatres and on the surgical wards.

Surgery

Is the service effective?

Requires Improvement

Since we last carried out a comprehensive inspection of this service, they have become part of a newly formed NHS trust. As such we cannot compare previous ratings with this one. We rated effective as requires improvement.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Staff protected the rights of patients subject to the Mental Health Act 1983.

The trust operated a central online policy hub. However, during our inspection of the core services, we found that some services were using legacy policies from the previous trusts or accessing a suite of policies separate to the central Northern Care Alliance hub. As part of our ongoing monitoring of the trust, and throughout the inspection, we found there was a need to align some legacy Salford and Pennine policies to ensure there were trust-wide versions that reflected national or best practice guidance where appropriate.

Senior leaders were unable to confirm when policies would be standardised across the trust. However, they could describe how policies were being reviewed through collaborative networks across the trust for example they were currently involved in reviewing the trust's policy on venous thromboembolism prophylaxis.

Staff followed policies to plan and deliver high quality care according to best practice and national guidance. For example, National Institute for Health and Care Excellence (NICE), Royal College of Surgeons guidelines, the Association of Anaesthetists of Great Britain & Ireland (AAGBI) and the Association for Perioperative Practice (AFPP).

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Staff completed the Malnutrition Universal Screening Tool (MUST) for each patient, this screening tool is used to identify patients who are malnourished or at risk of malnutrition. The tool includes management guidelines which can be used to develop a care plan. If a patient scored high on the assessment, then staff would request input from the dietetics team.

The ward managers told us that dietetic support was available for patients who required it and we observed dietitians on several wards we inspected as part of multi-disciplinary teams reviewing patients.

Patients waiting to have surgery were not left nil by mouth for long periods. Systems were in place that followed current best practice guidelines to identify patients that were required to fast before surgery.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Staff completed patients' fluid balance charts where they were needed.

Ten patients provided us with information about the quality of the food provided by the hospital. All said that they were happy with the options provided and that staff regularly checked on the food and drink requirements.

Nutritional status boards were situated on all the wards we visited which included information about patients' dietary requirements such as if they were “nil by mouth” or required soft food.

Notice boards promoting the importance of staying hydrated were situated on wards that we visited.

Patients had choice of food they were given and there were optional menus for patients who had specific dietetic or religious requirements. The ward we visited had protected mealtimes, which allowed nurses and clinical support workers to be available to support patients who may need it. Patients with religious, cultural and other needs were supported and offered choice. For example, halal, kosher and gluten free menus were available for patients to choose from.

Staff supported patients with eating and drinking at mealtimes if they needed it. Patients requiring assistance with feeding were identified by use of a red tray.

Patients had access to water on their bedside tables. Staff offered patients hot drinks and ensured drinks were within reach.

Pain relief

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

Staff assessed patients’ pain using a recognised tool and gave pain relief in line with individual needs and best practice. We saw positive interactions between patients and staff in relation to pain management.

Pain was assessed during intentional rounding observations (also known as care and comfort checks) every two hours through the night and every hour during the day. For patients who were experiencing high levels of pain they would be reviewed more often if needed.

Patients that we spoke with said that their pain was being managed well and that staff were attentive if they observed any changes to their level of pain. Patients told us that pain relief would be administered soon after requesting it.

Staff prescribed, administered and recorded pain relief accurately. Staff had support from a specialist pain team.

Patient outcomes

The service generally achieved good outcomes for patients. However, the trust was unable to provide effective data to demonstrate patient outcomes were being monitored.

We asked the trust for data on patient outcomes and from national audits programmes, but none were received. We could not therefore be assured that patient outcomes were being effectively measured and monitored across the surgical division.

The service undertook local audits as part of the nursing accreditation and assessment system (NAAS). Audits included cannula and catheter care; dementia; documentation; falls; pain; medicines management; diabetes; safeguarding; infection control and hand hygiene. The tool measured the quality of nursing care delivered by individuals and teams on each ward. Each ward or unit received a red, amber or green rating. Managers shared and made sure staff understood information from the audits.

The surgical division at the Royal Oldham Hospital participated in some relevant national and local clinical audits such as the national hip fracture audit. In the 2021 hip fracture audit Royal Oldham hospital was within the top quartile (top 25%) for two metrics, the middle 50% for three and in the bottom 25% for two metrics. Action plans were in place to ensure improvements were made and monitored.

The surgical division had been accredited by the Royal College of Anaesthesia for achieving their safety and training standard.

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 development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.

Managers gave all new staff a full induction tailored to their role before they started work. Staff we spoke with confirmed they had received an appropriate induction which equipped them to work within the department. Junior doctors, theatre staff, newly registered nurses and student nurses, spoke positively about the induction process and the extra support they had received from the practice-based educators.

Health care assistants (HCA's) had a starter pack which was signed off to say they were competent. Nursing and theatre staff worked through competencies that were signed off by the ward manager or sister/mentor to show they were competent in various tasks.

Managers mostly supported staff to develop through yearly, constructive appraisals of their work. Trust data for the Oldham care organisation showed that 90% of staff in the surgical division had completed an appraisal. Data for specific job roles showed that 90% of nursing staff and 91% of medical staff across the surgical division had received an appraisal in the last 12 months.

Managers identified poor staff performance promptly and supported staff to improve.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Ward managers and sisters carried out clinical supervision of nursing staff.

The practice educators supported the learning and development needs of staff.

Wards had link nurses who were aligned to the 14 clinical areas of the nursing accreditation and assessment system (NAAS). Surgical wards had several link nurses for the following subjects: infection prevention and control; pain management; safeguarding; dementia; pressure ulcers and tissue viability; nutrition and hydration; end of life care; medicines management; communication; students; diabetes; falls; patient centred care; leadership; staff wellbeing and engagement; alcohol and patient safety.

Wards had held limited team meetings recently due to the pressures of the pandemic. They had shared key learning from incidents and complaints and had updated one another via the newsletter and daily huddles and staff social media groups.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

There was effective multi-disciplinary team working between nurses and other staff across the division. Nurses, doctors and health care assistants told us that they had strong working relationships.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Staff on all wards told us that they have a multidisciplinary meeting every day attended by doctors, nurses, speech and language therapists (SALT), pain team, dietitians and allied health professionals such as physiotherapists and occupational therapists. Topics such as concerns about patients and estimated discharge dates were discussed. Macmillan nurses and enhanced recovery after surgery (ERAS) nurses also supported the surgical division.

The transfer of care team attended huddles every morning and would support staff to facilitate discharges for patients with complex needs from the hospital. This team sometimes attended ward rounds with doctors, a ward coordinator or sister and a physiotherapist.

Patients had their care pathway reviewed by relevant consultants. We observed a discussion between consultants from different departments about the need to admit a patient from the emergency department to a specialist medical ward. We saw that this was a healthy discussion and decisions made were in the best interest of the patient.

Staff referred patients for mental health assessments when they showed signs of mental ill health and depression. Staff knew how to contact the mental health team and told us the team would review a patient within 24 hours of a referral being made.

Seven-day services

Key services were available seven days a week to support timely patient care.

Most services within the division operated 24 hours a day for seven days, this included the surgical assessment unit and the virtual fracture clinic based on ward T7.

Consultants led daily ward rounds on all wards, including weekends. Patients were reviewed by consultants depending on the care pathway.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week.

Patients had access to most services over the weekend including palliative care, physiotherapy, pharmacy and urgent X-rays and scans. They did not have access to speech and language therapists or dieticians but access to prescribed supplementary feeds was still available.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards/units.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle.

We saw that there was health promotion information available on wards to promote better health. These were available in different languages on request. Staff could also refer to services such as the drug and alcohol team and smoking cessation services prior to elective surgery.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used authorised measures that limited patients' liberty.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. If staff assessed a patient and found that they lacked capacity a referral would be made to the safeguarding team who would complete a comprehensive capacity assessment.

Staff gained consent from patients for their care and treatment in line with legislation and guidance.

Compliance with training in Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards was 92% across the division.

When patients could not give consent, staff made decisions in their best interest, considering patients' wishes, culture and traditions.

Staff made sure patients consented to treatment based on all the information available.

Staff clearly recorded consent in the patients' records. Of ten patient records we reviewed consent was recorded in each patient record.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards.

Surgery

The safeguarding and complex care team supported the ward staff to keep patients safe. The safeguarding team supported staff to complete deprivation of liberty safeguarding (DoLS) applications for patients. They informed staff when they needed to be updated.

The surgical division was provided with a daily list of patients subject to a DoLS with expiry dates. This was shared with ward mangers who discussed this with their staff.

Compliance with the mental capacity act was reviewed at all the care organisation's safeguarding steering committees.

We reviewed four DNACPR forms during our inspection, the forms were all completed correctly. The forms included information on a reason why the DNACPR had been put in place, if a discussion had been had with the patient and where the patient lacked capacity a discussion was documented with a family member.

Is the service caring?

Good ➔➔

Since we last carried out a comprehensive inspection of this service, they have become part of a newly formed NHS trust. As such we cannot compare previous ratings with this one. We rated caring as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed kind caring interactions between patients and staff. Staff explained to patients what they were doing when providing care and treatment.

Therapy staff used bedside curtains when carrying out bedside therapy with patients to ensure that their privacy and dignity was maintained.

Staff followed policy to keep patient care and treatment confidential. The patient survey showed that 100% of patients felt they were treated with respect and dignity.

The patient survey showed that 100% of patients said they received help from staff if required when eating their meals.

Staff followed policy to keep patient care and treatment confidential. We saw staff interact with patients who were living with dementia in a calm and caring manner.

Staff that we spoke with understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Emotional support

Surgery

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. The hospital had a multi faith chaplaincy service and a bereavement service which staff could access to provide support to patients and their relatives.

Staff were able to provide emotional support to patients and their loved ones in relatives rooms which were based on some of the wards. Staff had attempted to make these rooms feel warmer and less clinical. All wards across the division had notice boards displaying thank you cards received from patients and relatives.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

The psychological needs of patients, relatives and their carers were considered by staff.

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

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. Patients we spoke with during our inspection understood their treatment plans and were involved in decision making about their care.

We observed staff talking with patients and families in a way they could understand.

Patients and those close to them could give feedback about their treatment and the service they had received. Feedback forms were available on the wards. Patients we spoke with gave positive feedback about the service.

The patient survey showed that 100% of patients felt fully informed about their care and treatment.

We requested details about feedback from patients and their families about the care they had received, on the surgical division, from the trust but the data that we received was for the hospital. The data from the hospital showed that 85% of patients and family members were positive about their experience at Royal Oldham Hospital.

Is the service responsive?

Requires Improvement 

Surgery

Since we last carried out a comprehensive inspection of this service, they have become part of a newly formed NHS trust. As such we cannot compare previous ratings with this one. We rated responsive as requires improvement.

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

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the changing needs of the local population. The trust worked closely with community stakeholders, including commissioners and GPs to discuss any changes.

The service provided a range of elective and unplanned surgical services for the communities it served. This included general surgery, trauma and orthopaedic, colorectal and vascular surgery.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. All wards inspected were adhering to the guidance regarding mixed sex accommodation.

Facilities and premises were appropriate for the services being delivered.

Staff could access emergency mental health support 24 hours a day, seven days a week for patients with mental health problems, or those living with learning disabilities and dementia. Staff described positive working relationships with the mental health liaison team and told us they were proactive in responding to requests for support and managers held regular meetings with the team.

The service had systems to help care for patients in need of additional support or specialist intervention. Appropriate notification systems were in place to 'flag' patients who had specific or complex needs.

The hospital had an integrated discharge team who supported patients with their discharge from hospital, where care and support needs had been identified. However, there were challenges for the provision of care in the community across the region, which impacted on staffs' ability to discharge patients.

The trauma nurse coordinator team based on ward T7 ran a virtual fracture clinic and ensured elective surgical patients where prepped for surgical admission or informed in a timely manner if surgery was delayed or cancelled.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and dementia received the necessary care to meet all their needs. Staff could access emergency mental health support 24 hours a day seven days a week for patients living with mental health problems.

Staff could refer patients to the learning disability and autism service to help support them and their carers. Specialist learning disability nurses were available to help make reasonable adjustments and help co-ordinate care. For example, pre-admission planning, ward visits, communication advice and discharge planning.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. We observed staff asking another staff member who spoke multiple languages to support them with a patient which they did.

The service had information leaflets available in languages spoken by the patients and local community. They offered different menus for different religious groups.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. There was a trust lead for dementia and the trust had a dementia strategy. Dementia awareness training was part of mandatory training for all staff. The wards we visited used wristbands or a butterfly symbol to discreetly identify patients living with dementia or a learning disability.

Some wards that we visited on the surgical division had patients who were living with dementia.

Wards were designed to meet the needs of patients living with dementia, for example they had dementia friendly signage for toilets and showers and dementia friendly digital clocks with the time, day and date.

Patients living with dementia, autism and learning disabilities completed 'this is me' forms and 'patient passports' when they were admitted on to the ward. Staff told us that carers would be involved with patients to complete the form which provided information such as the best way to communicate with the person. We witnessed nursing staff on several wards discussing patient 'this is me' forms during staff handover and demonstrating that they had taken time to read them.

Patients with learning disabilities were supported by the learning disability lead nurse if required. Staff told us that patients with learning disabilities could also be supported more frequently by carers and loved ones under 'John's Campaign'. (This is a nationally recognised campaign which promotes the rights of people in hospital, who are living with dementia to be supported by their family carers).

Staff could access the mental health liaison team for support. We witnessed a referral to the team from one of the wards during our inspection and the assessment was timely.

The service had suitable facilities to meet the needs of patients' families. Some wards that we visited had day rooms for patients that could be used for meetings with relatives. Wards that did not have these rooms shared with the nearest surgical ward.

Access and flow

People could not always access the service when they needed it and receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not always in line with national standards.

Managers did not always ensure that patients could access services when they needed to receive treatment within agreed timeframes and national targets.

Theatre lists did not always run to time. Between February and July 2022 there were 30 operations cancelled due to theatre lists over running. There were dedicated staff who kept patients informed about disruption and cancellations.

Surgery

Hospital data broken down by speciality for May 2022 showed that general surgery had treated 48% of patients within 18 weeks. Other surgical services were listed as 51% within 18 weeks but not broken down further.

NHS England sets out that patients should wait no longer than 18 weeks from GP referral to treatment (RTT). Trust data showed that the hospital overall treated 62% of patients within 18 weeks of referral in January 2022. This was worse than the England average of 70% and below the national target of 92%. This had increased to 71% in June 2022.

In January 2022, 51% of patients were waiting up to 18 weeks to start treatment. This had increased slightly to 50.4% in June 2022. However, this was worse than England average compliance for the same period which was 59%.

The Trust provided us with a referral to treatment trajectory for the different hospitals. For Royal Oldham Hospital the trajectory of patients waiting 52 weeks and 72 weeks was on track to reduce over time. However, the total referral to treatment waiting list trajectory was predicted to increase from 32,853 to 34,028 in March 2023.

There were several patients who were medically optimised to leave hospital. Their transfer or discharge was delayed because they were awaiting a residential home placement or awaiting completion of assessments within the hospital.

Patients could be admitted for surgical treatments through a number of routes, such as pre-planned day surgery, through accident and emergency or through GP referral. Patient records showed that patients were assessed upon admission to the wards or prior to undergoing surgery.

Managers monitored patient transfers and followed national standards. Bed management meetings were held three times per day. These were held online and included discussion on patient moves, discharge plans and use of escalation areas.

Managers made sure they had arrangements for surgical staff to review any surgical patients on non-surgical wards and worked to minimise the number of surgical patients on non-surgical wards.

Staff supported patients when they were referred or transferred between services.

Managers did not always monitor that patient moves between wards were completed during the daytime. We requested data from the last six months for ward moves that were completed after 8pm. We saw 394 ward moves for the surgical division were completed after 8pm between February 2022 and July 2022. Moving patients around a hospital, especially at night, can have a detrimental effect on their health and wellbeing.

The transfer of care team attended the ward each morning to identify those patients where they could start planning their discharge.

Staff planned patients' discharge early and carefully, particularly for those with complex mental health and social care needs. Staff we spoke with told us the biggest challenges to discharging patients were those who required ongoing care in a nursing home or who needed complex packages of care. There was some difficulty in accessing providers who could accept these patients.

The discharge lounge was used to facilitate discharges for patients.

Managers monitored the number of delayed discharges and knew which wards had the highest number.

Managers told us that delayed discharges and discharges that were deemed to be unsafe were incident reported and appropriate investigations carried out.

Patients were not always discharged before five o'clock. This meant those beds were not available for other patients waiting to be admitted. The trust provided data that showed that 3,626 patients had late discharges from February 2022 to July 2022. We asked the trust for the reasons for the late discharges but did not receive this information.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Royal Oldham Hospital received 255 complaints from 1 February 2022 to 31 July 2022. From those, the surgical division received 40% of those (102) complaints. Their compliance rate in responding to the complaints made during that time was 88%. For three for six months compliance rate was 100% achieved.

There was training available to ward managers about dealing with complaints.

Patients, relatives and carers knew how to complain or raise concerns.

The service clearly displayed information about how to raise a concern in patient areas. The service had a patient advice and liaison service (PALS) and displayed information to direct patients how to make a complaint if they needed to.

Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes. The outcomes from complaints was shared at the daily safety huddle meetings so that staff could learn and improve patient safety and experience.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Senior leaders told us about sharing the experience of people who had complained. They had recently brought people back to share their experiences with staff to enable them to identify what they could have done better.

Staff could give examples of how they used patient feedback to improve daily practice.

Is the service well-led?

Requires Improvement 

Since we last carried out a comprehensive inspection of this service, they have become part of a newly formed NHS trust. As such we cannot compare previous ratings with this one. We rated well-led as requires improvement.

Leadership

Surgery

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They supported staff to develop their skills and take on more senior roles. They were visible and approachable in the service for patients and staff.

The trust provided services through four care organisations. Each care organisation was managed by a medical director, director of nursing, director of operations, HR director and finance director. Royal Oldham Hospital was part of the Oldham care organisation.

The division of surgery had a triumvirate leadership team with a divisional clinical director, a divisional director of nursing and a managing director.

The trust was developing leaders to provide career progression. The leaders from the surgical service told us that there were leadership programmes across the trust that operational colleagues and nursing therapy colleagues benefitted from.

The ward managers told us that they had access to and had booked on to an accelerated leadership development programmes which was a two-day course. This course was developed to improve colleague experience through the development of capable leaders.

Staff told us that they felt well supported by ward managers and that they felt comfortable to approach senior leaders with any issues.

Staff we spoke with commented on the positive culture throughout the surgical wards, they said they felt there was good team working across all clinical staff.

Ward managers that we spoke with said that they were supported by the directors and assistant directors for the division and that they had a visible presence on the wards.

Due to the size of the trauma and orthopaedic ward the division recently took the decision to separate the trauma and orthopaedic ward (T8) and the trauma and surgical assessment unit (T7). Each ward had its own ward manager and staff and managers said that they had benefited from this positive change.

The divisional clinical director's and divisional director of nursing's offices were based on or close to the wards to ensure they were visible and accessible to staff and patients.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The division of surgery leaders told us that they shared the vision and strategy of the trust.

The trust vision for the next five to ten years was: "to be the safest and most effective organisation in the NHS and the place where people want to work." It then stated that the trust was "passionate about tackling inequalities and improving health outcomes and experiences in all our places".

Surgery

The trust had ambitions or objectives to achieve their vision. These were to improve the populations health, to care for and inspire people, to improve quality and performance, to support social and economic development in their locations and to be financially sustainable.

The trust had a mission statement that prioritised equality and diversity; safety and effectiveness and providing an excellent experience for all patients.

The surgical division also had a set of 16 priorities and objectives they intend to achieve for the period 2022-2023. By 2023 they wanted to eliminate 104 week waits and reduce 78 week waits further (in line with NHSE targets), reduce follow ups by 25% against previous years activity, develop workforce plans to ensure a safe and sustainable service, deliver Oldham theatres excellence programme and improve performance against all cancer targets. These objectives were underway.

Each department within the surgical division had set their own priorities for the next 12 months. These were broken down into high and low impact, to be achieved sooner and high and low impact to be achieved later. Senior leaders were confident these priorities would be achieved.

Ward managers and most staff across the surgical division had a good understanding of the vision and strategy for the hospitals within the trust.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Most staff told us that the culture in the division was positive. They highlighted staffing as the main issue that impacted on their work and understood the challenges for their work areas and for the division. Team working was recognised as a strength and staff said that the pandemic had strengthened teamwork and how they valued each other.

Senior leaders told us that staff sickness was linked to anxiety and stress at work.

The trust had a staff support programme called 'SCARF' (which stands for Supporting, Caring, Assisting, Recognising the NCA Family). This was a support programme to help staff look after their physical, emotional and psychological wellbeing and to make it easier for staff to gain access to practical resources and information. As part of the programme all staff were allocated four hours annually to take time away from work. Staff we spoke with were aware of the 'SCARF' programme, however they said it was difficult for them to be able to take their allocated hours due to staffing pressures on the wards.

Most staff told us they felt able to raise concerns with their line manager and most felt they were supported and encouraged to develop.

Senior leaders commented on the high levels of resilience shown by staff, they believed staff had risen to the challenges that had been presented over the last 12 months. All staff were seen to be keen to get involved in improvement of the service.

Staff were committed to improving care for patients and learning from when things went wrong.

The ward managers told us that there was a positive culture in the organisation and how staff had completed or planned to complete charity events together and had engaged in social events outside of work.

Staff told us that they had regular health and wellbeing reviews and annual appraisals with their ward managers.

The division had a named champion for equality and diversity. Champions promoted and raised awareness around equality issues and provided feedback to the wider equality and diversity strategy via senior leadership.

Wellbeing and staff awards events were planned for October 2022.

Leaders told us that they continued to promote Freedom to Speak up to empower colleagues to report bullying, discrimination and abuse.

Staff had access to various support groups within the organisation. These included a “Lesbian, gay, bisexual, transsexual, queer (LGBTQ)” group and one for women who were menopausal. These groups were advertised in the newsletter and on the notice boards on the wards.

Cultural ambassadors were required to be part of all disciplinary panels where there was the possibility of dismissal to ensure fairness.

The staff survey completed by staff in the division in 2021 revealed that overall staff were happy with the culture within the division. Staff scored within the trust average for the trust in relation to topics such as feeling that other staff treated them with respect and that managers valued or listened to them. They also answered within the average when asked about whether they were satisfied in their roles. They scored well above the trust average with regards to recommending the organisation as a place to work.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There were effective governance processes in place in the service. Leaders attended directorate, divisional and care organisation quality and performance meetings. The divisional governance meetings took place monthly and were led by the divisional managing director. We reviewed the minutes of a recent surgical division governance and assurance meeting. These included key discussions around workforce, current risks, clinical effectiveness and performance issues in relation to each speciality area.

The division of surgery at Royal Oldham Hospital held divisional senior meetings and directorate meetings. There were several directorate meetings including topics such as RTT, theatre utilisation and cancer waits.

Each division throughout the hospital had clinical, operational and nursing leadership. The leaders from each division met regularly.

Leaders from the division told us that there were weekly lead nurse meetings for the ward managers. Senior nurses shared any issues such as complaints and incidents with the ward managers who would then disseminate this information to their ward team via newsletters, huddles, email and social media groups.

Ward managers in the division met weekly and information from this meeting was communicated to staff.

Staff we spoke with understood what their individual roles and responsibilities were, what they were accountable for and to whom they were accountable. Staff told us that they were provided with information relating to learning and performance via themes of the week, safety huddles and staff meetings.

A nursing assessment and accreditation system (NAAS) was in place in the surgery division. This was in place to assess the quality of care delivered in the division. The assessment, completed by a multidisciplinary team reviewed 14 key standards based on care, leadership and the environment.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

There was a division risk register with actions and due dates and actions taken to mitigate risks. There were 157 risks identified on the register, each risk was assigned to a risk owner within the division. All risks on the register had been reviewed, prioritised and rated.

Following the inspection, we interviewed the leadership triumvirate for the division and asked about the top three risks on their risk register. The first two risks were workforce, they identified that there were risks associated with both medical staffing and nursing staffing and raised concerns regarding their ageing work force. Sickness and some high vacancy rates in certain specialities such as anaesthetics has also impacted but there had been successful recruitment campaigns and regular reviews of staffing establishments.

The third risk identified was access and performance post COVID-19 recovery and trying to reduce waiting lists. The service had achieved no 104 week waits by March 2022 and were now focussed on patients waiting over 78 weeks. The service was prioritising patients according to their clinical need, so that those with the most urgent needs were seen and treated as a priority.

Ward managers were aware of the risks in their areas of work and were able to verbalise these and the plans in place to mitigate these risks. Whilst staffing was an issue for ward managers, they told us about their risks specific to their ward and had action plans in place to try to mitigate the risks. However, due to the of data we could not be assured that risks associated with patient outcome measures and performance were being effectively captured and managed.

We reviewed minutes of a risk committee meeting from August 2022 in which the divisional directors had met to discuss the key risks within Royal Oldham Hospital. The meetings were held every three months, we saw evidence of this as the previous meeting had taken place in May 2022 and there was one scheduled for November 2022.

The trust provided us with meeting minutes from mortality and morbidity meetings which were held monthly for the hospital. We also received quarterly reports that they had completed regarding mortality and morbidity. The reports provided an overview of the number of deaths, the reasons for death, the learning identified by the medical examiner service, from the morbidity and mortality meetings and from the investigations.

Care organisation and risk committee boards were attended by the surgical triumvirate team. The triumvirate team approved new risks that came into the division.

The trust had appropriate policies to control outbreaks of COVID – 19 and other similar infections. We reviewed the COVID – 19 outbreak control process and management policy which had adequate preventative measures and information for staff to follow to escalate patient cases.

Information Management

The service collected data and analysed it. However, some staff were not confident the data was always accurate. In addition, staff could not always find the data they needed in accessible formats to help them understand performance, make decisions and drive improvements. Data was not recorded or presented uniformly across the trust and some important data was not captured such as patient outcome measures.

The information systems were secure. However, they were not always reliable or integrated well. On 18 May 2022 the trust experienced a major failure of some of its key information systems which affected Bury, Rochdale and Oldham care organisations. As a result, a critical IT incident was declared. The trust announced the issues were fully resolved on 20 June 2022. The failure disrupted diagnostic, pathology and pharmacy services, and referral pathways from GPs and primary care services.

Staff received training on information governance as part of their mandatory training, and the compliance rate across the surgical division was 92.5%.

There were enough computer terminals and laptops for staff. Staff had individual secure logins for computers.

Staff could access policies, procedures and clinical guidelines through the trust intranet site. Staff told us they could access patient information and up to date national best practice guidelines and prescribing formularies when needed.

There was a secure electronic incident reporting system in place that could be used to analyse themes and trends in reported incidents to enable reviews and appropriate mitigating actions to be taken.

There was data available to ward managers that provided the outcomes of the ward accreditation audits. These formed the basis of the action plans for improvement for each ward which were monitored at division level.

We received data from the trust for information governance breaches for the surgical division at Royal Oldham Hospital. Two information management incidents were raised for the surgical division in February and June 2022. We reviewed both incidents and found that they were well recorded, had appropriate actions and plans to reduce reoccurrence.

However, we were not assured that leaders and staff always received information to enable them to challenge and improve performance. This was because data we requested as part of the inspection process was not made available in formats which were easily accessible nor attributable to the service. For example, mandatory training data was difficult to analyse, and we did not receive any data relating to patient outcome measures.

Engagement

Leaders and staff actively and openly engaged with patients, staff, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Ward managers and lead nurses engaged with patients in the ward accreditation process. They used feedback to improve services.

The division used friends and family data for service improvement.

The trust worked with Healthwatch to monitor and understand service provision and to make changes as necessary.

The division worked with the local authority and other community partners to improve patient safety and patient experience.

The Oldham care organisation worked closely with the trust's other care organisations in relation to surgical pathways.

The wards that we visited had "you said, we did" notice boards on the wall near the entrance. These were not always completed but the ones that were showed what patients had fed back and how the ward had responded.

Patients were asked to give feedback about their stay on the ward and staff across the surgical services told us they routinely engaged with patients to gain feedback from them. This was done informally and formally through participation in the NHS Friends and Family.

Staff engaged in staff surveys.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The hospital had resumed participation in the nursing assessment and accreditation system (NAAS) in July 2022 to measure the quality of nursing care delivered by teams across the trust. All wards within the surgical division were currently being assessed with T5 recently graded blue, the highest level.

The surgery division theatre team recently received an award from the National Joint Registry (NJR) recognising the service for its commitment to patient safety. They were named as an NJR quality data provider after successfully completing in a national programme of local data audits. The NJR monitors the performance of hip, knee, ankle and shoulder joint replacement operations to improve the clinical outcomes for patients.

There was a culture of learning in the division, and we saw that staff at all levels wanted to improve services for patients and their relatives.

We saw that there were quality improvement and coaching projects taking place across the division and that staff were participating in these projects. They were using 'plan, do, study, act' cycles to support the quality improvement.

Medical care (including older people's care)

Requires Improvement

Is the service safe?

Requires Improvement

Since we last carried out a comprehensive inspection of this service, they have become part of a newly formed NHS trust. As such we cannot compare previous ratings with this one. We rated it as requires improvement.

Mandatory Training

The mandatory training was comprehensive and met the needs of patients and staff. Although, the service did not always make sure that staff completed mandatory training in key skills such as resuscitation.

The mandatory training was comprehensive and met the needs of patients and staff. Staff undertook mandatory training courses on infection prevention and control; moving and handling; health, safety and welfare; equality, diversity and human rights; information governance and data security; fire safety and resuscitation.

Staff did not always keep up to date with their mandatory training. The trust target for mandatory training was 90%. We reviewed data provided for the care organisation for the division of medicine. Nursing staff had not achieved a 90% compliance rate for adult basic life support (58%), immediate life support (50%), fire safety (83%) and moving and handling level two training (82%). Medical staff had not achieved a 90% compliance rate for moving and handling level two training (73%), health and safety (88%), adult basic life support (60%) and advanced life support (75%).

Nurses and medical staff from the division of medicine had completed other training, specific for their roles which had a better rate of compliance. Medical staff had a 92% compliance rate for sepsis training, whilst the nursing staff were at 89%. The nursing staff had a 94% compliance rate for falls awareness training whilst medical staff were 83% compliant.

Wards such as F9 and T4 had lower compliance rates for mandatory training for nursing staff than the other medical wards. Nursing staff on ward T4 had a 75% compliance rate for mandatory training. The ward manager explained that this was because they had a lot of new staff who had not managed to complete mandatory training yet and many of the staff were bank or agency staff who completed mandatory training elsewhere. They also advised that booking onto face-to-face training courses had been an issue for substantive staff since these had re-started after Covid-19 restrictions had been lifted but that e-learning courses were up to date.

The learning and development team recognised that there was a difficulty with staff attending mandatory training courses due to the demands placed on staff. In response, they were now offering training on the wards for staff to attend.

From 1 July 2022, all registered health care providers were required to ensure their staff received training in learning disability and autism, including how to interact appropriately with autistic people and people who have a learning disability. This training should be at a level appropriate to their role. At the time of the inspection, the NCA had not made completion of this training mandatory, and staff had not completed the necessary programme of learning as required. This meant staff may not have had the skills and knowledge to communicate effectively and provide safe care to these patient groups.

Medical care (including older people's care)

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 did not always have good compliance rates for safeguarding training.

The trust had safeguarding policies in place for adults and children, in order to support staff to recognise and report abuse and neglect. These were available on the trust intranet.

Staff we spoke with could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff generally discussed their concerns with the ward manager or ward sister who submitted the safeguarding referral to the hospital safeguarding and complex care team.

Patients who had a safeguarding referral submitted were clearly identified. We saw patient boards which clearly displayed this information.

Safeguarding training was mandatory for all staff. There was an expectation that staff in clinical areas would have level one and two for safeguarding adults and children. The courses included some classroom-based training. Managers above ward manager level were expected to undertake safeguarding courses to level three. Safeguarding training covered the mental capacity act (MCA) and deprivation of liberty safeguards (DoLS).

Training included female genital mutilation (FGM), child sexual exploitation and training in the government PREVENT strategy to protect vulnerable people from the threat of terrorism radicalisation.

The trust set a target of 90% for completion of safeguarding training. We reviewed data provided by the trust for the division of medicine at the care organisation. Ninety one percent of nursing staff had completed level one and level two safeguarding training for children, 97% had completed level one and level two safeguarding training for adults but only 69% had completed their training in level three safeguarding children and 77% had completed their training in level three safeguarding adults. Medical staff did not meet the target of 90% completion of safeguarding training for level one and two for children (85% and 82% respectively), nor did they meet it for safeguarding adults training for the three levels (level one: 82%, level two: 79% and level three: 52%).

Ward managers explained how safeguarding alerts were assessed and investigated appropriately.

Cleanliness, infection control and hygiene

The service kept equipment and the premises clean. Staff did not always use equipment and control measures to protect patients, themselves and others from infection. Substances hazardous to health were not always stored safely.

Ward areas were visibly clean and had suitable furnishings. The immediate environment was clean and dust free, floor space was clutter free, floors were covered in a wipeable material and chairs, couches and pressure cushions were in a good state of repair.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. We reviewed cleaning checklists, including those for high touch areas.

We checked 10 pieces of equipment on various medical wards, and all had been labelled with “I am clean” stickers to show that they had been cleaned.

Cleaning documentation for clean and dirty utility rooms were complete. Following the inspection, we requested data of cleaning audits that had been carried out across the division of medicine. An audit completed in August 2022 showed that nursing staff across most of the wards scored 100% whilst domestic staff scored just below the compliance target of 95%.

Patients were screened for infectious diseases when they arrived on the wards. Infectious patients were provided with individual side rooms to reduce the chance or transmission to other patients. However, we saw on ward T4 that this was not always possible for patients with methicillin-resistant staphylococcus aureus (MRSA) as side rooms had been prioritised for any patients with Covid-19 or C-difficile infections.

The Trust also monitored COVID-19 outbreaks and had policies and procedures for staff to follow when patients tested positive. There had been 16 outbreaks of COVID 19 on the medical wards between February and July 2022.

The trust had appropriate policies to control outbreaks of COVID 19 and other similar infections. We reviewed the COVID 19 outbreak control process and management policy which had adequate preventative measures and information for staff to follow to escalate patient cases.

The trust monitored incidences of healthcare acquired infections. We reviewed a recent audit which identified 15 cases of Clostridium Difficile (a type of bacteria that can cause diarrhoea) on medical wards between February and August 2022. The audit surmised that the trust had sustained low rates of Clostridium Difficile.

Hand washing facilities and sterilising gel were sited at all ward entrances. Hand gel was sited at each side room and bay.

Wards carried out infection prevention and control (IPC) audits, including for hand hygiene and personal protective equipment (PPE). On the cardiology ward (F8) the IPC link nurse carried out spot checks for hand hygiene and staff scored 94%. They also completed an audit for infection control and staff scored 96%.

We spoke with patients and seven mentioned IPC. All seven provided positive feedback. They said that staff wore appropriate PPE, that they mopped up daily and that staff completed good hand hygiene practices.

All ward areas had privacy curtains around patient bed spaces. Some of the curtains were not dated or were dated incorrectly. We spoke with staff on two of the wards who were unsure of the process for the curtains being changed and dated. Following the inspection, we received data which showed regular recording of curtains being cleaned and changed for all the medical wards. Twenty-three curtain cleans and changes had been completed on T4, F9 and F10 in the month of June 2022.

We saw an unlocked cupboard in an unlocked room on the cardiology ward which contained substances that were hazardous to health and should have been controlled. Staff have a responsibility to ensure that such substances are locked away to ensure safe practice.

Staff had access to adequate supplies of personal protective equipment (PPE) but did not always follow infection control principles when using it. We witnessed a doctor who had been attending to a patient who was COVID-19 positive move from the patient's side room to a patient bay without changing his PPE or washing his hands. This had the potential to lead to further patients contracting the virus through cross contamination. We also observed a student entering a bay on a ward with no gloves, no eye protection but on the door of the bay it stated that this was required.

We reviewed cancer and complex medicine and general and specialist medicine's medical staff's compliance rates for infection prevention control for the division of medicine. Medical staff had a 96% compliance rate for level one infection prevention control training and 80% for level two. Nursing staff compliance for level one training in infection prevention control level one was 92% and for level two 88% (does not include gastroenterology or endoscopy wards).

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. However, staff were trained to use equipment and managed clinical waste well.

Staff carried out daily checks of specialist equipment, however the equipment used was not always stored safely. There was no seal on an emergency trolley in the discharge lounge and the checklist had not been completed meaning that the contents may not have been checked to ensure everything required was present.

After the inspection we requested audits of resuscitation equipment checks. The trust provided us with evidence that these checks were being completed annually. The medical wards had all been reviewed, apart from the respiratory ward (F7) which was due. The division had completed 85% of checks successfully but one of the wards had failed the audit.

The service had enough suitable equipment to help staff care for patients. In the acute medical unit (AMU) and coronary care unit (CCU), we observed monitoring equipment that was connected to a central console so that staff could monitor patients remotely.

Staff told us that there were sufficient items of equipment with which to provide safe and timely patient care.

Staff had received training on equipment such as hoists and intravenous infusion pumps. Staff on the coronary care unit and cardiology ward had been giving immediate life support defibrillator training to staff in other areas.

Medical equipment was kept in the storerooms. Commodities checked were in date and appropriately labelled.

We checked 10 items of equipment, and all had portable appliance testing (PAT). This had been completed by the estates department.

The service had suitable facilities to meet the needs of patients' families. Some wards that we visited had day rooms for patients that could be used for meetings with relatives. Wards that did not have these rooms shared with the nearest medical ward.

Wards were a combination of bays and side rooms which were all gender specific apart from the cardiology ward (F8). A senior nurse explained to us that the male bay on F8 was COVID positive and that she had no step-down beds on the unit which had resulted in a mixed gender ward which did not meet national guidance.

Notice boards were on the walls of each ward. They displayed names of staff that were on duty and the numbers of staff available for the shift. Other notice boards on the wards displayed the number of falls, pressure ulcers and the number of days since the last incident.

The clinic room cupboards met basic standards for healthcare premises.

Each ward had fire extinguishers which had been serviced in the last 12 months. Fire exits were signposted clearly, and the wards had chairs and slides to move patients in an emergency.

Patients that we spoke with said that they could reach call bells and that they were responded to quickly by staff. We observed staff responding quickly to patients when a call bell had sounded.

Ward managers carried out risk assessments of equipment on the ward.

Staff disposed of clinical waste safely and appropriately. Dirty utility areas were organised and clear from clutter. Sharps bins that were situated in these areas were dated correctly and were not overfilled.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration. Staff did not have knowledge of the eating disorders guidance.

Staff used a nationally recognised tool called NEWS2 to identify deteriorating patients and escalated them appropriately.

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. Updates to risk assessments due for each patient were detailed on the handover document for each patient. Risk assessments carried out included risk of pressure ulcers; malnutrition and falls. There were nursing assessments for each patient that included hygiene, cannulas and physiological observations.

Staff knew about and dealt with any specific risk issues. Staff were able to inform us of the patients on the ward with identified risks, such as vulnerability and existing pressure sores.

The service had 24-hour access to mental health liaison and specialist mental health support that they could access if they were concerned about a patient's mental health. There had been 10 referrals from the general medicine division to the mental health liaison team between 16 July and the 16 August.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. Patients at risk of self-harm were assessed on arrival on the wards and ligature risks were removed where possible or mitigated.

Staff had access to an enhanced patient observation team who would review patients and decide as to whether they required enhanced patient observations or one-to-one observations 24 hours a day. However, we identified instances in which one-to-one nursing could not be offered due to a shortage of staff. For example, on 8 August three patients required a one-to-one on ward T4 but this could not be provided.

Staff completed handovers three times a day. Shift changes and handovers included all necessary key information to keep patients safe. We observed a shift handover and saw that all necessary information about patients on the ward was given to staff verbally and in written format, including: new patients; patients with the same surname or forename; Covid-19 positive patients; patients requiring enhanced patient observations; patients with raised NEWS scores; patients who were nil by mouth, on food charts or with altered food consistencies; diabetic patients; those with pressure ulcers or at risk of falls; end of life patients and patients who had a “do not attempt cardio-pulmonary resuscitation” (DNACPR) in place.

On AMU, a resuscitation team for the day was identified each morning; this supported timely care in an emergency. This included two staff for circulation; one for airways; one communicator; two runners and one scribe.

A member of staff on the AMU had developed a template for the team to use in the event of an emergency or a deteriorating patient and this had been recognised as good practice within the trust.

On the AMU ward staff had information boards with patient information on them which provided a clear oversight of their individual risks. For example, patients with diabetes, a high news score (a tool which improves the detection and response to clinical deterioration in adult patients) or who required more observations would be identified and relevant information recorded.

On the endoscopy unit, staff had a gastrointestinal endoscopy checklist that they followed when the patient signed in, prior to them being administered medication and when the patient was leaving the procedural area.

We saw that the division of medicine did not have an effective process in place for managing the risk of patients with eating disorders.

Nurse staffing

The service did not always have enough nursing and support staff to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service did not always have enough nursing and support staff to keep patients safe. This varied across the specialist areas. For example, Ward F8 which had the coronary care beds had no nurse vacancies and the newest staff member had been there for eight or nine months. There were minimal vacancies on the 56 bedded Acute Medical Unit (AMU) although five vacancies were being recruited to with some appointments made.

However, on one ward we found that there was only 22 of 45 substantive staff in post. The ward was made a substantive ward from an overflow ward and a full establishment of staff had to be recruited. However, this meant that there was regular use of agency staff on that ward which was on average six shifts per day. These agency staff had been block booked to work in that location on a regular basis so were familiar with the ward environment. When there was a shortage of agency nurses to fill shifts, nurses were moved from other wards to make staffing numbers as safe as possible. They had successfully recruited to six posts and there was a rolling recruitment programme in place to address the need for a further 16 band 5 nurses. They were also looking to recruit a band four co-ordinator and a pharmacy technician.

We saw from the staffing on several of the wards that the planned numbers of registered nurses could not be met.

On the acute medical unit (AMU), patients requiring non-invasive ventilation received one-to-one nursing or one nurse to two patients. This allowed the staff to identify the acuity of the patient and staff accordingly. This was in line with national guidance. However, we also saw occasions when there was one-to-one care required but the staffing numbers had not been elevated to accommodate this which meant that some areas fell below the staffing levels required to provide safe care.

Managers tried to fill shifts by using bank or agency staff if registered nurses were not available. Shifts were often filled by agency nurses. The sister also carried out clinical shifts if there were gaps in staffing.

The leaders from the division told us that staff retention was difficult. The service had a turnover rate of between 11% in July 2022.

We saw that wards used a red, amber or green flags rating system for staffing levels. If daily staffing levels were at red or amber, this was escalated so that more staff could be sought.

Sickness rates were high for nursing staff. Data from July 2022 for the trust for the medical division showed that 8.27% of nurses were off sick in July which equates to 16 nurses.

We talked to eight patients and relatives across two wards. Five provided positive feedback, they acknowledged that staff were stretched but that they were able to meet their demands. Three patients and relatives were unhappy with staffing levels and felt that it was impacting on them or their loved one's care. For example, a relative of a patient said that if she was not there, she does not think her relative would be provided with satisfactory care.

The trust used a measure of the average number of actual nursing care hours spent with each patient per day as a quality measure. From data we reviewed, on average similar trusts spend 8.3 hours with patients per day and the national average was 8.1 hours per day. Across the medical division at Royal Oldham Hospital nurses spent 8.8 hours per day with patients which was better than the national average, however this was lower on some wards than others.

The service developed staff to meet specialist needs such as, telemetry matrons and cardiac matrons were available to support on the Acute Medical Unit.

Medical staffing

The service did not always have enough medical staff to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The service did not have enough medical staff to keep patients safe. Consultants on ward T4 told us that they struggled to cover shifts due to the lack of staff. They told us on the first day of the inspection that there were no breaks planned for them. We requested information from the trust about the planned number of medical staff against the actual number of medical staff but did not receive this.

Junior doctors on medical wards rotated on a six-monthly basis and there was a new cohort of junior doctors on each ward at the time of our inspection who had started the previous week. Staff told us that this could be problematic with a lot of new medical staff on a ward who were unfamiliar with it.

The leaders from the division told us that staff retention was a challenge. The service had had a turnover of between 11 and 13% doctors per month from February 2022. A consultant on ward F9 told us that the division was having difficulty recruiting geriatricians and that there were three substantive vacancies for this position.

Medical staff in cardiology and endoscopy reported that some on-call medical cover was still being provided by doctors at another hospital that was no longer part of the trust and vice versa as the pathways were still integrated. There were plans in cardiology to integrate the work with Salford Royal cardiologists but at the time of our inspection this had not been possible because they also carried out general medical on-call duties.

Sickness rates for medical staff were low. Data from the trust showed that 4.09% of doctors were off sick in July 2022.

Managers could access locums when they needed additional medical staff. Managers ensured that locums had a full induction to the service before they started work.

On the Coronary Care Unit (CCU), the junior doctors who were newly rotated were one first year junior, one third year internal medicine trainee and two junior clinical fellows.

On the CCU on the cardiology ward there were 5.5 whole time equivalent (WTE) consultants, and they had planned to recruit two further consultants in addition to the current numbers. Staff explained to us that it was difficult to recruit consultants with the right skill set. There was one consultant covering ward F8; in-reach to the AMU and any other cardiology patients between 9am and 5pm.

Consultants worked on a hot week system, meaning they worked Monday to Friday 9-5, one week in four. During their hot week, the consultants had no other fixed commitments and were freed up to provide daily in reach to wards, as well as overnight on call duties. From September 2022 this was moving to one week in six.

The cardiology service always had a consultant on call during evenings and weekends. A medical registrar carried out daily ward rounds over the weekend.

Records

Staff kept detailed records of patients' care and treatment. In most cases the records were clear, up to date, stored securely and easily available to all staff providing care.

Patients' notes were paper records. The hospital had an electronic system that patients' notes were scanned on to and that referrals were made from. Patients' notes were comprehensive and easily accessible for staff.

The electronic system was accessed through computers and laptops throughout the wards. The computers and laptops were locked when they were not being used and were username and password protected.

We reviewed seven patient records. Six out of seven records reviewed had risk assessments, care plans, observations and NEWS scores recorded. In the other file, we did not see any evidence recorded for a daughter being the power of attorney to the patient, despite it stating that she was. The patients' notes had not been updated for almost two months. Staff did not always date and time notes as they are required to.

When patients transferred to a new team, there were no delays in staff accessing their records.

Paper records were stored securely in trolleys with working keypads.

The service had conducted some audit of records however they were on a small number of records. A documentation audit for August 2022 for the AMU reviewed five patients' records. It showed that 86% had been completed accurately. Areas in which the staff could have performed better were signing and printing their names and there were not always two entries in a 12-hour period in each patients' records. Appropriate actions were identified and were shared with staff.

We reviewed a 2022 audit of records that related to staff's reporting of the Mental Capacity Act. The compliance rate for staff accurately documenting the correct information was 97%.

Medicines

The service used systems and processes to safely prescribe, administer and record medicines. However, the service did not consistently use systems and processes to store medicines safely.

The service had an electronic system for managing medicines, a plan was in place when IT issues meant records were not available.

Medicines reconciliation was completed by pharmacy staff and records showed the trust target of 50% in 24 hours following admission had been achieved. However, this target was not compliant with the current guidance National Institute for health and Care Excellence (NICE) guidance which indicates 100% of patients' medicines should be reconciled within 24 hours or sooner if clinically necessary. This meant staff could not always be assured they had a complete understanding of the medicines each patient took and the potential impact on their diagnosis and treatment.

Staff followed systems and processes to administer medicines safely. The trust's antimicrobial stewardship audit showed good compliance with choice of antimicrobial and recording people's allergies [Q1 2023-23.] Documentation of duration or review date (67%) scored below target. Potential actions to bring about improvement were being explored.

We saw that some medicines were not stored safely. For example, several medicines trolleys could not be locked, and door codes were accessible to the public. Therefore, we were not assured medicines were stored safety and securely.

We reviewed five electronic prescribing and medicines administration patient records. All the records were complete with allergy status recorded. The name of the prescriber was documented for each medicine and the appropriate assessments had been documented.

Take home medicines were delivered promptly to the discharge lounge but staff did not counsel the people we met in the lounge when handing them their medicines. The emergency trolley in the discharge lounge was sealed. All the contents were in date but there was no record of the trolley being checked.

We saw evidence of medicine management audits whilst on inspection. The AMU ward had scored 80% on their last audit from August 2022. The audit reported that some internal medicine cupboards were not locked and that individual patient lockers were not always secure.

We reviewed the storage and recording of controlled drugs. All medicines we reviewed were in date and recorded correctly in the controlled drug register.

Each area we visited had piped oxygen and portable cylinders. On the discharge lounge the cylinders were not secured to the wall, there was no signage, and one was empty.

We saw evidence on all the wards inspected that fridge temperatures were correct and recorded accurately.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. 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. Managers ensured that actions from patient safety alerts were implemented and monitored.

No never events had been reported to the CQC in the last six months. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Never events have the potential to cause serious patient harm or death but neither need to have happened for an incident to be a never event.

Staff knew what incidents to report and how to report them. There was an electronic system for reporting incidents and near misses. Staff raised concerns and reported incidents and near misses in line with Trust policy.

Staff understood the duty of candour. They were open and transparent and gave families a full explanation when things went wrong. Clinical meetings were held regularly to discuss incidents triggering duty of candour. We reviewed evidence of letters apologising for treatment that patients had received whilst in hospital.

Staff reported serious incidents clearly and in line with trust policy. Serious incidents were investigated jointly between medical and nursing staff. We reviewed three incident investigations. They were detailed, provided the root causes of the issues which had contributed to the incidents and actions were proposed with an action plan owner and action plan review date to ensure continuity.

Staff met to discuss the feedback and look at improvements to patient care. Incidents were discussed at a clinical leads meeting and learning from incidents was fed back to staff in safety huddles and via a staff newsletter.

Staff told us that they felt informed about incidents that had happened on their ward and serious incidents elsewhere and that learning from incidents was shared well.

Staff were able to give examples of incidents where learning had been shared. For example, on ward T4 they had two incidents involving pressure sores in quick succession. From the investigation the ward created a discharge list which staff adhere to now prior to discharging patients with pressure sores.

Is the service effective?

Requires Improvement 

Since we last carried out a comprehensive inspection of this service, they have become part of a newly formed NHS trust. As such we cannot compare previous ratings with this one. We rated it as requires improvement.

Medical care (including older people's care)

Evidence-based care and treatment

The service did not always provide care and treatment based on national guidance and evidence-based practice. Managers did not always check to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

The trust operated a central online policy hub. However, during our inspection of the core services, we found that some services were using legacy policies from the previous trusts or accessing a suite of policies separate to the central Northern Care Alliance hub. As part of our ongoing monitoring of the trust, and throughout the inspection, we found there was a need to align some legacy Salford and Pennine policies to ensure there were trust-wide versions that reflected national or best practice guidance where appropriate.

We saw that some staff still accessed a previous version of an intranet policy store that belonged to the hospital prior to it becoming part of the Northern Care Alliance. There was a risk that documents were no longer up to date and that staff were not following the most recent trust wide policies or practices. We saw an example of this when staff were unable to locate trust guidance and pathways on caring for and managing patients with eating disorders.

The endoscopy unit was accredited by the Joint Advisory Group on gastrointestinal endoscopy.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice.

The psychological needs of patients, relatives and their carers were considered by staff.

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

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Patients' nutrition and hydration needs were calculated and recorded using the Malnutrition Universal Screening Tool (MUST).

The ward managers told us that dietetic support was available for patients who required it.

The service ensured that patients had protected mealtimes.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs.

Six patients provided us with information about the quality of the food provided by the hospital. Five out of six were happy with the quality of the food stating that there was "good vegetarian choice", that there was "lots of choice" and that it was "five star".

Nutritional status boards were situated on all the wards we visited which included information about patients' dietary requirements such as if they were “nil by mouth” or required soft food.

Notice boards promoting the importance of staying hydrated were situated on some of the wards that we visited, such as the AMU.

The service ensured that patients had protected mealtimes. Patients requiring assistance with feeding were identified by use of a red tray. We saw staff supported patients with eating and drinking at mealtimes if they needed it.

Patients with religious, cultural and other needs were supported and offered choice. For example, halal, kosher and gluten free menus were available for patients to choose from.

Patients had access to water on their bedside tables. Staff offered patients hot drinks and ensured drinks were within reach. The endoscopy unit provided refreshments after procedures when patients were fully recovered after their procedure prior to leaving the department.

Pain relief

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

Staff assessed patients’ pain using recognised tools including the pain assessment tool chart, the patch monitoring chart and the pain assessment for cognitively impaired patients. Staff gave pain relief in line with individual needs and best practice. We saw positive interactions between patients and staff in relation to pain.

Ward managers showed us evidence that they used a process known as intentional rounding to assess patients’ level of pain, as well as other factors such as their skin condition and falls risk.

Patients that we spoke with said that their pain was being managed well and that staff were attentive if they observed any changes to their level of pain. Patients told us that pain relief would be administered soon after requesting it.

Staff prescribed, administered and recorded pain relief accurately.

Patient outcomes

The service mostly achieved good outcomes for patients. Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The endoscopy service had been accredited under the Joint Advisory Group (JAG) accreditation scheme.

The medical division at the Royal Oldham Hospital had completed 12 national clinical audits this year. Certain specialities in the hospital such as cancer care performed better than the national average. The National Heart Failure Audit for 2020/2021 showed mixed assurances whilst the National Diabetes Audit for 2020/2021 showed poor compliance for care processes and treatment targets. Recommendations and actions were documented on all audits or were planned for later this year.

We saw evidence of a local diabetes audit that the AMU ward had completed in August 2022, following the national audit, although only a small number of patients were reviewed. They reviewed five patients with diabetes against certain criteria such as if they had diabetes best practice documents in place, if they had been highlighted as diabetic on handover and if blood sugar measurements were recorded following meals. They scored 92.7% and areas that had not been completed were added on to the safety huddle discussion.

Some other audits, such as the myocardial ischaemia national audit (MINAP), although they were published in 2022, used data relating to 2020 and 2021 before the hospital moved into the new trust. We have not used these audits on which to form any judgement.

Audits such as the MINAP audit, heart failure audits, treatment of heart attacks and angioplasty data were discussed at cardiology multidisciplinary meetings.

Several local audits for patient outcomes were completed by the Trust between 2021 and 2022 and showed mixed outcomes. For example, the medical handover audit on ward F8 (cardiology) received limited or partial assurance, as did the correct anticoagulation audit for acute medical wards. The improvement of a Venous Thromboembolism (VTE) assessment on ward F8 as per policy provided high assurance as did the McMillan “My Care Plan” audit for palliative patients in medical wards. An alcohol and mental health audit on the acute medical wards provided high assurance.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Managers and staff investigated outliers and implemented local changes to improve care, examples are given below.

The service undertook audits as part of the trust’s nursing accreditation and assessment system (NAAS). The NAAS scheme, which had recently been restarted in July 2022, measured the quality of nursing care delivered by individuals and teams and provided evidence that teams were meeting the Care Quality Commission’s (CQC’s) fundamental compassionate care standards. The NAAS assessment measured 13 standards covering areas including patient safety, infection control, safeguarding, medicines management and several other key care standards. The scheme helped support nurses to understand how they deliver care, identified what worked well and areas where further improvement was needed. Each ward or unit received a red, amber or green rating.

We received data that showed that NAAS audits had been completed for wards F8, F9, F10 and the general medical unit. Ward F10 had their NAAS assessment on 19 November 2021 following Salford Royal NHS Foundation Trust legally acquiring Pennine Acute Hospitals NHS Trust. F10 had not performed as well as it had a year before but overall, they achieved satisfactory scoring for 11 of the 14 assessment measures with eight green standards, three amber standards and three red standards. They had improved in their management of infection control prevention and nutrition and hydration. Reassessment of the red standards was planned for two months' time.

Ward managers also completed monthly audits which reviewed DNACPR, pain, rounding logs, MRSA and documentation. We reviewed the cardiology wards’ (F8) audit from May 2022. The ward had made improvements in areas such as cannula care, catheter care, PPE adherence, hand hygiene and cleaning. Some areas such as commode cleaning and central venous catheter care had lower scores from the months prior. The ward manager had actions in place to address scores below 90%.

Staff were involved in quality improvement projects to improve care for patients. For example, the respiratory and cardiology wards were involved in an initiative to reduce the number of acquired pressure ulcers by 50%.

Managers shared and made sure staff understood information from the audits.

Medical care (including older people's care)

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 development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.

Managers gave all new staff a full induction tailored to their role before they started work.

Health care assistants (HCA's) had a starter pack which was signed off to say they were competent. Nursing staff worked through competencies that were signed off by the ward manager or sister to show they were competent in various tasks.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Ward managers and sisters carried out clinical supervision of nursing staff.

Managers supported staff to develop through yearly, constructive appraisals of their work. From the medical care division 17 doctors were due an appraisal between 2022 and 2023. Thus far, 14 out of 17 doctors had completed their appraisals which was a 79% compliance rate. The remaining doctors on the medical division had either completed an appraisal in the last 12 months or were new to the UK and currently compliant with the Trust policy. However, ward T4 had only completed 60-70% of staff appraisals; we were told this was because the ward manager had only become substantive in her role in July 2022.

Following the inspection, we requested further data to show staff competency on the medical division. The trust sent evidence of medical and nursing staff's competencies in relation to chemotherapy training and cardiology. Staff had to complete various assessments before being deemed competent to assess and care for patients in need of continuous positive airway pressure ventilation in patients in acute heart failure.

The practice educators supported the learning and development needs of staff, including those who were newly qualified. The medical division had a new clinical educator in post who was starting to roll out training to staff.

Wards had link nurses who were aligned to the 14 clinical areas of the nursing accreditation and assessment system (NAAS). Ward T4 were short on link nurses due to the lack of substantive staff at the time of our inspection. We were told that as new nurses were recruited, the ward manager planned to recruit them as link nurses to an area of interest to them. Other medical wards had several link nurses for the following subjects: infection prevention and control; pain management; safeguarding; dementia; pressure ulcers and tissue viability; nutrition and hydration; end of life care; medicines management; communication; students; diabetes; falls; patient centred care; leadership; staff wellbeing and engagement; alcohol and patient safety.

Each ward had a NAAS board, and this displayed a weekly training theme known as "take five" with five pieces of training around a particular topic. We saw a board where the theme was pain assessment and included training on structured writing for pain assessment sections in notes; the pain assessment tool chart; the patch monitoring chart and pain assessment for cognitively impaired patients.

The band seven senior sisters on the acute medical unit specialised in three to four subject matters each on which they mentored the other staff on the unit. Examples of the subject matters were person-centred care; pressure ulcers; medicines management; patient safety; infection prevention and control; pain management and nutrition and hydration.

Wards had not had team meetings recently due to the pressures of the pandemic. They had shared key learning from incidents and complaints and had updated one another via the newsletter and daily huddles.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. On the cardiology ward (F8), nursing staff with no previous cardiology experience carried out bespoke cardiology competencies. They were trained by two experienced nurses. Staff on AMU had received training in treat and transfer so they could receive patients after angiograms rather than them having to be transferred directly to the cardiology ward.

The ward was working with Fairfield Hospital, who led on the cardiology specialism, to develop an accredited cardiology training course. Band six nurses on the acute medical unit were being trained in post-angiogram recovery.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

There was effective multi-disciplinary team working between nurses and other staff across the division. Nurses, doctors and health care assistants told us that they had strong working relationships.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Staff on the AMU ward told us that they had a multidisciplinary meeting every day at 9am and 1pm and that it was attended by the nursing coordinator; consultants; junior doctors; registrars; physiotherapists and bed managers. Topics such as concerns about patients and estimated discharge dates were discussed.

Speech and language therapists, occupational therapists, dieticians and podiatrists were also available to support staff and patients.

The transfer of care team attended huddles every morning and would support staff with complex discharges from the hospital. This team sometimes attended ward rounds with doctors, a ward coordinator or sister and a physiotherapist.

Patients had their care pathway reviewed by relevant consultants. We observed a discussion between consultants from different departments about the need to admit a patient from the emergency department to a specialist medical ward. We saw that this was a healthy discussion and decisions made were in the best interest of the patient.

Social workers worked closely with other members of staff on the division. One of the wards shared their offices with social workers which the ward manager felt worked well as they could easily discuss patients that may need to be discharged into the community.

The cardiology ward manager explained how they have good links with the cardiology teams at Fairfield and Wythenshawe Hospitals. She explained how they shared training and had a divisional meeting once a month. Medical staff such as cardiologists, endocrinologists and respiratory doctors also met to share learning.

Staff referred patients for mental health assessments with the mental health liaison service when they showed signs of mental ill health. There were signs in each area of the medical wards with information on how to refer patients to this team.

The enhanced patient observation (EPO) team worked closely with the staff on the medical wards and would complete assessments for patients living with dementia and offered training if required.

Seven-day services

Most key services were available seven days a week to support timely patient care. There was limited access to some support services at weekends.

Consultants led daily ward rounds on all wards, including weekends. Patients were reviewed by consultants depending on the care pathway.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic testing, 24 hours a day, seven days a week.

Patients had access to most services over the weekend including palliative care, physiotherapy, pharmacy, mental health services and urgent X-rays and scans. They did not have access to speech and language therapists or dieticians.

A 2021 audit showed that patients were just as likely to be seen by a consultant within 14 hours of an emergency admittance to hospital at weekends as a patient admitted during the week.

Despite IPC services being available seven days a week, one ward manager said that she had found it difficult to get the appropriate support her ward required at a time that they had experienced a COVID outbreak.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards/units.

Staff assessed each patient’s health when admitted and provided support for any individual needs to live a healthier lifestyle.

We saw that there was health promotion information available on wards to promote better health. Staff could also refer to services such as the drug and alcohol team.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. If staff assessed a patient and found that they lacked capacity a referral would be made to the safeguarding team who would complete a comprehensive capacity assessment. The enhanced patient observation team would also support the patient.

Medical care (including older people's care)

Staff gained consent from patients for their care and treatment in line with legislation and guidance.

When patients could not give consent, staff included family members and made decisions in the patient's best interests, considering their wishes, culture and traditions.

There was no separate specific training for the Mental Capacity Act (MCA) or Deprivation of Liberty Safeguards because it was included as part of the safeguarding training requirements.

Staff made sure patients consented to treatment based on all the information available.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards.

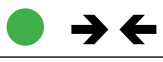
The safeguarding and complex care team supported the ward staff to keep patients safe. The safeguarding team supported staff to complete deprivation of liberty safeguarding (DoLS) applications for patients. They informed staff when they needed to be updated.

The medical division was provided with a daily list of patients subject to a DoLS with expiry dates. This was shared with ward mangers who discussed this with their staff.

Compliance with the Mental Capacity Act was reviewed at all the care organisations' safeguarding steering committees.

Following the inspection, we requested audits from the trust in relation to the Mental Capacity Act. They provided us with an MCA audit from quarter one 2022/23 which had reviewed patient records to check staff's compliance with the standards of the MCA. Compliance with regards to each standard had improved and their overall compliance rate in relation to MCA was 90%.

Is the service caring?

Good 

Since we last carried out a comprehensive inspection of this service, they have become part of a newly formed NHS trust. As such we cannot compare previous ratings with this one. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed a staff member on one of the wards laughing, joking and singing with the patients. On another ward, we observed a patient leaving his side room in a confused state, the staff member interacted with him and discretely helped him back into his room.

Therapy staff used bedside curtains when carrying out bedside therapy with patients to ensure that their privacy and dignity was maintained.

Seven out of eight patients we spoke with said staff treated them well and with kindness. Generally, patients said that although wards were short of staff that they still showed compassion overall. Patients said, “they (staff) are very kind and good, they are doing their best” and “they’ve (staff) been kind, considerate and you can feel the empathy.”

Staff followed policy to keep patient care and treatment confidential.

Staff that we spoke with understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

One of the ward managers said that the lack of staff did impact on their ability to offer the level of compassionate care that they would like to. Patients supported this view but, overall, felt staff were still supportive, one patient from F8 stated “the staff are hard pushed, but if you need anything, they are there for you.”

We carried out a group observation using the Short Observational Framework for Inspection (SOFI) method on 9 August 2022. The SOFI tool is used to review services for people who cannot reliably give their verbal opinions on the services they receive. We continually observed what happened to patients over a chosen observation period. We found that the general mood state for patients throughout the observation was positive for 53% of the period and for 43% of the time it was neutral and that all staff interactions were positive.

Throughout the observation we saw staff engage with patients in a warm and friendly way, for example staff were holding patients' hands and were seen to be validating their experiences. Patients felt comfortable with staff, we saw an example in which a patient had their hands on a staff's shoulders for support.

Comfort bags, containing toiletries, were offered to patients who are receiving palliative care, these were created by children's social groups such as “brownies” and “cubs”.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations.

Staff were able to provide emotional support to patients and their loved ones in specific rooms for the use of relatives which were based on some of the wards. Staff had attempted to make these rooms feel warmer and less clinical. A file of “thank you” cards from patients and relatives was evident in the Ashton suite on the acute medical unit.

Medical care (including older people's care)

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

A patient on ward F8 told us that he had witnessed a nurse sitting with a patient who was nervous about their admission for hours before they fell asleep.

Staff had a good understanding of John's Campaign which promotes a culture in which primary carers of those living with dementia have the right to support their loves ones whilst they are in hospital.

We witnessed carers supporting patients on some of the wards.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff spoke with patients and their relatives sensitively and appropriately, dependant on their individual needs and wishes.

Staff supported patients and their relatives' choices about their care.

Staff made sure patients and those close to them understood their care and treatment. During the SOFI we observed a doctor providing a clear explanation of a patient's treatment to them.

We observed staff talking with patients and families in a way they could understand.

Patients and those close to them could give feedback about their treatment and the service they had received. Feedback forms were available on the wards.

We requested details about feedback from patients and their families about the care they had received, on the medical division, from the trust but the data that we received was for the hospital. The data from the hospital showed that 85% of patients and family members were positive about their experience at Royal Oldham Hospital.

Is the service responsive?

Requires Improvement 

Since we last carried out a comprehensive inspection of this service, they have become part of a newly formed NHS trust. As such we cannot compare previous ratings with this one. We rated it as requires improvement.

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

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Medical care (including older people's care)

Managers planned and organised services, so they met the changing needs of the local population. The trust worked closely with community stakeholders, including commissioners and GP's to discuss any changes.

The service had wards with specialities such as cardiology, respiratory and endoscopy where staff with specialist skills were available including advanced nurse practitioners.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. When there had been a breach due to an outbreak of a communicable disease such as COVID-19, this was incident reported.

Facilities and premises were appropriate for the services being delivered.

The endoscopy unit had an out of hours on call system where a consultant endoscopist was available to perform emergency procedures for any patients who required lifesaving procedures.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia.

The service had systems to help care for patients in need of additional support or specialist intervention. The service had access to specialist lead nurses for people with learning disabilities, mental health problems and autism. Speech and language therapists, occupational therapists, dieticians and podiatrists were also available to support staff and patients.

The care organisation had an integrated discharge team who supported patients with care and support needs with their discharge from the hospital.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff had access to guidance on learning disabilities and/or autism which provided them with an overview of the conditions, reasonable adjustments that should be made and the roles and responsibilities of key staff that should be involved within care such as the associate director of nursing and the LD lead nurse.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. We observed staff asking another staff member who spoke multiple languages to support them with a patient, which they did.

The service had information leaflets available in languages spoken by the patients and local community. They offered different menus for different religious groups, and we saw a religious resource box on ward T4 which included a Koran, a Bible and rosary beads.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. There was a trust lead for dementia and the trust had a dementia strategy. Dementia awareness training was part of mandatory training for all staff.

Medical care (including older people's care)

Most wards that we visited on the medical division had some patients who were living with dementia. Wards were designed to meet the needs of patients living with dementia, for example they had dementia friendly signage and dementia friendly digital clocks with the time, day and date.

The AMU ward had a quiet area for patients living with dementia. This area had comfortable chairs, puzzles, historical images on the wall and activities for patients to engage in such as puzzles. Staff told us that they would also use this area for patients with mental health issues and autism if it was required.

Patients living with dementia, autism and learning disabilities completed “this is me” forms and “patient passports” when they were admitted on to a ward. Staff told us that carers would be involved with patients to complete the form which provided information such as the best way to communicate with the person.

Patients with learning disabilities were supported by the learning disability lead nurse if required. Staff told us that patients with learning disabilities could also be supported more frequently by carers and loved ones under John’s Law.

Staff could access the mental health liaison team for support. We witnessed a referral to the team from one of the wards during our inspection and the assessment was timely.

Tissue viability nurses were available to support patients at risk of developing a pressure ulcer.

Staff told us that they had a refrigerator for patients receiving palliative care which provided easy to consume foods such as ice cream and lollies. Patient’s loved ones had access to a fold out bed and food/drink on the acute medical unit.

Access and flow

People could not always access the service when they needed it and receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not always in line with national standards.

Managers did not always ensure that patients could access services when they needed to receive treatment within agreed timeframes and national targets.

With regards to referral to treatment times for the general medicines service at Royal Oldham Hospital, 94.12% of patients referred in January 2022 received their first treatment in line with the national standards of 18 weeks, however this had dropped to 74.56% in June 2022.

Patients with suspected cancer were not always seen within the national targets. Data from Royal Oldham Hospital for June 2022 showed that only 34% of patients with suspected cancer started their treatment within 62 days. Seven and 14-day targets for referral to treatment for patients with suspected cancer were not met in June 2022. The leaders of medical care recognised the waits and had a plan to reduce them which included trying to set up alternative pathways to reduce referral to treatment timescales and by working closely with community partners to help cancer patients have treatment in their local centres to avoid hospital admission.

The endoscopy unit was using an external in reach company to reduce the waiting list backlog. They ran clinics in the department at weekends.

Medical care (including older people's care)

The Trust provided us with a referral to treatment trajectory for the different hospitals. For Royal Oldham Hospital there was a plan and trajectory to reduce the number of patients waiting 52 weeks and 72 weeks. However, the total referral to treatment waiting list trajectory was predicted to increase from 32,853 to 34,028 by March 2023.

Managers and staff started planning each patient's discharge as early as possible. Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs.

The transfer of care team attended the ward each morning to identify those patients where they could start planning their discharge. At ward level, discharges were monitored through huddles and board rounds.

The discharge lounge was used to facilitate discharges for patients.

We received data that informed us that in July 2022, 94% of discharge summaries were completed in 24 hours.

Managers told us that delayed discharges and discharges that were deemed to be unsafe were incident reported and appropriate investigations carried out.

Patients were not always discharged before five o clock. The trust provided data that showed that 3,626 patients had late discharges from February 2022 to July 2022. We asked the trust for the reasons for the late discharges but did not receive this information.

Managers monitored the number of delayed discharges and knew which wards had the highest number. However, they did not always take action to prevent them.

Medically optimised patients were also reviewed during the inspection. In July, the hospital reported 39 patients who were medically optimised for discharge though still occupied a bed. On ward T4, the ward manager told us that 50% of the ward's patients were medically optimised. A patient on another medical ward had been waiting for a residential placement since July 2022. Over the last six months 212 patients experienced a delayed discharge because of external factors including awaiting care home availability and care home assessments. In the same period, 32 patients experienced delayed discharges due to internal factors including delayed medicines, awaiting therapy input to enable discharge or awaiting transport.

The coronary care unit reported that delayed discharges due to patients awaiting beds in a community setting was not a particular problem but that sometimes patients requiring heart surgery had to wait for a bed to become available at another trust where the surgery was to be performed. On ward F8 there was one patient awaiting discharge to a community setting who was medically optimised.

Managers made sure they had arrangements for medical staff to review any medical patients on non-medical wards.

Managers worked to minimise the number of medical patients on non-medical wards. Although Ward F8 took patients who were not cardiology patients if there was a bed free to avoid patients spending prolonged periods in the emergency department, these patients were referred to a more appropriate specialist ward, following assessment by a specialist consultant.

Medical care (including older people's care)

Managers did not always ensure that patient moves between wards were completed during the daytime. We requested data from the last six months for ward moves that were completed after 8pm. It was reported that there were 446 ward moves, for the medical division, that were completed after 8pm between Feb 2022 and July 2022. These could disturb rest and disorientate patients.

Managers told us that ward T4 had some social admissions as inpatients at the time of our inspection. Social admissions are patients that had been admitted mainly because of social reasons who did not have enough social support at home to maintain their care needs or had been moved to hospital from a care home, for example, when there were temporarily not enough staff to care for all the residents safely.

Cardiologists reported that patients contacting the hospital for advice because they could not contact their own GP was impacting on workloads.

The service had an escalation ward open for COVID-19 patients at the time of our inspection.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns.

Royal Oldham Hospital received 255 complaints from 1 February 2022 to 31 July 2022. From those, the medical division received 23 complaints. Their compliance rate in responding to the complaints within the set timeframe was 100% for four out of the six months.

The service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them. One ward manager told us how a senior nurse on her ward had managed two complaints well whilst she had been on annual leave.

Ward managers and lead nurses were aware of complaints in their areas of work and investigated these complaints. They identified themes from complaints and patient feedback. The outcomes from complaints were shared at the daily safety huddle meetings so that staff could learn and improve patient safety and experience.

We reviewed evidence sent in from the trust that provided examples of complaints that had been made and the improvements made. One example had been a complaint made by a family member of a patient regarding a lack of communication between staff and themselves. The ward manager and her staff members discussed the complaint in a huddle and came up with actions including reminding staff to record daily communication with family members on a sheet to ensure it happened regularly.

Is the service well-led?

Requires Improvement ↓

Medical care (including older people's care)

Since we last carried out a comprehensive inspection of this service, they have become part of a newly formed NHS trust. As such we cannot compare previous ratings with this one. We rated it as requires improvement.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They supported staff to develop their skills and take on more senior roles. However, senior leaders were not always visible and approachable in the service for patients and staff.

Medical care services were part of the division of specialist medicine at the hospital. The division was led by a divisional managing director, a divisional clinical director and a divisional director of nursing. They were supported by matrons who oversaw two to three medical wards each.

Lead nurses were visible on the wards during our inspection.

The trust was developing leaders to provide career progression. The leaders from the medical care service told us that there were leadership programmes across the trust that operational colleagues and nursing therapy colleagues benefitted from.

The ward managers told us that they had access to and had booked on to accelerated leadership development programmes which were a two-day course. This course was developed to improve colleague experience through the development of capable leaders.

Staff told us that they felt well supported by ward managers and that they felt comfortable to approach senior leaders with any issues.

Ward managers that we spoke with said that they were supported by the directors and assistant directors for the division.

The lead nurses' offices were purposefully based on or close to the wards to ensure they were visible and accessible to staff and patients. However, staff did comment that senior leaders were not as visible on the wards though prior to the pandemic they had conducted walk arounds on wards every Friday, but these did not appear to have resumed.

Vision and Strategy

The service had a set of priorities and objectives for what it wanted to achieve but did not have a specific vision or strategy to turn it into action.

The division of medicine leaders told us that they shared the vision and strategy of the trust.

The trust had a vision for the next five to ten years and a set of ambitions and objectives to achieve their vision.

The division of medicine had a set of priorities and objectives. By March 2023 they planned to improve the numbers of staff across the division, make stronger links with other divisions and ensure financial sustainability by reducing high costs and identifying innovative ways of working. The division had longer term priorities for the next 12 months which included reducing long stays for patients and improve nurse development to allow nurses to take up more senior positions.

Ward managers had a good understanding of the vision and strategy for the hospitals within the trust.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff that we spoke with during our inspection felt respected, supported and valued. Examples included: A Health Care Assistant (HCA) explained to us that despite the challenges with staffing levels that it had brought the staff "closer together" as they had to support each other. The ward managers told us that there was a positive culture in the organisation and how staff had completed or planned to complete charity events together and had engaged in social events outside of work. An administrative staff member told us that they were always willing to stay at work longer to help if anything needed to be done urgently and received praise for going above and beyond.

We observed staff working well together. For example, we observed a ward round on the cardiology ward (F8) in which the ward manager engaged well with the doctors. There was a balance of support and challenge offered by the ward manager.

The divisional clinical director told us that medical trainees who had trained within the division had chosen to return as consultants.

There was a health and wellbeing agenda. This included a women's wellbeing strategy, a refreshed wellbeing and attendance policy, bespoke SCARF support sessions, and a programme of micro briefing sessions to support and enable leaders.

Staff were aware of the staff health and wellbeing support programme (SCARF). The SCARF programme offered staff a wide range of resources and health and wellbeing support and was available across the trust. A stress management pathway, mental health champions and an evidence based computerised therapy package was available for staff who may require support.

The division had a named champion for equality and diversity. We were told champions promoted and raised awareness around equality issues and provided feedback to the wider equality and diversity strategy via senior leadership.

Staff told us that they had regular health and wellbeing reviews and annual appraisals with their ward managers.

A wellbeing and staff awards event was planned for October 2022.

Substantive staff were provided with a "Wellbeing Passport" which provided them with four hours a year to take off from work to benefit their wellbeing.

Pregnant members of staff were supported by the leadership team and moved on to low-risk areas at 28 weeks of their pregnancy to reduce any risks to the unborn baby.

Leaders told us that they continued to promote Freedom to Speak Up to empower colleagues to report bullying, discrimination and abuse.

Staff had access to various support groups within the organisation. These included a lesbian, gay, bisexual, transgender, queer (LGBTQ) group and one for women who were menopausal. These groups were advertised in the staff newsletter and on the notice boards on the wards.

Leaders told us that the culture had moved away from silo working and that departments and groups within the organisation shared information and knowledge and supported one another.

Leaders told us that staff sending in compliments regarding other staff had increased. For example, in May 45 compliments were made from staff about other staff.

Governance

Leaders operated effective governance processes, throughout the service. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The division of medicine at Royal Oldham Hospital held divisional senior meetings. There were several divisional meetings including topics such as chemotherapy, governance, diabetes and geriatric medicine.

Each division throughout the hospital had clinical, operational and nursing leadership. The leaders from each division met regularly.

Leaders from the division told us that there were weekly lead nurse meetings for the ward managers. Senior nurses shared any issues such as complaints and incidents with the ward managers who would then disseminate this information to their ward team via newsletters, huddles or email.

Ward managers in the division met weekly and information from this meeting was communicated to staff.

Ward managers told us that team meetings had not taken place as regularly as they had prior to the pandemic due to service demands. Despite this, we did see team meeting minutes completed by staff on the AMU. Their meeting reviewed incidents, compliments, audits, training and staffing updates.

Information was shared via safety huddles, weekly handovers, newsletters and emails. We reviewed evidence of an AMU handover from the 25 July – 31 July which provided staff with an overview of the most important information from that week which included learning from incidents, pay dates etc. Staff told us that safety huddles were effective in relation to information sharing.

Staff that we spoke with were clear about their roles and accountabilities and felt that they had regular opportunities to engage with their fellow colleagues and senior staff. Staff were familiar with the leaders within the division and their roles.

A nursing assessment and accreditation system (NAAS) was in place on the medicine division. This was in place to assess the quality of care delivered in the division. The assessment, completed by a multidisciplinary team reviewed 14 key standards based on care, leadership and the environment.

We saw meeting minutes from a divisional clinical chemotherapy group who met fortnightly. They reviewed chemotherapy care, incidents, provided a department update and any changes to policies and guidelines were discussed. In a similar way, the cardiology/cardiorespiratory services met monthly.

The senior management team were responsible for patient flow on the medical division, as well as other areas of the hospital. The senior bed manager chaired daily capacity meetings and provided clinical leadership to the duty bed managers who liaised with the divisional management teams as required. On the medical division they had one bed manager who was allocated primarily to medical bed flow.

Management of risk, issues and performance

Leaders and teams used systems to manage performance. They did not always identify and escalate relevant risks and issues and identify actions to reduce their impact. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Staff at ward level were aware of the risks in their own area of service. There was evidence of risk registers on the wards that we visited.

Following the inspection, we interviewed the leadership triumvirate for the division and asked about the top three risks on their risk register. The first risk was workforce, they identified that there were risks associated with medical staffing. To mitigate this, they had secured investment from the management board to recruit new doctors. They had recruited a new chief registrar, a diabetes consultant and there were plans in place to recruit senior clinical fellows. They recognised the problems around recruiting certain positions and had plans in place to recruit overseas doctors if required.

The second risk identified was the constraints around the number of beds available. They had introduced a virtual ward for COVID patients, they were looking at ways to support early discharges.

The third risk was about the financial sustainability of the division. The divisional leadership were reviewing how they could treat patients better whilst lowering their expenditure and maintaining a high quality of care.

The triumvirate team approved new risks identified by the division. Care organisation and risk committee boards were attended by the medical triumvirate team.

We reviewed minutes of a risk committee meeting from August 2022 in which the divisional directors had met to discuss the key risks within Royal Oldham Hospital. The meetings were held every three months. The division of medicine had 84 approved and live risks all within review and had closed seven risks since 1 May 2022.

The division of medicine's risk register was reviewed. It showed that the division had oversight of the risks faced. Risks such as the financial impact of COVID on the division, infection prevention control measures and an oversight of mandatory training were all stated. Risks were prioritised, rated and action plans were developed.

Two-week cancer referral to treatment waits were classified as a moderate risk on the risk register. Although we identified that in June 2022 the trust was not meeting targets for seeing cancer referrals within two weeks, the risk register reported that in July 2022, the waiting list had reduced from 800 to 311 patients. Other referral to treatment waiting lists and post-Covid recovery plans were not, however, cited as specific risks on the risk register.

Medical care (including older people's care)

The trust provided us with meeting minutes from mortality and morbidity meetings which were held monthly for the service. We also received reports from each quarter that they had completed regarding mortality and morbidity. The reports provided an overview of the number of deaths, the reasons for death, the learning identified by the medical examiner service, from the morbidity and mortality meetings and from the investigations.

We spoke with a senior nurse on the AMU ward and a ward manager who did not have an understanding of the "Management of really sick patients with anorexia nervosa (Marsipan)" guidance despite an increase in patients with eating disorders attending hospital in recent years and the trust giving previous assurances that guidance had been rolled out to relevant staff. We requested the number of staff trained on managing patients with eating disorders but did not receive this data.

Information Management

The service collected data and analysed it. However, some staff were not confident the data was always accurate. In addition, staff could not always find the data they needed in accessible formats to help them understand performance, make decisions and drive improvements. Data was not recorded or presented uniformly across the trust and some important data was not captured.

The information systems were secure. However, they were not always reliable or integrated well. On 18 May 2022 the trust experienced a major failure of some of its key information systems which affected Bury, Rochdale and Oldham care organisations. As a result, a critical IT incident was declared. The trust announced the issues were fully resolved on 20 June 2022. The failure disrupted diagnostic, pathology and pharmacy services, and referral pathways from GPs and primary care services.

The leaders from the triumvirate interview told us that the electronic systems at the care organisation did not link up well and that this was an issue that needed to be addressed.

The care organisation did not have access to electronic patient records. They had a mixture of electronic and paper records. Patient records were mainly paper based, and referrals were completed electronically.

We observed staff managing problems with wi-fi connection on the AMU ward whilst we were on inspection. This meant that staff had to use ethernet connection cables to plug their laptops in to the wall.

There was enough computer terminals and laptops for staff. Staff had individual secure logins for computers.

Information management and data protection was part of the mandatory training. Medical staff from the cancer and complex medicine and general and specialist medicine divisions had a compliance rate of 84% for information governance training. Nursing staff had a 95% compliance rate.

We received data from the trust for information governance breaches for the medical division at Royal Oldham Hospital. Two information management incidents were raised for the medical division in July 2022. We reviewed both incidents and found that they were well recorded, had appropriate actions and plans to reduce reoccurrence.

Engagement

Leaders and staff actively and openly engaged with patients, staff and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Leaders from the division held “listening lunches” at which they provided food for ward staff to allow them an opportunity to voice any concerns and share ideas.

Leaders from the triumvirate interview told us that staff retention was a challenge. The leaders had spoken with the staff about this and in response had tried to offer professional development, had introduced a buddy system in which junior staff were supported by more experienced staff and supported overseas recruits in achieving their professional registration.

The division worked in partnership with Healthwatch.

The general medical division staff completed a staff survey for 2021. Only 30.8% of staff completed the survey. Apart from a section of the survey on personal development, staff who completed the survey scored below the average for the trust in all other categories. This included feeling positive about their job, their team, people in the organisation, their managers, their health and safety and about the organisation.

Leaders of the division told us that there were patient experience groups for the division. In the last 12 months, the division had linked in with a charity for cancer care to review patient’s experiences.

We saw evidence of patient experience group meetings that had been attended in May 2022. The meetings were held bi – monthly and reviewed patient feedback and provided updates. The medical division had reported an improvement to response rates from family and friends about their experiences in hospital. In response to patient feedback they had extended the availability and the variety of snacks on the general medical unit and had purchased eye masks and ear plugs for the acute medical unit.

The wards that we visited had “you said, we did” notice boards on the wall near the entrance. These were not always completed but the ones that were showed what patients had fed back and how the ward had responded.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

There was a culture of learning in the division from all staff.

The division won a national award for digital excellence in relation to the virtual simulation ward. The virtual simulation ward was used to simulate the ward environment to help students to gain valuable experience in common scenarios that they may experience on the wards. Students were unable to gain necessary, hands on experience on wards during the COVID-19 pandemic.

The ward manager on F8 told us how they had completed four collaborative sessions on improving pressure ulcers following two cases in quick succession. Following the sessions, they involved the staff members on the ward in changing their rounding tool. Since then, the new tool has been audited and positive results for pressure ulcers had been found. A re-audit was due to take place and if there were further positive results there was a potential for it to be rolled out across the trust.

The ward manager on F9 explained to us a further initiative her team had been involved with in relation to pressure damage. She explained how they had collectively developed a new prompt card which was attached to the patient's bed with additional prompts to remind staff to check the patient's mattress and catheter.

On the endoscopy ward the team were involved in two pilot studies. The first was “Cytosponge” which is a new diagnostic test. Cytosponge is a small capsule which is attached to a fine string and identifies any cell abnormalities in the lining of the gullet or food pipe. The second was “Capsule Endoscopy” which is a capsule that is swallowed which contains a wireless camera and takes images of the digestive tract and can examine the small intestine.

Urgent and emergency services

Requires Improvement ➔➔

Is the service safe?

Requires Improvement ➔➔

Since we last carried out a comprehensive inspection of this service, they have become part of a newly formed NHS trust. As such we cannot compare previous ratings with this one. We rated safe as requires improvement.

Mandatory training

The mandatory training was comprehensive. However, the service did not always ensure staff completed mandatory training in key skills and it did not always include the highest level of life support training.

Nursing staff did not always receive and keep up to date with their mandatory training. The service aligned itself to the skills for health; core skills training framework's (CSFT) recommended subjects. In August 2022, four of the 11 mandatory training compliance rates for registered and unregistered nursing staff were below the trust's target of 90%. These were fire safety, life support training and both adults and children's safeguarding.

Nursing staff received annual life support training through either basic or intermediate life support (BLS or ILS). In August 2022, 76% of nursing staff had adults BLS training and 46% had adults ILS training. For the same time period, 62% of nursing staff had children's BLS and 48% had children's ILS.

Medical staff did not always receive and keep up to date with their mandatory training. In August 2022, five of the 11 mandatory training compliance rates for medical staff were below the trust's target of 90%. These were life support training, health, safety and welfare, infection prevention and control level two and safeguarding for both adults and children.

Medical staff did not always receive and keep up to date with annual life support training. The service provided compliance rates for basic life support (BLS). In August 2022, 67% of medical staff had adults BLS training yearly and 52% had children's BLS training yearly.

In addition, medical staff and senior nursing staff were required to complete advanced life support training every four years. In August 2022, 71% of medical staff and 40% of senior nursing staff had up to date adult's advanced life support training. For children's advanced life support training, 75% of medical staff and 44% of senior nursing staff had up to date training. From 25 July 2022 to 21 August 2022, out of the 28 days provided 100% of the night shifts and 93% of day shifts had a registered nurse trained in advanced paediatric life support on every shift.

During the COVID-19 pandemic, available spaces for the accredited adults and children's advanced life support courses were limited due to social distancing. This meant staff training became out of date. To mitigate the shortfall in courses for staff, the practice development team in the emergency department developed their own in-house versions of advanced life support for both adults and children. This was reflected in the divisional risk register with a risk rating of seven and the mitigations documented appropriately (defined as moderate risk in the trust policy).

Urgent and emergency services

Leaders did not ensure that staff completed training on recognising and responding to patients with learning disabilities and autism. From 1 July 2022, all registered health care providers were required to ensure their staff received training in learning disability and autism, including how to interact appropriately with autistic people and people who have a learning disability. This training should be at a level appropriate to their role. At the time of the inspection, the NCA had not made completion of this training mandatory, and staff had not completed the necessary programme of learning as required. This meant staff may not have had the skills and knowledge to communicate effectively and provide safe care to these patient groups.

Managers monitored mandatory training and alerted staff when they needed to update their training. Leaders monitored mandatory training through the directorate operations and performance committee meetings and as a standard agenda item at the divisional senior management meetings.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff did not always have up to date training on how to recognise and report abuse, but they knew how to act on concerns.

Nursing staff did not always receive training specific for their role on how to recognise and report abuse. In August 2022, we were given compliance rates level three safeguarding training which showed 88% had received adult safeguarding training and 88% had children's safeguarding training which was slightly below the trust's required compliance of 90%.

Medical staff did not always receive training specific for their role on how to recognise and report abuse. In August 2022, we were given compliance rates level three safeguarding training which showed 86% had received adult safeguarding training and 50% had children's safeguarding training.

Medical and nursing staff were above the trust target for safeguarding level one and two training.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns. On 08 August 2022, we observed nursing staff recognise when referral was needed and talked us through the referral process to protect vulnerable adults.

Staff followed safe procedures for children visiting the emergency department. The service had a separate waiting area for children requiring treatment that was secure with swipe card access. They had age appropriate toys available.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. They did not always use equipment and control measures to protect patients, themselves, and others from infection. However, they kept equipment and the premises visibly clean.

The service did not have effective processes in place to assess the risk of, and prevent and control, the spread of infections. We saw variable staff understanding, identification and management of patients with infections across the department. On the 08 August 2022, we observed a patient with a confirmed COVID-19 infection without any indicators to alert staff to the need to wear appropriate personal protective equipment (PPE). The door to their cubicle was left open and the patient was found walking around the department. We did not see evidence that isolation signage was

used within the department. Staff could not tell us how they identified an infectious patient using isolation signage. On 10 August 2022, we observed three further patients with infections that were not appropriately isolated. This meant staff were not following the trust policy dated 20 June 2022, which could put patients at risk of harm. We requested but did not receive infection control audits.

Staff did not always follow infection control principles including the use of PPE. PPE was available throughout the emergency department. However, staff's approach to using it was inconsistent. During the inspection, several staff of all grades were observed entering patient cubicles without donning and doffing appropriate PPE. This also occurred in a cubicle where a patient had a confirmed COVID-19 infection. The service provided a PPE audit data for the March 2022 which showed on average 99% compliance.

The service provided a hand hygiene audit for the emergency department, in March 2022, which showed an average compliance of 98%.

Staff did not always clean equipment after patient contact and did not always label equipment to show when it was last cleaned. During our inspection, we observed a member of staff taking a commode to a second patient without cleaning it between uses. The member of staff was wearing the same PPE. We raised our concerns with the staff member.

Cleaning records were not always up to date, but the service demonstrated that all areas were cleaned regularly. Staff we spoke with told us there were no formal cleaning schedules. We did not see evidence of cleaning schedules or audits during inspection. However, on 31 August 2022, the trust provided standardised copies of the cleaning schedules and an audit tracker. From the 28 March 2022 to 08 August 2022, the audit tracker showed average cleaning compliance was above the trust's compliance target set as 90%.

All areas were clean and had suitable furnishings which were well-maintained. We saw that the emergency department was visibly clean and tidy. However, we saw no consistent use of the green 'I am clean' stickers. Curtains were disposable in all areas and dated when last changed.

We observed that cubicles were cleaned between uses. On 09 August 2022, we observed patients being moved from cubicles and they were cleaned thoroughly within minutes.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff were trained to use equipment. Staff did not always manage clinical waste well.

The design of the environment did not always follow national guidance. We observed the paediatric department did not have a mental health assessment room that meets the 2017 Psychiatric Liaison Accreditation Network (PLAN) Quality Standards for Liaison Psychiatry Services. However, staff told us they would risk assess the patient and place them in the adult mental health assessment room when required. The adult mental health assessment room met the required PLAN standards.

The main emergency department was split into two; non-respiratory and respiratory areas. The respiratory resuscitation area and majors A were for those patients with COVID-19 infection symptoms. The non-respiratory areas, majors B and the resuscitation step-down area were for patients without COVID-19 symptoms. The department also had an urgent treatment centre, a separate paediatric treatment area and waiting room and one ligature free room for, both adult and child patients with mental health illnesses.

Each sub-section within the emergency department had single cubicles to aid privacy and dignity for patients. The cubicles within the respiratory areas had wipeable glass doors to ensure patients could be isolated when they had infections and allowing visibility for staff and patients.

We observed that there was a lack of space within the department. On each day of our inspection, we observed patients waiting on the corridors for care and treatment. Leaders had considered the privacy of the patients in the corridor, staff used movable screens when providing care and treatment in the corridor. However, the corridors were a thoroughfare for patients from the urgent treatment centre to the x-ray department. Staff told us that other patients would move screens to enable them to pass to get to x-ray and back again. Waiting rooms could not always support social distancing.

We observed the lack of space in the corridor was problematic during the transfer of a patient. Staff had to temporarily move 15 corridor patients to allow the transfer to be brought through. This was labour intensive for the staff in the department who facilitated the temporary movement leaving the respective units low on staff for around 10 mins.

Patients could not always reach call bells, but staff responded quickly when called. On 09 August 2022, we observed that seven out of the 10 patients observed were given their call bells while in a cubicle.

Staff carried out daily safety checks of specialist equipment. During inspection, we observed that resuscitation equipment checks were completed weekly for functionality and out of date items. We saw that daily equipment checks were completed. We requested but the trust did not send usable data to evidence auditing of resuscitation equipment. The evidence supplied showed that two of the four resuscitation trolley locations in the emergency department were checked in December 2021. The other two trollies had not been checked and documented. This meant that the service did not have oversight that daily and weekly checks for resuscitation equipment were being completed.

The service had enough suitable equipment to help them to safely care for patients. Electrical equipment received portable appliance testing (PAT). During the inspection, we checked 30 pieces of equipment and all had been PAT tested and dates were recorded for future testing. We observed that where an item was faulty it was logged and reported on the internal electronic computer system.

Staff did not always dispose of clinical waste safely. On 10 August 2022, we observed a member of staff walking down the corridor with a sharp that had been used to take blood. Best practice would be to take a sharps bin to the patient to dispose of the sharp immediately after use. We observed that temporary closure devices on sharps bins were not always used.

Assessing and responding to patient risk

Staff completed risk assessments for each patient swiftly. But they did not always remove and minimise risks. Staff did not always identify and quickly act upon patients at risk of deterioration.

Managers monitored waiting times. However, the service did not always meet the national standard of triage to be completed within 15 minutes of arrival. During inspection, we saw that triage times for patients who walked in the emergency department varied from 15 minutes to one hour and 24 minutes. The electronic computer system guided reception staff to stream patients when they walked into the emergency department. Registered nursing staff used the Manchester Triage System to undertake a more thorough triage and provide a priority category.

Urgent and emergency services

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. The service used the National Early Warning Score version two (NEWS2) to observe and recognise patients who were at risk of deterioration. From February to July 2022, the senior nurses audit showed average compliance for NEWS2 accuracy for reporting was 100% and on average 98% of NEWS scores were escalated as per the policy.

Staff did not always complete neurological observations and escalate them appropriately. From February to July 2022, the senior nurses audit showed average compliance of 82% for neurological observations.

Staff completed risk assessments for each patient on arrival using a recognised tool. From February to July 2022, the senior nurses audit showed average compliance of 100% for completion of falls risk assessment. However, staff did not always remove and minimise risks to patient safety. On 08 August 2022, we observed a confused patient who was in a room with the lights off and the glass doors closed. The patient was recognised as being at risk of falls on the assessment, but we observed no alerts placed anywhere to state this. We observed the patient wandering and being escorted back to bed three times. We raised our concerns during inspection about the patient's safety. Staff had not considered methods to protect the patient, such as moving the patient to a more observable location or requesting one to one care for the patient. There was limited use of the magnetic icons for the patient boards in the department to alert staff to patients that were living with dementia, were at risk of falling and patients with infections.

We saw that staff completed paper risk assessments for pressure ulcer risk and surface, skin inspection, keep moving, incontinence, and nutrition (SSKIN) assessments. From February to July 2022, the senior nurses audit showed average compliance of 88% for SSKIN assessment and care plans.

Staff knew about but did not always deal with any specific risk issues in a timely manner. In August 2022, 90% of medical staff and 92% of nursing staff received sepsis training. However, during inspection staff had varied understanding of sepsis management. Staff told us that the service had a sepsis pathway which we saw was aligned to National Institute for Health and Care Excellence, sepsis: recognition, diagnosis, and early management [NG51] guidance. During our inspection, we did not see evidence of the sepsis pathway within any of the six patient medical records we reviewed, despite them all having signs and symptoms of sepsis. Leaders told us this was because there was an information technology system problem during our inspection.

From the 08 to 10 August 2022, out of the six patients we observed with signs and symptoms of sepsis, one did not have the recommended sepsis treatment, including antibiotics, started within one hour of diagnosis.

During inspection, we saw that senior nurses undertook a weekly nursing documentation audit and physiological peer review and audit tool for majors and resus patients. On 04 July 2022, the audit showed one out of the 10 patients audited was appropriately screened for sepsis. The audit did not check for presence of the sepsis pathway and whether timely treatment had been provided.

We identified concerns regarding the identification of sepsis within other services of the trust. In response to our concerns the trust rapidly implemented a unified sepsis pathway across all four hospitals within the NCA. From 13 August to 15 of August 2022, the service undertook an audit of 10 patients to check the identification, recognition, and commencement of treatment for patients with signs and symptoms of sepsis. Of the 10 patients records that were reviewed, three patients, received antibiotics within one hour of the initial triage and observations into the department.

The service had 24-hour access to mental health liaison and specialist mental health support. The mental health liaison service had a base room in the emergency department. The mental health liaison service received referrals for adults and children and young people through three main pathways: from the hospital and the emergency department, community mental health services and patients requiring detention under section 136 of the Mental Health Act 1983.

The mental health liaison service had access to a dedicated Section 136 suite (specialist mental health facility) on the hospital site, but it was not managed by Royal Oldham Hospital. Staff in the emergency department would refer a patient to the mental health liaison team through the electronic computer system.

Shift changes and handovers included all necessary key information to keep patients safe. The shift changes observed were thorough and provided the staff team with relevant information. A "7 Day" reporting system was used to ensure staff members across all shift patterns were informed of key updates.

Nurse staffing

The service did not always have enough nursing staff and support staff with the right qualifications, skills, training, and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix and gave bank and agency staff a full induction.

The service did not always have enough nursing and support staff to keep patients safe. During our inspection, managers provided us with a list of agency nursing staffing used from 13 July 2022 to 08 August 2022 and staffing allocations from 01 August 2022 to 09 August 2022.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. However, the number of nurses and healthcare assistants did not match the planned numbers. From 01 August 2022 to 09 August 2022, the service did not have enough registered nursing staff for adult services when compared to the planned staffing in 74% of shifts, and for unregistered staff in 89% of shifts. The service did not have enough children's registered nursing staff compared to the planned staffing in 11% of the shifts and 19% for unregistered staff.

The service provided fill rate data for the time period 01 January 2022 to 30 June 2022. There was an average fill rate of 89% for registered nursing staff and 81% for unregistered staff. Staff told us that they did not always feel the department was safe.

Managers requested bank and agency staff familiar with the service. From 13 July 2022 to the 08 August 2022, the service had on average 33 agency, registered and unregistered staff per day.

Managers made sure all bank and agency staff had a full induction and understood the service. Of the 897 agency shifts from 13 July 2022 to 08 August 2022, none of the staff allocated required an induction. Staff told us that there was an induction checklist completed for all agency nurses when they attend for the first shift.

Information from the trust included turnover and sickness rates. From February to July 2022, the emergency department had average turnover rates of 12% for nursing staff. For the same time period, the emergency department had average sickness rates of 7% for registered nursing staff.

Following the inspection, the service provided two different spreadsheets for vacancy rates. Neither clearly defined the vacancy rates by staff role in the department.

Urgent and emergency services

Medical staffing

The service did not always have enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix and gave locum staff a full induction.

The service did not always have enough medical staff to keep patients safe. From March 2022 to August 2022, the service had fill rates of 90% of all shifts; 66% as permanent and 24% as locum staff. The remaining 10% of shifts were unfilled.

Information was provided regarding bank and locum staff rates. Managers could not always access locums when they needed additional medical staff. Over the six-month period, the service required extra cover for 34% of all shifts; 12% of those were filled with internal locum staff and the remaining 12% were filled with external locum staff. This meant there was a risk that there may not always be the enough locum staff to cover outstanding shifts.

Managers made sure locums had a full induction to the service before they started work. Most of the external locum medical staff working on shifts were known to the service and had received an induction.

The service always had a consultant either on duty or on call during evenings and weekends and at least one consultant allocated to work each shift. We were told consultants were in the department from 8am to midnight and there was always a consultant on call overnight. This aligned to the Royal College of Emergency Medicine (RCEM) consultant workforce recommendations.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. Within the Trauma Audit and Research Network (TARN) report, from January to March 2022, 100% of patient's received senior medical staff led trauma teams on arrivals for a pre-alert or trauma. This was higher than the national mean of 38%.

The service provided vacancy rates for medical staff. From February to July 2022, the emergency department had average vacancy rates of three whole time equivalent consultant medical staff. In addition, four registrar vacancies, five clinical fellow vacancies and one advanced care practitioner vacancy.

Information from the trust included turnover and sickness rates. From February to July 2022, the emergency department had average turnover rates of 12% for medical staff. For the same time period, the emergency department had average sickness rates 2% for medical staff.

The service did not have job plans for all consultants. On 30 August 2022, for urgent and emergency care four out of the 16 consultants had job plans completed and the other 12 clinicians' jobs plans were in progress. We were told that job plans were reviewed yearly by the clinical director for the division.

At the time of the inspection the emergency department did not have sufficient paediatric emergency medical (PEM) consultant cover. We were told the previous post-holder had taken a career break, but a permanent replacement had not been appointed. The divisional risk register did not specify the gap in PEM consultants and did not specify control measures in place. The service told us that they had a locum paediatric consultant working 8am to 4pm on Monday to Fridays in the department and a registrar to support. However, if children did not always have timely access to a PEM consultant it could lead to harm. The service had an advert out for a permanent PEM consultant.

Staff were aware that there was not always enough staff to see patients in a timely manner. The service had advertised for more medical staff. However, leaders told us they had medium-term plans to ensure the department was safe for the future. The plan was to develop their advanced care practitioner roles and develop their clinical fellows through the Certificate for Specialist Registration (CESR) to support their medical staffing establishment.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, and easily available to all staff providing care but were not always stored securely.

Patient notes were comprehensive, and all staff could access them easily. The service used paper records for documentation of patient care and treatment and prescriptions while in the emergency department. The service used an electronic patient system for tracking patients within the department, but medical records were not electronic.

When patients were transferred to a new team, there were no delays in staff accessing their records as records were on paper. The exception was prescriptions which were transferred to the electronic prescribing system once the admission had been completed by the relevant speciality teams.

Records were not always stored securely. We observed some medical notes on the desks and not within folders in the emergency department when they were not in use. However, we saw that the service had lockable storage trolleys for medical records to secure records, but they were not always used.

Medicines

The service did not always use systems and processes to safely record, prescribe, and administer medicines. However, staff did record and store medicines safely.

Whilst staff did not always follow systems and processes to prescribe and administer medicines safely. Staff completed medicines records accurately. Medicines required on admission were prescribed on a paper chart. During inspection we observed that prescriptions on paper charts for analgesia was not always clearly written which could lead to patient harm. Within the Medicines Management Report from April to June 2022, the Emergency department recorded 24% of all the medicines due to be given were not administered. Therefore, we were not assured that all patients received their prescribed medicines.

When patients were seen by a speciality Dr and for admission, the patient's regular medicines were prescribed onto the electronic computer system. It was not immediately obvious to staff in the Emergency department when regular medicines had been prescribed. On 09 August 2022, we observed a patient who had not received their regular medicines for 18 hours and 29 minutes. This could be a risk for patients requiring time critical medications, such as to treat Parkinson's Disease.

Medicines reconciliation was completed by pharmacy staff and records showed the trust target of 50% in 24 hours following admission had been achieved. However, this target was not compliant with the current guidance National Institute for health and Care Excellence (NICE) guidance which indicates 100% of patients' medicines should be reconciled within 24 hours or sooner if clinically necessary. This meant staff could not always be assured they had a complete understanding of the medicines each patient took and the potential impact on their diagnosis and treatment.

A medicines reconciliation report indicated that of the 19 patients' medicines reconciled in the emergency department, from January to March 2022, 5 medicines reconciliations were completed within 24 hours of arrival and 14 were completed within 72 hours of arrival. The report recognised that the delays in patient flow contributed to the delays in medicines reconciliation.

Staff did not always store and manage all medicines and prescribing documents safely. The safe and secure storage audit for April 2022 showed an average of 85% compliance of the four areas audited in accident and emergency. This was similar figures to the audit in December 2021. However, during inspection we saw that medicines in clinic rooms were stored securely and at right temperatures. We checked a random sample of medicines and they were all in date.

Controlled medicines and medicines liable to misuse, including patients' own medicines, were managed safely. We observed staff adding new controlled medicines into the locked cupboard in the clean utility room and the process was structured and documented correctly. From 06 July 2022 to 07 August 2022, controlled medicines were checked twice a day for 31 out of 33 days. The other two days were checked once a day. The lead nurse undertook a weekly check and the ward manager undertook a monthly check.

Pharmacy staff followed national practice to check patients' medicines and provided advice to medical and nursing staff, patients, and carers. Staff told us that people with critical medicines were prioritised for medicines review by the pharmacy team in the emergency department. The pharmacy team were available in daytime in the emergency department to talk to patients and counsel patients about medicines to take home.

The trust had a pathway to ensure people's behaviour was not controlled by excessive and inappropriate prescribing. The service had a policy, but it was for the previous trust. The policy did not include the required frequency of observations and flowchart for giving medicines. There was a varied knowledge of the policy. During inspection, we observed one patient who was given medicines for calming distressed behaviour. The medicines were given appropriately, and appropriate monitoring was in place as per the National Institute for Health and Care Excellence guidance.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses 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. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them according to the provider's policy. In the last seven months, the service reported 523 incidents. Within the trust's hospitals, the top five reported incident categories in the emergency department were described as: "Emergency department incidents (AED only), patient missing or escaped, pressure ulcer/injury, treatment issues/delays, and fall, trip, and slips". The data provided by the trust did not allow for breakdown into individual departments.

The top five reported incident categories in the children's emergency department were described as: "Emergency department incidents (AED only), general communication, treatment issues or delays, medicine, and transfer related incidents".

In the last twelve months the service had no never events.

Urgent and emergency services

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. We reviewed five incidents that had been investigated within the Emergency department that occurred from March to July 2022. Each incident had a thorough review and chronology of events and recommendations of actions to reduce reoccurrence of the incident. Some of the actions included sharing the incidents, reiterating the importance of venous blood gases, and a workforce review.

Staff understood the duty of candour. However, within all five of rapid review documents reviewed there was no clear evidence of recording that duty of candour had taken place. Leaders told us that the initial verbal duty of candour would be provided within two days followed up with a letter ten working days after the incident. The final duty of candour contact would be arranged after the completion of the root cause analysis and followed up with a letter and a copy of the report. This was monitored through the weekly divisional governance meetings.

Staff met to discuss the feedback from incidents and look at improvements to patient care. Leaders shared learning from all incidents and root cause analysis from within the department during the staff meetings.

There was evidence that changes had been made as a result of feedback. In the June 2022 staff meeting minutes we saw evidence of learning and changes to procedure.

Staff received feedback from investigation of incidents, both internal and external to the service. We were told that the member of staff who reported the incident would receive a copy of the investigation undertaken. This would be shared with the wider team in the emergency department during safety huddles for 14 days to ensure the majority of staff captured the learning from the incident.

Is the service effective?

Requires Improvement ↓

Since we last carried out a comprehensive inspection of this service, they have become part of a newly formed NHS trust. As such we cannot compare previous ratings with this one. We rated it as requires improvement.

Evidence-based care and treatment

Not all policies and procedures were ratified and in date. The service did not always provide care and treatment based on national guidance and evidence-based practice.

The trust operated a central online policy hub. However, during our inspection of the core services, we found that some services were using legacy policies from the previous trusts or accessing a suite of policies separate to the central Northern Care Alliance hub. As part of our ongoing monitoring of the trust, and throughout the inspection, we found there was a need to align some legacy Salford and Pennine policies to ensure there were trust-wide versions that reflected national or best practice guidance where appropriate.

During inspection, we saw the majority of printed policies and procedure documents were from the previous trust rather than the Northern Care Alliance NHS Foundation Trust. In addition, staff had access to a separate internet site containing

Royal Oldham Hospital Emergency Department specific policies and procedures. Not all of the policies and procedures on the internet website contained dates for review or information indicating ratification. For example, we saw the ketamine procedural sedation for children in the emergency department did not have evidence of ratification or expiry date.

The adult loading doses policy was out of date and expired in 2017, including Aminophylline and Amiodarone medicines. The management of massive blood loss policy expired in 2015. We saw that the policies and procedures in the emergency department were from varied agencies including Australia and New Zealand, Intensive Care Society and National Tracheostomy Safety Project.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. We saw that staff offered a variety of food and drink options to patients regularly including halal and gluten free food. Patients we spoke with were happy with the food and drink options provided.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. We observed staff assisting patients with food and drink while we were in the department when they could not feed themselves.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain but did not always give pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool but did not always give pain relief in line with individual needs and best practice. Staff assessed pain scores during triage. We observed that pain was reassessed with the NEWS2 documentation.

The service participated in the Royal College of Emergency Medicine (RCEM) national audit for pain in children. We were provided with an interim report for 2020 to 2021 which was published in March 2022. Data from 25 January 2021 to 29 March 2021, for the first standard that pain was assessed within 15 minutes, indicated the service average was 33 minutes. This was lower than the national average of 16 minutes. The second standard was that patients in moderate to severe pain received pain relief within 30 minutes. On average children received their first pain relief within 43 minutes of arrival to the hospital, which was lower than the national average of 32 minutes. The service aimed to produce an action plan by October 2022.

We observed that pain relief was given when prescribed in a timely manner. However, we requested but did not receive evidence of audits relating to the assessment of pain and the administration of pain relief.

Staff prescribed, administered, and recorded pain relief accurately. Staff had access to patient group directions which were mostly in date apart from one which was dated 2019. We observed that children's patient group directions were all approved by the previous trust and had not been updated for consistency across the Northern Care Alliance NHS Foundation Trust.

Patient outcomes

Staff did not always complete records to allow them to monitor the effectiveness of care and treatment in accordance with guidance and best-practice. The service had been accredited under relevant clinical accreditation schemes.

Patient outcomes were not always positive, consistent, and met expectations, such as national standards. The service participated in the Royal College of Emergency Medicine mental health care in the emergency department national audit, the results were published in March 2021. The data was collected from 1 August 2019 to 31 January 2020, it showed that 54% of patients had a mental health triage assessment, none of the patients that were recorded as medium or high risk had evidence of mitigation actions documented. 29% of patients had emergency department medical staff reviews which documented a brief risk assessment of suicide and further self-harm. Overall, the audit identified a cause for concern in all three key standards of care and provided limited assurances at this time. The service had produced an action plan on 03 June 2021 which included the NCA mental health risk assessment document to be completed at triage and prompts on the intentional rounding tools.

We reviewed the RCEM national audit for the care of children in the emergency department. Older children and adolescents did not have psychosocial risk assessments. The report recommended that the service educates staff on the need for all adolescents to be opportunistically risk assessed using appropriate psychometric tools and the required actions to be taken. We saw that the service produced an action plan, but we did not see evidence that the provider had risk assessment tools for children and adolescents on the policy hub. This meant that children or adolescents who may be at risk of self-harm or leaving without being seen would not be assessed effectively, which could lead to harm.

From January to March 2022, the Trauma Audit and Research Network (TARN) data showed that 60% of patients met the National Institute for Health and Clinical Excellence (NICE) head injury guideline to receive a computerised tomography (CT) scan within 60 minutes of arrival. This was better than the national mean percentage of 47%. The service had better than the national mean for the proportion of patients with a low Glasgow coma score with definitive airway management within 30 minutes of arrival to the emergency department.

Managers and staff used the results to plan improvements in patients' outcomes, repeated audit results had not been published at the time of our inspection. The service was participating in the Royal College of Emergency Medicine (RCEM) national audits for 2022 to 2023 for consultant sign off, infection prevention, mental health and control and pain in children and were progressing to the schedule.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. The service provided an advancing quality audit report for 2021 which showed 64% of patients received all of the treatments as expected for sepsis within Royal Oldham Hospital, the data was not broken down by area. The audit showed that 65% of patients received antibiotics within one hour, 8% received antibiotics but not within one hour. The other patients did not receive antibiotics. The data showed that 28% had the sepsis care pathway within the notes.

As part of the inspection, we identified concerns regarding the management of sepsis within other services of the trust. In response to our concerns the trust rapidly implemented a unified sepsis pathway across all four hospitals within NCA. The service provided an action plan and was going to monitor its effectiveness through monthly audits.

Managers used information from the audits to improve care and treatment. We were given a list of local audits undertaken from 1 April 2021 to the 31 March 2022 with associated action plans. Three local accident and emergency department audits had been undertaken, the displaced Percutaneous Endoscopic Gastrostomy (PEG) audit was incomplete and data collection was still in progress. The other two audits; venous thromboembolism (VTE) in lower limb immobilisation and D-dimer blood tests audits, showed limited or partial assurances.

Managers shared and made sure staff understood information from the audits. Improvement was checked and monitored on a monthly. The lead nurse audits, and children's audits were discussed during emergency department staff meetings.

The service was accredited by a trust-wide Nursing Assessment and Accreditation System (NAAS). Each department was assessed using 14 core standards, including patient safety, medicines management, infection control and person-centred care. Wards and departments were assessed using the Red, Amber and Green (RAG) ratings. On 1 May 2019, the service received three green ratings on consecutive assessments. Staff told us they received three green ratings they could submit a portfolio of evidence to apply for the highest accreditation award of Safe, Clean and Personal Every time (SCAPE). SCAPE was awarded to the service which was recognised by the maroon coloured uniforms worn by the senior sisters. The service did not provide any further evidence of reassessment since May 2019 due to COVID-19. The trust had restarted the NAAS in July 2022.

The service had a similar risk of re-attendance to the National average. From August 2021 to July 2022, an average of 9% of all patients presenting were patients reattending the emergency department within seven days. This was similar to national comparisons.

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 development.

Staff were experienced, qualified, and had the right skills and knowledge to meet the needs of patients.

Managers gave all new staff a full induction tailored to their role before they started work. Medical staff received a three-day specific emergency department induction. Staff told us this had recently been increased from feedback from previous inductions to ensure soft tissue injuries were included in the induction programme. New nursing staff were given a competency-based workbook based on the Royal College of Nursing's emergency nursing competencies.

The department supported student nurses during their time in the department with a workbook to complete during their placements. However, we were concerned that student nurses were not seen as supernumerary in the department which was against the Nursing and Midwifery Council recommendations. On the staffing rotas provided on our inspection, a student nurse was counted in the nursing workforce figures.

Managers supported staff to develop through yearly, constructive appraisals of their work. Data from August 2022 showed completion rates in excess of 75% for staff in the department.

Medical staff were on a cycle for appraisals, out of the five staff due an appraisal in the emergency department, four had been completed. The service told us that all other medical staff had completed appraisals in the last 12 months.

Most nursing staff were supported to develop through regular, constructive clinical supervision of their work. Data provided by the trust indicated 85% of nursing staff in the department received an appraisal.

Managers did not support medical staff to develop through regular, constructive clinical supervision of their work. Data provided by the trust indicated 0% of medical staff in the department received an appraisal.

Managers made sure staff attended team meetings or had access to full notes when they could not attend.

Multidisciplinary working

Doctors, nurses, and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff ensured regular and effective multidisciplinary reviews for patients, so they had the right care and treatment. The frailty team worked within the emergency department. During the inspection, we observed that patients were receiving frailty assessments when required, to ensure patients were on the most appropriate care pathway.

The service had physiotherapists and occupational therapists working within the emergency department to assist in helping patients to return to their own place of residence. From February to July 2022, we saw that 103 patients were seen by the physiotherapy team and 28 patients were seen by the occupational therapy team in the emergency department.

Staff worked across health care disciplines and with other agencies when required to care for patients. There was access to social workers and the community through the transitional hub team within the hospital, to aid in ensuring that care can be restarted when required.

Staff referred patients for mental health assessments when they showed signs of mental ill health or depression. However, we did not always see that mental health risk assessments were being completed. We observed staff working well with police to protect patients with mental health conditions while they were in the emergency department.

Seven-day services

Key services were available seven days a week to support timely patient care.

Staff could call for support from doctors and other disciplines and diagnostic services, including mental health services, 24 hours a day, seven days a week. Staff from the psychiatric liaison team from a local NHS mental health trust was based in the emergency department 24 hours a day, seven days a week. There were six practitioners available in the day and three at night-time. On the hospital site there was one section 136 suite to care for patients who required to be in a place of safety for their own safety.

Health Promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support in the emergency department. During inspection, we observed the department did not always have health promotion information immediately available for patients, except for generic National Health Service posters in the reception area. However, staff told us that they had access to online health promotion leaflets and advice in different languages and with different varieties of complexity to aid understanding which could be printed.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. The service had access to an external drug and alcohol liaison service to make referrals if patients needed support.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used to agree personalised measures that limit patients' liberty.

Staff were provided with female genital mutilation and PREVENT training. In August 2022, 100% of medical staff and 96% of nursing staff had received training.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Oldham Care Organisation undertook a mental capacity assessment audit from April to June 2022. Over 90% of the records audited evidenced support was given to the patient to make an informed decision.

When patients could not give consent, staff did not always record decisions had been made in their best interest, considering patients' wishes, culture and traditions. According to the mental capacity assessment audit from April to June 2022, 16% of the records where a best interest decision had been made did not have it documented.

Managers monitored how well the service followed the Mental Capacity Act but did not always make changes to practice when necessary. The action plan produced for the mental capacity assessment audit did not include how the hospital would improve documentation of mental capacity in line with Mental Capacity Act 2005. The audit documented that the service would re-audit quarterly.

Staff made sure patients consented to treatment based on all the information available. Staff clearly recorded consent in the patients' records. We observed staff providing information to patients around care and treatment as well as gaining verbal consent prior to providing care.

Staff understood Gillick Competence and Fraser Guidelines and supported children who wished to make decisions about their treatment. Staff in the paediatric service confirmed understanding of Gillick Competence and Fraser Guidelines and noted this was covered within related training. They were unable to provide examples where this was used in practice.

Nursing and clinical staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Data for nursing staff showed a compliance rate of 88.35% for nursing staff and 86.49% for clinical staff.

However, staff we spoke with provided an inconsistent understanding of consent and decision-making requirements, legislation, and guidance. We observed one instance where a patient's capacity was queried within their notes, but no formal capacity assessment was completed. We reviewed a sample of capacity assessments which were completed appropriately with principles upheld.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. Staff we spoke to confirmed they could access relevant policies online. They also confirmed they would speak with a senior staff member for support or guidance if needed.

Is the service caring?

Good 

Since we last carried out a comprehensive inspection of this service, they have become part of a newly formed NHS trust. As such we cannot compare previous ratings with this one. We rated it as good.

Compassionate care

Staff did not always treat patients with compassion and kindness or respect their privacy and dignity. However, staff respected and understood their individual needs.

Staff did not always take time to interact with patients and those close to them in a respectful and considerate way. However, at times staff displayed discreet and responsive care. It was noted this was not always consistent for corridor care. We witnessed staff querying and discussing intimate details about patient's care in corridors where visitors and patients were present.

Patients said staff treated them well and with kindness. Patients we spoke to confirmed they were happy with the care they received from staff. Patients felt staff treated them well and with kindness.

Staff did not always follow policy to keep patient care and treatment confidential. We observed some use of curtains or privacy screens when consulting with patients or providing personal care, however it was noted this was not always possible when providing care on corridors, and not used consistently across the department.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. Support workers were available through the psychiatric liaison team based in the department. The support workers would support patients throughout the department and discussed their support needs in a non-judgemental and caring manner.

Emotional support

Staff provided emotional support to patients, families, and carers to minimise their distress. They understood patients' personal, cultural, and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it.

Staff supported patients who became distressed in an open environment. However, staff could not always maintain their privacy and dignity. In one instance staff in the paediatric department were able to support a patient to access a quiet space separate from the waiting room as they were struggling to tolerate the environment.

Staff did not undertake training on breaking bad news. Staff noted difficulty demonstrating empathy when having difficult conversations. The trust did not provide details of any additional training for staff regarding delivery of bad news. Staff told us they do not feel the department had a suitable space to discuss sensitive or upsetting information with families.

Staff understood the emotional and social impact that a person's care, treatment, or condition had on their wellbeing and on those close to them. Staff we spoke with described a thorough understanding of the emotional and social impact a person's care and treatment has on their wellbeing. They also described the impact on families and carers.

Staff understood and respected the personal, cultural, social, and religious needs of patients and how they may relate to care needs. They confirmed meals were offered to accommodate halal and kosher diets. Staff gave examples of accommodating patients who require a specific regime of prayer as well as importance of religious dress.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families, and carers to understand their condition and make decisions about their care and treatment.

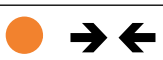
Staff made sure patients and those close to them understood their care and treatment. We observed staff speaking to patients and families in detail around their care and treatment. Patients told us that staff were keeping them informed around their care and treatment and what to expect moving forward.

Staff talked to patients in a way they could understand, using communication aids where necessary. We observed staff using additional supports in order to maintain communication with patients. This included visuals, Sign-along, and the use of a telephone interpreter service.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. We observed opportunities for patients to give feedback in the paediatric waiting area including a children and young people's survey. Feedback boxes were also available for friends and family, however the forms which needed to be completed were not readily available.

Patients were invited to take part in the family and friend's test. We requested the survey results. We saw that 66 [45%] patients who completed the survey, would recommend the department.

Is the service responsive?

Requires Improvement 

Since we last carried out a comprehensive inspection of this service, they have become part of a newly formed NHS trust. As such we cannot compare previous ratings with this one. We rated it as requires improvement.

Urgent and emergency services

Service delivery to meet the needs of local people

The service did not always plan and provide care in a way that met the needs of local people and the communities served.

Managers planned and organised services, but they did not always meet the needs of the local population. Facilities and premises were not always appropriate for the services being delivered. We saw that the urgent treatment centre had a whiteboard containing the waiting times, but they were not always updated. There was no clear signage to explain the urgent treatment centre process to patients. During inspection, we observed that there was not enough seating in the waiting areas to allow for social distancing.

The signage and information for a patient to navigate through the accident and emergency department was not always clear. We observed patients asking for directions to the urgent treatment centre and to the X-ray department.

There was one mental health ligature free room within the emergency department, used for both adult and child patients. From February to July 2022, we saw the service had 296 patients with mental health concerns on average per month. In the six-month period, patients with mental health concerns stayed in the department from 1 to 97 hours. The service did not always have the provisions to support adults and children with mental health problems in a ligature free room in accordance with the Royal College of Psychiatry recommendations.

The accident emergency department was designed to accommodate children and their parents. The service had a separate waiting area and treatment areas for children, had appropriate toys available and employed play specialists. We saw folders containing information to help patients understand “what is an X-ray?” and “what is surgery?”.

The trust had implemented a Same Day Emergency Care (SDEC) for patients that could be seen and treated within a day which helped to avoid admissions. These included services such as DVT and gastroenterology clinics.

The service had systems to help care for patients in need of additional support or specialist intervention, but they were not always used. Staff did not routinely use the forget me not symbol to signify that patients were living with dementia, and we did not see the falls leaf being used to signify patients were at risk of falling. However, staff had access to a dementia champion in the service and learning disability link nurses. Leaders told us they were in discussion with staff regarding improvements in compliance for the use of symbols, but these had not been implemented at the time of our inspection.

Meeting people’s individual needs

The service was inclusive and took account of patients’ individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Staff from the psychiatric liaison team from a local NHS mental health trust were based in the emergency department. We observed support workers keeping in touch with patients with mental health needs waiting in all areas of the department. We observed a patient with a disability being supported to wait in a quiet space due to their difficulty tolerating the waiting room environment.

The service was not designed to meet the needs of patients living with dementia, but the service had considered other measures to support patients with dementia and learning disabilities. The emergency department had a room for

patients to go for a quieter space. Staff had access to single-use 'twiddle blankets' and puzzles for patients. A 'twiddle blanket' was a lap sized blanket with ribbons, buttons and beads for patients to twiddle with their hands. These were designed to stimulate senses, keep restless hands busy and trigger memories for patients. Staff allowed families and carers in as chaperones for people with disabilities.

Staff did not always use 'This is me' or patient passport documents for patients living with dementia or learning disabilities. We saw three patients' notes with a 'this is me' document; two were blank and one was completed. We requested but did not receive evidence of auditing of the 'this is me' documents within the service.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Staff we spoke with were confident in meeting communication needs of patients with a disability or sensory loss, however this was more prominent within the paediatric team. The paediatric team actively used visuals and Sign-along and reflected this in all paediatric waiting areas. They also provided examples of when these skills were used to support the wider department, however visuals and communication needs were not as clearly used and documented within wider areas of the department.

Staff told us printed information leaflets were available in some languages spoken by patients and the local community, however they noted these were most readily available in English. Staff gave examples of where online translate services were used to tailor information to patients. The paediatric team made use of an online system which sent a text to families included a link to the information online; this information could be translated into a wide array of languages.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. We observed the use of the telephone interpreter system where consent was gained from the patient and treatment explained throughout. Staff told us they used the telephone system even when family members were present, however we observed staff request support from a child to interpret for their mother. Staff we spoke with were unsure how to access BSL interpreters if needed.

Staff had access to communication aids to help patients become partners in their care and treatment. Staff in the children's emergency department led on teaching sign language to staff through a programme called "Sign-along". Staff had Sign-along aids kept in their pockets to help to communicate with staff and posters were seen around the department.

Access and flow

People could not always access the services in a timely manner when they needed it and did not always receive the right care promptly. Waiting times from arrival to treatment and arrangements to admit, treat and discharge patients were not in line with national standards.

The service had 46 trolley spaces in the emergency department and also used 12 escalation corridor spaces. During our inspection, on 10 August 2022, there were 96 patients in the department which staff told us was higher than the expected capacity of the department. This significant increase in patients within the department had become a regular occurrence. This meant that the department was significantly overcrowded and that risks could not always be managed and mitigated effectively.

Urgent and emergency services

In the six-week period from 25 July 2022 to 04 September 2022, on average 409 patients arrived by ambulance per week. Data showed on that ambulance handovers, in 16% of cases, were between one and three hours, and 2% of ambulances waited over three hours with patients. This was causing delays for ambulance crews to attend patients waiting in the community.

Managers monitored waiting times but could not always make sure patients could access emergency services when needed. In addition, patients did not always receive treatment within agreed timeframes and national targets. The national standard is that patients should wait no more than one hour from time of arrival to receiving treatment. From July 2022 to August 2022, the department had not met the standard in line with the national trend since the pandemic.

Of the 7,142 patients seen in the department throughout July 2021, the percentage of patients seen for treatment within 60 minutes was 29%. From 01 to 30 July 2022, the longest wait to be seen for treatment was 11 hours and 13 minutes. Delays in being seen for treatment could cause harm to patients.

The national standards states that emergency departments should admit, transfer or discharge 95% of patients within four hours of arrival. Information provided from July 2022, showed that 47% of patients were admitted, transferred, or discharged within four hours. This was worse when compared with the England average of around 73% from April 2022. From 01 to 30 July 2022, the longest length of stay in the emergency department was two days, nine hours and 30 minutes.

The national standard states that patients should not stay longer than 12 hours after the decision to admit (DTA) was made. The service provided data, for July 2022, that showed 53% of patients did not receive a decision to admit within four hours from arrival in the department. In July 2022, there were recorded delays of up to one day, nine hours and 23 minutes to make the decision for admission.

The number of patients leaving the service before being seen for treatment was worse than the England average of 6%. In April 2022, the percentage of patients that left the trust's urgent and emergency care services before being seen for treatment was 7%. In July 2022, data provided showed that 12% of patients left without being seen by a doctor.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

The service displayed information about how to raise a concern in patient areas. Staff understood the policy on complaints and knew how to handle them. Complaints were managed by a central team and each was managed by a case manager. Once a complaint was received it would be triaged and actioned by the central team. This was aligned to the complaints policy.

Complaints were triaged as "red" if an urgent clinical review was required. This would be allocated to appropriate medical staff to undertake an urgent review. If the complaint should have been reported as an incident it would be reported at that point and would be investigated as an incident.

Urgent and emergency services

Managers investigated complaints and identified themes. Complaints were investigated and monitored through the weekly divisional governance meeting. Leaders received regular details on the compliance for responding to complaints in a timely manner as per the trusts complaints policy. The emergency department had responded to 100% of complaints within the trust's targets in June 2022 and 89% in July 2022.

Managers shared feedback from complaints with staff and learning was used to improve the service. Staff meeting minutes for the department contain discussion of complaint details and guidance for the team as a result.

Is the service well-led?

Requires Improvement 

Since we last carried out a comprehensive inspection of this service, they have become part of a newly formed NHS trust. As such we cannot compare previous ratings with this one. We rated it as requires improvement.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were not always visible and approachable in the service for patients and staff. They did not always support staff to develop their skills and take on more senior roles.

The emergency and urgent care directorate sat within the Oldham care organisation's division of medicine. The directorate was managed by a directorate manager supported by an assistant director of nursing and clinical leads. At the time of our inspection, there was no assistant director of nursing in post, however, the post was filled and the person was due to start within a few weeks.

Local leaders had the skills and experience to ensure the service could be run effectively. Leaders in the department could clearly articulate the challenges the service faced. However, some of these challenges were outside of their control. For example, factors affecting the availability of suitable beds within the hospital.

Not all staff felt leaders were visible, approachable and did not always feel supported. Some staff told us that though they felt supported by local leaders they did not see any leaders from the care organisation or wider trust in the department and would not know how to contact them.

The department leads and senior leaders were committed and passionate about the service and worked to ensure patients were kept safe.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The department had a set of annual objectives based on the six principles of the trust's vision 10 strategy. The ambitions aligned with local priorities and the needs of the local community. Ambitions for the department included; a review of same day emergency care pathways, supporting staff, improve discharge and flow, recruit substantive staff and participate in national audits relevant to the department.

We spoke with leaders in the department who demonstrated their involvement in workstreams related to these ambitions. They attended a trust-wide same day emergency care working group meeting with other emergency department leads in order to share learning about initiatives teams had put in place as part of the trust's triple plus strategy to improve flow through the hospital. Department leaders were able to articulate this strategy and give examples of how the department would contribute to successful outcomes.

Culture

Staff did not always feel respected, supported and valued. However, they were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear, but staff did not always feel listened to.

Staff satisfaction was mixed. Staff expressed concerns to the inspection team about the safety of the department. Some staff told us pressures in the department and staff shortages left them feeling undervalued, unsupported and unable to carry out their roles to the standard they would like.

Staff told us that the service allowed for self-rostering for any permeant medical staff above foundation year two. We were told that this was well received by staff.

Staff were focused on the needs of patients, but some staff told us they were not able to meet these needs and provide care to an adequate standard. Staff told us they felt demoralised when providing corridor care.

Managers told us their main priority was staff wellbeing. They had a wellbeing committee who arranged regular wellbeing conversations with staff. The department also had a room available for staff to access when they needed a physical or emotional break.

Staff could access support from a Freedom to Speak Up Guardian. A Freedom to Speak Up Guardian works alongside the trust's senior leadership team to ensure staff have the capability to speak up effectively and were supported appropriately if they have concerns regarding patient care.

The service also provided staff with four hours paid time off annually as part of the Support, Caring, Assisting, Recognising our NCA Family (SCARF) trust-wide initiative.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There were effective governance processes in place in the service. Leaders attended directorate, divisional and the care organisation's quality and performance meetings. The divisional governance meetings took place monthly. Outcomes from this were fed through to the care organisation's assurance and risk committee. Leaders told us they had confidence relevant information was provided to the care organisation and trust through this structure.

However, we were not assured the senior leadership were fully sighted on the activity and performance in the emergency department. This is because we found areas of concern such as the completion of mandatory training, where poor audit results and performance had not been addressed.

The division had weekly divisional governance meetings alongside the division of medicine to discuss incidents, complaints, serious incidents, and ongoing root cause analysis.

Managers told us they shared learning about never events with their staff and across the trust. We did not see within the June 2022 staff meeting records that staff shared learning from other incidents that had occurred across the trust. Incidents were shared through the divisional Quality and Patient Experience (QPE) meetings. Divisional QPE meetings fed into the Royal Oldham hospital care organisation quality and patient experience meetings. This was then reported up to the executive board.

Information such as learning from incidents was shared through staff meetings.

Management of risk, issues and performance

Leaders and teams used systems to manage performance. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

During our meeting with the senior leadership team we were assured they were fully sighted on the activity and performance of the emergency department.

The service had eight risks rated 10 or above on the divisional risk register. Of these, reducing costs in line with Productivity and Value Based Efficiency (PAVE) targets was the top risk and rated red. Demand in triage and assessment was also one of the top risks and rated amber.

We reviewed the risk register and saw that it allocated a risk owner, dates for review, controls, gaps in controls and action plans. For example, one of the controls for demand in triage is a triage bypass system for patients who present with chest pain or possible neutropenic sepsis.

However, we were not assured that the risk registers accurately reflected all the risks. For example, within the paediatric emergency department there was no available mental health assessment room that met the 2017 Psychiatric Liaison Accreditation Network (PLAN) Quality Standards for Liaison Psychiatry Services. There were no rooms available that were ligature free. Staff told us that the children requiring the use of a mental health assessment room would be placed in the adult department. This risk was not reflected within the risk register. The risk was recorded, and control measures were put in place. However, they did not adequately address all risks. For example, the register did not make reference to making rooms ligature free.

Information Management

Urgent and emergency services

The service collected data and analysed it. However, some staff were not confident the data was always accurate. In addition, staff could not always find the data they needed in accessible formats to help them understand performance, make decisions, and drive improvements. Data was not recorded or presented uniformly across the trust and some important data was not captured.

The information systems were secure. However, they were not always reliable or integrated well. On 18 May 2022 the trust experienced a major failure of some of its key information systems which affected Bury, Rochdale and Oldham care organisations. As a result, a critical IT incident was declared. The trust announced the issues were fully resolved on 20 June 2022. The failure disrupted diagnostic, pathology and pharmacy services, and referral pathways from GPs and primary care services.

Data was collected to measure performance. This included ambulance handover times, time from arrival to treatment, length of stay in the emergency department and time for referral to specialty. However, the department did not submit any data for May 2022 for patients admitted, transferred or discharges within four hours and time to assessment.

The service had two information governance breaches within the last six months. both had a severity rating of no harm and actions were recorded.

We were not assured that leaders and staff always received information to enable them to challenge and improve performance. This was because data we requested as part of the inspection process was not made available in formats which were easily accessible nor attributable to the service. For example, mandatory training data was difficult to analyse.

The service submitted data regarding incidents to national reporting systems. However, this was not always assigned to the service within the systems and therefore did not allow external agencies, such as CQC clear oversight.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Leaders shared NCA wide updates with staff. For example, regular connect newsletters and NCA policy updates were shared with staff.

Patient engagement sessions were run by the department. However, we did not observe any friends and family test information being shared.

The service engaged with external partners and other stakeholders to plan and manage services. For example, they were seeking external guidance on improvements that can be made for people accessing the department with mental health, learning difficulties and dementia.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Staff identified areas of training that needed to be developed within the department. For example, a training session was developed by the department to raise awareness around support for victims of domestic abuse. The program was developed in partnership with and delivered by a survivor of domestic abuse. The training program linked in with local services for survivors, familiarised staff with relevant referrals, and developed discreet methods of providing victims with helpline contact details. Staff said this training provided them with confidence in supporting victims and using professional curiosity to raise or challenge signs of domestic abuse.

Leaders encouraged staff to put forward ideas to improve patient safety. For example, nursing staff were involved in the design and implementation of a new alert system for time critical medications.

Maternity

Requires Improvement

Is the service safe?

Requires Improvement

Since we last carried out a comprehensive inspection of this service, they have become part of a newly formed NHS trust. As such we cannot compare previous ratings with this one. We rated safe as requires improvement.

Mandatory training

The service provided mandatory training in key skills to all staff. However, did not meet national guidance standards in line with Ockenden recommendations and clinical negligence scheme for trusts (CNST) to meet the needs of women and staff.

Staff at the trust were required to complete mandatory training modules that were a combination of face to face and eLearning. The target for all modules was 90% except for information governance which had a target of 95%. For midwives equality, diversity and human rights compliance was 90%, fire safety was 66%, health, safety and welfare was 88%, moving and handling level one was 82% and level two 38%, NHS conflict resolution was 85%, preventing radicalisation – basic prevent awareness was 92% and prevent workshop to raise awareness about prevent (WRAP) was 77%, blood transfusion theory was 88% and competence training was 88%, falls awareness was 77% and pressure ulcer awareness training was 74%.

For medical staff who had responsibilities for maternity and gynaecology the service monitored compliance for mandatory training. For equality, diversity and human rights compliance was 87%, fire safety was 50%, health, safety and welfare was 77%, moving and handling level one was 93% and level two 57%, NHS conflict resolution was 80%, preventing radicalisation – basic prevent awareness was 87% and prevent workshop to raise awareness about prevent (WRAP) was 53%. for blood transfusion theory and competence training, compliance was 63%, falls awareness was 70% and pressure ulcer awareness training was 50%.

There was no mandatory training received for meeting the needs of people with mental health concerns, learning disabilities or autism. From 1 July 2022, all registered health care providers were required to ensure their staff received training in learning disability and autism, including how to interact appropriately with autistic people and people who have a learning disability. This training should be at a level appropriate to their role. At the time of the inspection, the NCA had not made completion of this training mandatory, and staff had not completed the necessary programme of learning as required. This meant staff may not have had the skills and knowledge to communicate effectively and provide safe care to these patient groups.

The recently appointed deputy director of midwifery had identified that the mandatory training programme for the service was not comprehensive, in line with Ockenden recommendations and clinical negligence scheme for trusts (CNST) to meet the needs of women and staff. The CNST handles all clinical negligence claims against member NHS bodies where the incident in question took place on or after 1 April 1995 (or when the body joined the scheme, if that is later). Although membership of the scheme is voluntary, all NHS Trusts (including Foundation Trusts) in England currently belong to the scheme.

There were no simulations of different types of birth scenarios, at the time of inspection. A newly appointed practice educator took up the role during the onsite inspection. There were plans for a re-launch of mandatory training requirements from September 2022 that included a multidisciplinary approach. Experienced midwives were being trained as facilitators, both in the hospital and community, to assist with the delivery of the new training.

Clinical staff had been allocated to sessions and senior leaders were clear that mandatory training should be completed with protected time. We were told that all staff should have completed the required training by March 2023.

Safeguarding

Staff understood how to protect women from abuse and the service worked well with other agencies to do so. Not all staff had received current training on how to recognise and report abuse but knew the processes in place.

Midwifery staff received training specific for their role on how to recognise and report abuse. Compliance levels varied across departments. Staff were required to complete safeguarding level three for adults and level three for children with trust targets of 90%. For midwives, safeguarding adults levels one compliance was 86%, level two was 86% and level three was 77%. Compliance for safeguarding children level one was 87%, level two was 87% and level three was 83%. For medical staff, safeguarding adults level one compliance was 83%, level two was 87% and level three was 57%. Compliance for safeguarding children level one was 83%, level two was 83% and level three was 65%.

Staff were required to complete training about female genital mutilation (FGM). This was included in the safeguarding training rather than a separate course.

There was a named safeguarding lead midwife for the service as well as a second safeguarding midwife who supported midwives on the wards. The trust monitored details of individual staff members training compliance and any outstanding training. We received a copy of the quarterly maternity safeguarding report that was a comprehensive summary of all aspects of safeguarding that included training compliance, supervision and referrals.

Staff could give examples of how to protect women from harassment and discrimination, including those with protected characteristics under the Equality Act 2010.

Staff had access to contact numbers for safeguarding alerts or concerns in staff offices and on the intranet. Staff could access a national system that alerted them to women who may be vulnerable and access care locally.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Staff followed the baby abduction policy and we were told a simulation had taken place earlier this year, however; we did not receive any details of the outcome.

Staff followed safe procedures for children visiting the ward. Entry to all wards was restricted and secure with staff requiring appropriate swipe access rights. Buzzers at entrances were connected to an intercom system with cameras attached so that staff could monitor visitors to wards. We observed that all visitors were challenged when entering wards. We observed that a door at the rear of the postnatal ward was not locked. We escalated to the ward manager who took actions for the door locking mechanism to be fixed.

Maternity

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect women, themselves and others from infection. They kept equipment and the premises visibly clean.

Ward areas were clean and had suitable furnishings which were clean and well-maintained.

Privacy curtains were disposable with appropriate dates added for when last changed. We were provided with the schedule for routine changes of bed and cubicle curtains that indicated they had been changed in the six months prior to inspection. The labour ward included all single rooms for women. Staff reported that the beds were challenging to clean but had not experienced any concerns.

Staff followed infection control principles including the use of personal protective equipment (PPE). Gloves, masks and apron dispensers were available along with wall-mounted sanitising stations or clinical sinks with hand washing instructions. We observed staff wearing masks, if not exempt.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We observed I am clean stickers on equipment.

In the antenatal clinic we observed posters and information for women with guidance related to COVID-19, including vaccine advice.

The triage area was combined with the antenatal day unit (ANDU). This included one room with individual spaces for women to be seen. There were no individual consulting rooms. In the birth centre, two rooms had been identified to treat any women who presented, for triage, with symptoms of COVID-19 to help prevent any spread of the infection. The rounding tool that was used to capture the services activity, identified any women who had tested positive to COVID-19.

Between October 2021 and June 2022, there were nine women who had been identified as positive for Methicillin-resistant Staphylococcus aureus (MRSA). There was no information that indicated if this was hospital or community acquired.

Staff completed mandatory training modules for infection prevention and control. For midwives, compliance for level one was 79%, level two compliance was 74%, and aseptic non touch technique compliance was 47%. For medical staff level one compliance was 83%, level two was 67% and aseptic non touch technique compliance was 60%. The trust target for compliance was 90%.

Audits for COVID-19 compliance, hand hygiene and use of personal protective equipment (PPE) were audited. The postnatal ward results were above the 90% target when audited in February and March 2022. On the labour ward, hand hygiene was above the target when audited. However, PPE was 83% in February 2022.

Quarterly audits of hand hygiene were completed in March 2022 and May 2022 with compliance rates of 98%. However, these were for the whole hospital rather than the service alone.

The domestic staff and clinical staff maintained cleaning lists and we received copies of cleaning schedules and checklists for each area. There were some gaps in checks in all areas. Audits were completed weekly with a target

compliance of 95% for areas identified as very high risk such as labour ward, the birth centre and obstetric theatre. For areas identified as high risk including antenatal and postnatal wards, the target was 90%. We were provided with results from January to August 2022; domestic and nursing audits were generally above their targets, for this time frame with an average of 96.3% compliance for domestic and 98.3% compliance for nursing audits.

We were provided with a copy of the infection prevention and control annual community work plan. This included target dates for completion. However, there was no detail about progress with the plan.

Senior managers told us that if a baby needed to be readmitted when needing phototherapy for jaundice, they came back to the postnatal ward rather than paediatrics. There was a concern that this may be an infection risk as babies had been outside of the hospital environment. Phototherapy is a method of using artificial light to treat conditions like jaundice.

Environment and equipment

The design and use of facilities, premises kept people safe. However, we observed equipment that was either missing a date when last maintained or with stickers showing they were passed their date for a maintenance check. Staff managed clinical waste well.

The design of the environment followed national guidance. The maternity unit was purpose-built in 2012 to meets needs of women and their babies. Most of the maternity services were on the same floor close to each other. These included the combined triage and antenatal day unit (ANDU), antenatal ward and antenatal clinic. The labour ward was linked to the neonatal intensive care unit (NICU) and the two obstetric theatres. This meant that a theatre was available for obstetric emergency births as well as elective bookings. The postnatal ward was on the floor above all other services.

Women could reach call bells and staff responded quickly when called. Emergency buzzers were available in all areas and we observed staff responded immediately when sounded.

Staff carried out daily safety checks of specialist equipment. However, we noted gaps in environment and equipment checks both during the onsite visit and in the information shared by the trust. These included the labour ward adult and neonatal trolleys and the postnatal adult trolley. We observed that the process for maintenance checks was not robust. We saw that not all equipment was labelled and some were labelled with the former trust name. This included equipment on wards and in theatres such as a resuscitaire not dated, weighing scales with stickers with service due dates of January 2021, January 2022, February 2022 and March 2022, baby scales with a service due date of June 2022, as well as two blood pressure monitoring machines with service due dates of May 2022, an infusion pump service due date of June 2022 and phototherapy unit service due date of June 2022. This meant staff could not be assured that all equipment, including for emergencies, was accurate and safe to use.

On the postnatal ward we observed that the control of substances hazardous to health (COSHH) cupboard was not locked in an unlockable sluice room. We escalated to the ward manager and the cupboard was repaired during the onsite visit. Staff disposed of clinical waste safely in colour-coded disposable bags and sharps bins.

The postnatal ward had nominated rooms to examine new-borns either in the paediatric room for an emergency situation or routine newborn and infant physical examination (NIPE) prior to discharge. These doors were open at the time of inspection. Cupboards in the paediatric room were not locked and included needles and syringes that were accessible to all staff or visitors.

The service had suitable facilities to meet the hygiene needs of women. Bays included separate toilets and shower facilities; side rooms were en-suite.

Storage was limited in some areas although equipment was re-located during the inspection from a corridor area.

The maternity voices partnership told us that they had completed a 15 steps exercise with the service to experience what the women may encounter. There was a concern that the estates were in need of expansion to accommodate women and babies.

Assessing and responding to patient risk

Midwives completed and updated risk assessments for each woman and took action to remove or minimise risks. Midwives identified and quickly acted upon women at risk of deterioration.

Staff completed risk assessments for each woman from the time of booking and reviewed them at further appointments antenatally.

Smoking was included in the risk assessing process. Between October 2021 and June 2022, there was an average of 10.7% of women who smoked at the point of booking. The regional median was 11.2%. At delivery there was an average of 10.5% of women who smoked. The regional median was 10.4%. Staff monitored carbon monoxide (CO) levels in the bloodstream for smokers at booking. 93.2% of those who smoked had this measurement completed. The measurement was repeated at 36 weeks. The percentage of women having this measurement taken reduced to 67.4% at this point.

Staff used a nationally recognised tool, when monitoring and when admitted, to identify women at risk of deterioration and escalated them appropriately. Staff used the Modified Early Obstetric Warning Score (MEOWS). The Maternity Early Obstetric Warning System tool has been specifically modified to reflect the physiological adaptations of normal pregnancy and should therefore be used for pregnant, labouring and postnatal women. We requested any audits of MEOWS and were told that audits had not been undertaken for the 12 months prior to inspection. There were plans in progress to re start this audit as part of a reviewed audit programme.

Staff completed mandatory training modules in resuscitation. For midwives, compliance with resuscitation level two adult basic life support was 73% and level two newborn basic life support was 76%. For medical staff, compliance with resuscitation level two adult basic life support was 58%, level two newborn basic life support was 55%, advanced life support compliance was 74%, advanced paediatric life support was 81%, paediatric life support compliance was 70% and paediatric immediate life support was 100%. The trust target compliance rate was 90%

Staff knew about and dealt with any specific risk issues including sepsis and venous thromboembolism (VTE). Sepsis and VTE were included in mandatory training requirements. For midwives, compliance was 79% and 73% for medical staff. The trust target for compliance was 90%. Venous thromboembolism (VTE) compliance was 97% for midwives. There was a policy for sepsis, however; at the time of inspection, the policy was passed the date for review. We requested details about the incidence of puerperal sepsis within 42 days of delivery and readmission rates for infections. However, we did not receive this information.

There was a policy for management of a primary postpartum haemorrhage (PPH) (bleed after giving birth); however, this did not refer to the Wales pathway or equivalent. Senior managers told us that there were plans to implement the

pathway as part of their improvement plan. The Wales pathway is a tool developed by the Obstetric Bleeding Strategy (OBS) Wales for the management of a PPH. It signposts which pathway to follow dependent on the measurement of accurate blood loss using a rotational thromboelastometry (ROTEM) machine. ROTEM provides an assessment of the efficiency of blood coagulation at the point-of-care (POC). This was not available on the labour ward.

The service had 24-hour access to mental health liaison and specialist mental health support if staff were concerned about a woman's mental health. There were specialist perinatal mental health midwives. Community midwives discussed any mental health concerns at booking and subsequent antenatal appointments. They could signpost support for women thought to be at risk of self-harm or suicide. Staff shared key information to keep women safe when handing over their care to others. Alerts could be added to electronic systems.

Shift changes and handovers included all necessary key information to keep women and babies safe. On the postnatal ward safety huddle information was shared with all staff prior to midwives' handovers for allocated women and babies. The ward co-ordinators had oversight of all women and babies in a separate handover from the shift lead.

Prior to the onsite inspection visit there had been changes in theatre responsibilities. For elective caesarean sections, a dedicated midwife supported women prior to the surgery. Once in the obstetric theatre, staff from theatre managed the care of the woman and baby. For emergency caesarean sections, neonatal staff were required to attend in theatre to review the baby. The labour ward, theatre and neonatal unit were linked and easily accessible for staff.

The labour ward had introduced Local Safety Standards for Invasive Procedures (LocSSIPs) to monitor safety at each birth including swab counts.

The service completed the World Health Organisation (WHO) surgical safety checklist adapted for maternity services. The surgical safety checklist is a tool designed to improve communication and teamwork by bringing together the surgeons, anaesthesia providers and nurses involved in care to confirm that critical safety measures are performed before, during and after an operation. We observed the use of the checklist and found it was completed appropriately. Audits were completed for May, June and July that were both observational and document review. There was 100% compliance for all audits.

Feedback from staff was that utilising theatre staff rather than midwives meant that staff could give complete focus to other women and babies in their care.

The labour ward hosted a safety huddle each morning. This was attended by a multidisciplinary team and had recently included a governance representative.

There was no formal triage process and triage was combined with the antenatal day unit. There were plans to review the estate and introduce the Birmingham Symptom Specific Triage System (BSOTS). The BSOTS assesses women presenting themselves with unexpected pregnancy related problems or concerns, and then allocates a colour code, so hospital staff can see at a glance who needs to be prioritised.

Women who needed additional monitoring in the antenatal period were admitted to the antenatal ward which was close to other antenatal services. It included an area that was dedicated to induction of labour where staff could monitor women closely. The rounding tool monitored if women waited longer than 24 hours and 48 hours. At the time of inspection three women had waited more than 24 hours but no women waited longer than 48 hours.

The service had an escalation policy to guide staff when the service was challenged; however, it did not include the birth centre. The rounding tool used twice daily identified any concerns across the service and also confirmed that all safety checks had been completed for each area.

Emergency equipment was a combination of trolleys that were security tagged and others that were covered only. Audits of resuscitation trolleys were completed in 2021. Trolleys in triage and labour ward were assessed as passed in August 2021 and the birth centre was assessed as passed in March 2021. The antenatal trolley was assessed and failed in November 2021, there was no audit reported for the obstetric theatre and all trolleys were passed their planned date for re-audits.

In the event of an emergency, one of the lifts included technology that meant the lift was recalled immediately to help prevent further delay.

Midwifery staffing

The service did not always have enough maternity staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank staff a full induction.

The service did not always have enough nursing and midwifery staff to keep women and babies safe. Managers had been completing an acuity tool. However, it had been identified that this was an outdated tool that was not appropriate for their needs. This was discontinued during the onsite visit.

Staffing numbers were displayed daily on entrances to ward areas, on 'open and honest care boards' for women and visitors to view.

Managers adjusted staffing levels dynamically according to the needs of women. At 8am and 2pm daily, 'rounding' took place. A co-ordinator for one of the maternity wards was allocated to visit each area and review information about staffing numbers and skill mix as well as the numbers of women and babies including acuity levels. Based on the information, a rag rating was assigned that was aligned to the regional acuity tool. Staff redeployed were identified and recorded. There were plans to change this process to a dedicated unit co-ordinator, who would be contactable by bleep, to allow maternity staff to continue other duties.

At the time of inspection midwives from the birth centre supported the labour ward if it was deemed appropriate to maintain safe staffing levels. This meant that there were times when the birth centre needed to close. In the event of a closure, a woman assessed as low risk who had chosen to attend the birth centre was then required to attend the labour ward.

There were plans to link the birth centre with community midwives so that staff could rotate into the birth centre to maintain safe numbers of midwives and support maintaining appropriate skills.

There were staff identified as core staff and other staff that were rotational. The rotational midwives tended to be those who were completing preceptorship programmes. Preceptorship is a structured period of transition that develops the newly qualified midwife from student to an accountable midwife able to work confidently to the Nursing and Midwifery Council's (NMC) Code.

Posters indicated the grades of staff for women and their visitors.

Midwives we spoke with understood the challenges in recruitment and expressed that an increase in non-registered staff would assist them with certain tasks. This meant the midwives could utilise their skills appropriately.

The service employed regular bank staff to support any shortfalls in numbers.

Volunteers had recently been re-introduced to the service and helped where needed to support the staff.

We were provided with staffing data for the antenatal ward, labour ward and postnatal ward from January 2022 to July 2022. There was no data for May 2022. For registered midwives, during the day, there was an average of 88.2% fill rate across the three areas. For non-registered staff, during the day, there was an average of 80.2% fill rate.

At night time, for registered midwives, there was an average fill rate of 97.6%. For unregistered staff, at night time the average fill rate was 92.1%.

The establishment of midwives was 191.03 whole time equivalent (WTE) midwives. There was 181.62 in post, at the time of inspection, with a vacancy rate of 4.93%. The service was in the process of recruiting six WTE midwives.

Information from the trust included turnover figures. Between February 2022 and July 2022 there was an average turnover of 12.9%. Sickness information, for the same time period, was an average of 8.7%. However, this data referred to maternity services so not clear if it included medical and midwifery staffing.

All staff we spoke with considered that an increase in non-registered staff would help to release midwives to apply their skills appropriately. Senior leaders told us that they were considering using registered nurses to support in areas such as caring for women following a caesarean section.

Senior leaders were reviewing how staff were utilised on the wards and considering teaming up health care assistants with midwives with responsibilities for an allocated group of women. Senior leaders told us they would be interested to support recruitment from the locality.

Medical staffing

The service had enough medical staff with the right qualifications, skills and experience to keep women and babies safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave locum staff a full induction.

Senior leaders told us the service had enough medical staff to keep women and babies safe.

Senior leaders told us that there were sufficient senior doctors to manage the service. The service had employed three long-term locum consultants. Junior doctors were required to support gynaecology and the emergency department in addition to maternity services.

We requested information about the establishment of medical staff including numbers in post, however; did not receive this.

The service had a good skill mix of medical staff on each shift and reviewed this regularly.

There was a doctor assigned to triage and a dedicated maternity anaesthetist to attend any deliveries in theatre.

There were daily consultant ward rounds, including weekends, that began on labour ward prior to rounds on the antenatal ward and the postnatal ward and we observed a round on the labour ward.

The service always had a consultant on call during evenings and weekends. Staff we spoke with told us that doctors were readily available if needed.

Records

Staff kept detailed records of women's care and treatment. Records were clear, up-to-date, stored securely however not always easily available to staff providing care as a combination of paper and electronic.

Women's notes were comprehensive and all staff could access them although in different formats.

Women carried their own 'green notes' during the antenatal period. Records, by midwives, were a combination of electronic and paper.

There were plans for a dedicated electronic maternity system to be introduced that was in line with other maternity providers. Phase one was planned in November 2022, for antenatal and community staff. Phase two was planned to follow for in-patient services.

When women transferred to a new team, there were no delays in staff accessing their records.

Paper records were stored securely in trolleys. Electronic records were password protected.

Medicines

The service did not always use systems and processes to store and administer medicines safely.

Pharmacy staff worked with the multidisciplinary teams to support the safe use of medicines during pregnancy and postnatal care. They facilitated discharge prescriptions from the postnatal ward to expediate discharges and reduce the number of women going home and returning to collect their medicines.

Policies supported community midwives with management of medicines when attending homebirths. The pharmacy team and birth centre were working together to improve the transporting of medicines by the community midwives. The development of an Obstetrics Antibiotic Policy had also been identified as a priority to support staff with appropriate prescribing of antimicrobials for the treatment of infections. The trust had an electronic prescribing and medicines administration system (EPMA).

In the postnatal ward, medicines were not always kept at the right temperatures, the temperature of the room where medicines were stored was regularly above 25oC. There was an emergency trolley for neonatal resuscitation on the ward, fluids and flushes were stored in small plastic boxes, one box was only tagged on one side, therefore, there was a risk the contents could be tampered with. This was actioned at the time by a midwife. Emergency trolley checks were not being completed daily. We observed that it had not been recorded as completed on third and fourth of August 2022.The pharmacy staff completed a ward 'top up' of stock levels.

There was a pharmacy team based on the ward, they facilitated discharge prescriptions from the postnatal ward to expediate discharges and reduce the number of women going home and returning to collect their medicines. However,

we observed that a number of discharge medicines were awaiting collection from the ward. They were kept for a week then returned to pharmacy. Staff on the ward had access to a supply of medicines to dispense to patients out of hours when the pharmacy was closed. Pharmacy staff were available to support with medicine related queries including prescribing of antibiotics.

In the labour ward, the system for checking of expiry dates within the sepsis box was confusing as there was more than one recording chart in place; one chart indicated there were out of date items within the box. When opened, all items inside the box were within their expiry date. Access to a sepsis box will promote swift treatment. We found that processes in place to check medicines had not expired were not always followed. One medicine that has a shortened expiry once opened; did not have the open date recorded. We also found one medicine was administered on three occasions when it was past its expiry date. This was brought to the attention of the Matron to be investigated promptly. Controlled drugs were kept securely; a recent controlled drugs incident had been appropriately investigated. Controlled drugs were checked twice daily, and records made of administration.

Policies supported community midwives with management of medicines when attending homebirths, random checks were completed by team leaders for expiry dates. The pharmacy team and birth centre were working together to improve the transporting of medicines by the community midwives. Community midwives collected cannisters of medical gases on their way to the patient, there were no stickers or bags for safe transport in cars. The home birth guideline states cylinders should be stored securely in the vehicle in a position they cannot freely move or collide with each other. Staff linked in with patient's own GP, or urgent care provider if they identified antibiotics were needed when women were seen at antenatal clinic. A process was being developed to have medicines dispensed at the hospital pharmacy and collected from there.

Staff completed medicines management training. Compliance for midwives was 75% and 83% for medical staff against a target of 90%.

Audits were completed to demonstrate the safe and secure storage of medicines. One maternity ward showed an improvement in the safe storage of medicines in July 2022 compared to June 2022. Two wards showed a decline in the audit results for the same time period. Monthly audits of medicine management, 'safe and secure', were completed. In March 2022, compliance was 89% on the antenatal ward and 90% in the labour ward. In June 2022 compliance was 89% on the antenatal ward, 84% on labour wad and 86% on the postnatal ward.

Medicines reconciliation was completed by pharmacy staff and records showed the trust target of 50% in 24 hours following admission had been achieved. However, this target was not compliant with the current guidance National Institute for health and Care Excellence (NICE) guidance which indicates 100% of patients' medicines should be reconciled within 24 hours or sooner if clinically necessary. This meant staff could not always be assured they had a complete understanding of the medicines each patient took and the potential impact on their diagnosis and treatment.

We observed that there were babies, such as those in transitional care, who had been prescribed intra venous (IV) antibiotics for periods of up to 10 days. The ward co-ordinator was responsible for the administration of the IV antibiotics dependent on the prescription. Some were administered by staff from the neonatal unit. The process was being reviewed to have more involvement from the transitional team based in the neonatal intensive care unit (NICU). The guidelines for the management of the late preterm neonates within maternity services had been reviewed in June 2022. There was an emphasis on monitoring and prevention of complications rather than active treatment.

Incidents

Maternity

The service managed safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents although did not always ensure that shared lessons learned were understood for the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. The trust used an electronic reporting system. Staff raised concerns and reported incidents and near misses in line with trust policy.

The service had declared two never events; however, these were reviewed and reported as serious incidents and not never events by an external stakeholder. Never Events are serious incidents that are entirely preventable because guidance or safety recommendations providing strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.

Staff reported serious incidents clearly and in line with trust policy. Senior leaders told us that all the previous days incidents were reviewed by the governance team and the senior midwife in order to highlight any immediate actions required.

Between February 2022 and July 2022, the trust told us that there were 1,317 incidents for the service. Of these 1,104 involved women, 52 were for staff, 157 were organisation related and three involved visitors. There were no details about grading of incidents or level of harm. There were 812 categorised as maternity and neonatal incidents. There were 156 incidents related to records and 68 were staffing related issues. We requested copies of serious incident investigation reports for women. However, did not receive any information to review. There were serious incidents, for babies, reported to Healthcare Safety Investigation Branch (HSIB). We were told that there was a total of 49 referrals that had been made. Of these, 17 were rejected, 27 investigations have been completed and five were active cases. These investigations had either been completed or rejected between April 2020 and July 2022. We were provided with copies of completed investigations that included findings and any safety recommendations. The service had received feedback from HSIB that staff had not always felt supported following serious incidents. In response to the feedback, the service had introduced 'hot' and 'cold' briefs. The HSIB maternity investigation programme is part of a national action plan to make maternity care safer. They undertake independent maternity safety investigations to identify common themes and influence systemic change.

Staff we spoke with told us they received feedback from investigation of incidents that they reported. Lessons learned were shared in huddles and via email; however, it had been identified that learning was not always taking place for making improvements to women's care. There were plans to introduce a newsletter as part of sharing information.

Staff understood the duty of candour. They were open and transparent and gave women and families a full explanation if and when things went wrong.

Managers investigated incidents thoroughly. Women and their families were involved in these investigations. Monthly perinatal morbidity and mortality meetings were held where case studies were reviewed and lessons learned shared.

Is the service effective?

Requires Improvement

Maternity

Since we last carried out a comprehensive inspection of this service, they have become part of a newly formed NHS trust. As such we cannot compare previous ratings with this one. We rated effective as requires improvement.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Staff protected the rights of women subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance. The service's audit team reviewed any updates in national guidance and reviewed policies to reflect changes. We reviewed a range of policies and guidelines that were all within their review days with the exception of the sepsis policy. This had been extended to March 2022 from 2021 and we were told the service was awaiting the introduction of an additional national maternity early warning system.

Trust policies were available on the trust's website for staff and the public to view. These were the latest versions of the policies. The trust operated a central online policy hub. However, during our inspection of the core services, we found that some services were using legacy policies from the previous trusts or accessing a suite of policies separate to the central Northern Care Alliance hub. As part of our ongoing monitoring of the trust, and throughout the inspection, we found there was a need to align some legacy Salford and Pennine policies to ensure there were trust-wide versions that reflected national or best practice guidance where appropriate. The service was in the process of reviewing guidelines to ensure they were robust and effective. It was also reviewing how information was shared with staff to ensure they had the most current information available.

The service completed audits for avoiding term admissions into neonatal units (ATAIN). ATAIN is a programme of work to reduce harm leading to avoidable admission to a neonatal unit for infants born at term, i.e. more than 37 +0 weeks gestation. Meetings in January 2022, February 2022, March 2022, April 2022 and July 2022 identified common themes such as not following the hypoglycaemia policy. Hypoglycaemia is low blood glucose levels. Other themes identified included babies with hypoxic-ischaemic encephalopathy (HIE) that had been referred in from another trust. HIE is when a baby's brain does not receive enough oxygen and/or blood flow around the time of birth. Acquiring documentation to audit was identified as a challenge as well as senior medical review. Staffing challenges have impacted on continuity and the service.

Policies were available for staff to refer to for 'Neonatal Hypoglycaemia in the Full Term Infant; Identification and Management of' and 'Care of the Late Preterm Infant (35+0-36+6weeks gestation) within Maternity Services' to support staff.

There was a process for the management of post-partum haemorrhage; however, the service had identified that they were an outlier for post-partum haemorrhages (PPH). As part of the maternity improvement programme the service was introducing the Wales pathway. The Wales pathway was a tool developed for the management of a PPH. It indicated which pathway to follow dependent on the measurement of accurate blood loss using a rotational thromboelastometry (ROTEM) machine. ROTEM provides an assessment of the efficiency of blood coagulation at the point-of- care (POC).

Staff protected the rights of women subject to the Mental Health Act and followed the Code of Practice. There were perinatal mental health midwives available to support staff and women.

At handover meetings, staff routinely referred to the psychological and emotional needs of women, their relatives and carers. We observed handovers on antenatal, labour and postnatal wards and saw that both physical and mental wellbeing was discussed.

Senior leaders were introducing monthly trust “shine walkarounds” reviewing a range of areas such as equipment and infection prevention and control. They were planning to hand over responsibility of these checks to ward managers who could peer review other areas for their oversight.

Nutrition and hydration

Staff gave women enough food and drink to meet their needs and improve their health. The service made adjustments for women’s religious, cultural and other needs.

Staff made sure women had enough to eat and drink, including those with specialist nutrition and hydration needs. Drinks machines were available for women and their partners to access in all areas. The service included kitchen facilities where meals could be prepared outside of recognised meal times.

The service had been accredited with the United Nations Children's Fund (UNICEF) UK Baby Friendly programme but this was suspended at time of inspection. Staff we spoke with told us that this had not been a priority for the service at the time of inspection. The UNICEF UK Baby Friendly Initiative enables public services to better support families with feeding and developing close and loving relationships so that all babies get the best possible start in life.

The service monitored the initiation of breast feeding. Between October 2021 and June 2022 there was on average 61% of women who breast fed their baby. The England standard was 65% and the regional median was 64%.

The service had an infant feeding team who were available to support staff in supporting women re positioning, latching and expressing. Staff could refer women to the team. However, if the team were not immediately available women may not continue with breast feeding and use bottles instead. Cups, for feeding babies, were available but not used. Cups help to assist with breastfeeding and it is considered beneficial to use a cup rather than a bottle with a teat. Cup feeding encourages a baby to use their tongue and lower jaw in a similar way as they would when breastfeeding. The postnatal ward had access to breast pumps. However, there was no breast feeding room except for in the hospital restaurant. Expressed breast milk was either stored in a dedicated milk fridge in a locked room or taken directly to the neonatal unit.

National breast feeding week was the week prior to the inspection. We observed bunting, in languages other than English, and posters to promote the week throughout the department. In the antenatal clinic pouches could be taken away that contained colostrum kits.

The maternity voices partnership (MVP) told us that women had shared with the MVP that support for breast feeding on the postnatal ward was not always available particularly in the evenings and at weekends. Women had recognised that staff were busy and were reluctant, at times, to request support. The MVP had been told that breast feeding had not been one of the service’s priorities. In the community women had accessed a volunteer group to support women. Over the whole service, there was some variations in the level of support available in the community. The value of peer support was shared.

Pain relief

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

Staff assessed women's pain using a recognised tool and gave pain relief in line with individual needs and best practice. Women received pain relief soon after requesting it. Staff prescribed, administered and recorded pain relief accurately. Women had access to an epidural if required in a timely manner.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They had not always used the findings to make improvements or achieve good outcomes for women.

The service monitored outcomes for women and families and reported these in a maternity dashboard. Between October 2021 and June 2022, 45% of births were in the labour ward, 43% were in theatre, 10% were in the birth centre and 2% were home births. There were 51.2% of births that were spontaneous, 7.1% were forceps deliveries and 3.6% were vacuum deliveries. There was 39.3% of births by caesarean section. Of these, 14.7% were elective sections. The regional median was 14.4%. There were 24.6% of caesarean sections that were non elective. This compared to a regional median of 19.5%. The two highest reasons for requiring a caesarean section were when the woman had needed a previous section or if the cardiotocograph (CTG) showed abnormal readings.

For the same period there were 1318 inductions of labour. This was an average of 146 per month which was 35%. The England average was 27.9% and the regional median was 37.2%.

There were 209 babies born at term who needed admission to the neonatal unit, with an average of 23 per month. This was lower than the regional average of 36 term babies each month.

Senior staff had identified that the service had a higher than average preterm birth rate and was an outlier for stillbirths. Between October 2021 and June 2022, there was an average of 11.2% of babies born at less than 37 weeks gestation. For the same time period there were 24 stillbirths. The average for the trust was 5.4 per month, compared to an England average of 4.2 and a regional average of 4.4 per month. Of these stillbirths some had been identified as early losses, some termination of pregnancy for fetal anomalies and some late gestation intra uterine fetal deaths. The service had identified themes from these losses including appropriate escalation when assessed risk had changed antenatally.

The service monitored hypoxic-ischaemic encephalopathy (HIE). Hypoxic-ischaemic HIE is when a baby's brain does not receive enough oxygen and/or blood flow around the time of birth. Between October 2021 and June 2022 there had been four babies who had experienced HIE. This was higher than the regional median which was one each month.

For term babies who were found to weigh below the third centile, there was an average of 2.4% of births for the same time period. The regional median was 14.4%. If a baby is on the third percentile, this means that only 3 out of 100 are below.

The service had identified that intermittent auscultation documentation did not always correspond to times of contractions and were in the process of auditing records. Intermittent auscultation (IA) is the technique of listening to and counting the fetal heart rate for short periods during active labour. We were told that an audit was planned, at the time of inspection; results to be shared when available.

The service had recognised an increasing number of placenta accreta and were monitoring this. Placenta accreta occurs when all or part of the placenta attaches abnormally to the uterine wall. Between October 2021 and June 2022, there were five women who had experienced a uterine rupture and three women who required post-partum hysterectomies. There were two high dependency rooms in the labour ward where 56 women had received care for the time period above, with four women requiring extra support in the hospital's intensive care unit. For post-partum haemorrhages 92.2% were measured as less than one litre, 6.1% were between one and one and a half litres, 1.5% were between one and a half and two and a half litres and 0.3% were greater than two and a half litres. Senior leaders told us their main concerns on the dashboard were post-partum haemorrhage and stillbirth. The services maternity improvement programme plans included a governance workstream. This indicated that the service had Implemented their revised best practice approach to serious incident reviews as well as the introduction of the Wales pathway.

There was an average of seven third and fourth degree tears each month, for the same time period. This was an average of 1.8% compared to the regional median of 2.9% monthly.

The new management team and staff were monitoring their data to improve women's outcomes. Managers and staff investigated outliers and were implementing local changes to improve care.

Minutes from maternity voices partnership meetings included any changes in outcomes such as reporting a reduction in induction rates for women.

Competent staff

The service had not made sure staff were competent for their roles. Managers had not always appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced and qualified although had not always completed the necessary updates to ensure they had the right skills and knowledge to meet the needs of women.

Managers gave all new staff a full induction tailored to their role before they started work.

A practice educator had been appointed to manage the mandatory training and competencies for all staff including midwives and medical staff. The senior midwife had identified that the training programme was not sufficient to meet the needs of the Ockenden recommendations.

Training was being re-launched in September 2022. It was proposed that it would be a multidisciplinary approach for skills and drills and Practical Obstetric Multi-Professional Training (PROMPT) with simulations and community specific elements. We were provided with copies of competency assessments for intra partum fetal monitoring and intermittent auscultation. The PROMPT course covers the management of a range of obstetric emergency situations. It contributes to the training standards for the Clinical Negligence Scheme for Trusts (CNST) in England. At the time of inspection, the compliance with PROMPT training was 72% for midwives and 49% for medical staff.

Weekly training for cardiotocography (CTG) had been established where individual women were discussed and was available for any staff to attend. Cardiotocography is a technique used to monitor the fetal heartbeat and the uterine contractions during pregnancy and labour. The machine used to perform the monitoring is called a cardiotocograph. At the time of inspection, the compliance with CTG training was 50% for midwives and 66% for medical staff.

Staff who supported in theatre were independent of maternity services. A training booklet was being developed to train theatre staff to support women and their partners in the obstetric theatre.

Staff were being assigned to training and there was an expectation that this time was protected to complete mandatory requirements. There were posters displayed to support learning such as sepsis and cord management.

Band five midwives we spoke with expressed concerns that due to staffing issues they were delayed in achieving competencies required to progress to a band six. However, they reported that recently there had been more support from the practice education facilitators (PEFs) and other midwives in the service.

The trust provided appraisal rates for staff. The service had professional midwifery advocates (PMAs) available. For community midwives, 82% of staff had completed an appraisal. On the birth centre it was 62% of staff. There were 57% of specialist midwives and 52% of labour ward staff who had completed their appraisal. On the antenatal ward 27% of staff had completed an appraisal and no one in the antenatal clinic. For the postnatal ward, 20% had completed an appraisal and 15% in triage. There were no medical staff who had completed an appraisal.

Multidisciplinary working

Doctors, midwives and other healthcare professionals worked together as a team to benefit women. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss women and babies and improve their care.

Staff referred women for mental health assessments when they showed signs of mental ill health or depression. There were perinatal mental health midwives who were contactable for guidance and support.

Seven-day services

Key services were available seven days a week to support timely care.

Consultants led daily ward rounds on the labour ward, including at weekends. Women were reviewed by consultants depending on the care pathway.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week.

Specialist midwives and the antenatal day unit were available during week days. Triage was open 24 hours a day.

Health Promotion

Staff gave women practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards/units.

Staff assessed each woman’s health when admitted and provided support for any individual needs to live a healthier lifestyle.

Maternity

The antenatal clinic had a range of information to support women during their pregnancy. These included carbon monoxide monitoring, fetal monitoring, baby movements, baby vision, safer sleep, skin to skin, how to cope with a crying baby, infant feeding and breech presentation.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff supported women to make informed decisions about their care and treatment. They followed national guidance to gain women's consent. They knew how to support women who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit women's liberty.

Staff understood how and when to assess whether a woman had the capacity to make decisions about their care.

Staff gained consent from patients for their care and treatment in line with legislation and guidance.

The trust told us that there was no specific training for Mental Capacity Act and Deprivation of Liberty Safeguards although it was included as part of safeguarding training requirements.

When patients could not give consent, staff made decisions in their best interest, taking into account women's wishes, culture and traditions.

Staff made sure women consented to treatment based on all the information available.

Staff clearly recorded consent in the woman's records.

Staff understood Gillick Competence and Fraser Guidelines and supported children who wished to make decisions about their treatment.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice.

Specialist midwives including perinatal mental health, Rochdale and Oldham midwifery enhanced service (ROMES) team and safeguarding midwives were approachable and available to provide guidance and support both to women and staff. Their roles included caring for women who had been identified as possibly needing additional support such as younger mothers.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards.

Is the service caring?

Good

Maternity

Since we last carried out a comprehensive inspection of this service, they have become part of a newly formed NHS trust. As such we cannot compare previous ratings with this one. We rated caring as good.

Compassionate care

Staff treated women with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for women. Staff took time to interact with women and those close to them in a respectful and considerate way.

Women said staff treated them well and with kindness.

Staff followed policy to keep women's care and treatment confidential.

Staff understood and respected the individual needs of each woman and showed understanding and a non-judgmental attitude when caring for or discussing women with mental health needs.

The service monitored skin to skin contact between the mother and her baby. Between October 2021 and June 2022, 74.6% of women were reported to have experienced initial skin to skin contact as part of the bonding process. The median for the region was 79.1%.

Staff understood and respected the personal, cultural, social and religious needs of women and how they may relate to care needs.

We requested details about feedback from women and families about care received either in surveys or the NHS Friends and Family test; however, the data received was for women's and children's services rather than individual services. The NHS Friends and Family Test (FFT) was created to help service providers and commissioners understand whether patients are happy with the service provided, or where improvements are needed. It's a quick and anonymous way to give views after receiving NHS care or treatment. Between February 2022 and July 2022, the average score for recommending women's and children's services was 75.3%; however, there was no data for April 2022 and May 2022. The average response rate was 18.6%.

We spoke with the maternity voices partnership for feedback about women receiving care locally. We were told that women were very positive about the care they received from all staff at the trust.

Feedback we received from the trust was generally very positive about the staff and the service. Thank you cards from families were displayed in ward areas.

Emotional support

Staff provided emotional support to women, families and carers to minimise their distress. They understood women's personal, cultural and religious needs.

Staff gave women and those close to them help, emotional support and advice when they needed it.

Staff supported women who became distressed in an open environment and helped them maintain their privacy and dignity.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

Posters were displayed to indicate the date for the annual baby memorial service planned for October 2022.

Understanding and involvement of women and those close to them

Staff supported and involved women, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure women and those close to them understood their care and treatment.

Staff talked with women, families and carers in a way they could understand, using communication aids where necessary.

Women and their families could give feedback on the service and their treatment and staff supported them to do this.

Staff supported women to make advanced decisions about their care.

Staff supported women to make informed decisions about their care.

Women gave positive feedback about the service.

Is the service responsive?

Good

Since we last carried out a comprehensive inspection of this service, they have become part of a newly formed NHS trust. As such we cannot compare previous ratings with this one. We rated responsive as good.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services so they met the needs of the local population. Between October 2021 and June 2022, there were 3,774 births at the trust. This was an average of 419 births per month. Of these, 641 were homebirths with an average of 71 births a month. For the same period last year there was a total of 3,622 births.

Antenatal services included a range of specialist clinics. There were midwifery led clinics in the local communities such as in children's centres or GP surgeries as well as in the hospital. There were consultant led clinics in the hospital for women who were assessed as needing additional monitoring. These included a preterm clinic, diabetic, twins, renal, endocrine, anaesthetist clinic, specialist midwifery teams and anti-D. (Anti-D neutralises any RhD positive antigens that may have entered the mother's blood during pregnancy. If the antigens have been neutralised, the mother's blood won't produce antibodies.)

The service had systems to help care for women in need of additional support or specialist intervention. Staff could access emergency mental health support 24 hours a day 7 days a week for women with mental health problems, learning disabilities and dementia.

Managers ensured that women who did not attend appointments were contacted.

The service had employed midwives for continuity teams. However, at the time of inspection there was a re-organisation of midwives focusing on safe provision in the hospital. This was in line with a national directive. Midwives we spoke with and the maternity voices partnership expressed a concern that the lack of continuity may affect personalised care.

The maternity voices partnership told us that they had completed a 15 steps exercise with the service to experience what the women may encounter. They made suggestions regarding signage; some did not appear to be in the right place and wondered if there could be pictorial representation for those having difficulties reading signs.

There were posters to display the trust's spiritual care team showing representatives from a range of faiths.

A public phone was available to call for a taxi if needed. A team of dedicated staff had added artwork to the service in public areas for all to view that was colourful and welcoming.

Meeting people's individual needs

The service was generally inclusive and took account of women's individual needs and preferences. Staff made reasonable adjustments to help women access services. They coordinated care with other services and providers.

Staff made sure women living with mental health problems and learning disabilities received the necessary care to meet all their needs. Staff supported women living with learning disabilities by using a personalised document; reasonable adjustments form to inform staff about their needs.

Staff understood the policy on meeting the information and communication needs of women with a disability or sensory loss. However, we did not see a hearing loop. The service had information leaflets available in languages spoken by the women and local community. Leaflets in languages other than English could be sourced from the trust or downloaded from the website. The trust's website had accessibility tools.

Managers made sure staff, women, families and carers could get help from interpreters or signers when needed. We observed an interpreter supporting a woman when speaking with clinical staff on the postnatal ward. An interpreter was based in the antenatal clinic daily, who spoke Urdu. A trust wide telephone interpreter service was available if needed along with cordless phones.

A phone application was available, that was bespoke to the trust's needs. A QR code could be scanned for information translated into versions other than English. The antenatal clinic displayed posters to request feedback about care. There were a number of these in languages other than English.

Women were given a choice of food and drink to meet their cultural and religious preferences. The postnatal ward had a kitchen where food was prepared and served from.

There were four transitional care beds on the postnatal ward. This meant that women and babies needing some extra support could be cared for together. Staff on the ward were supported by the transitional care team who were based on the neonatal intensive care unit (NICU).

Antenatal staff carried out clinics in children's centres where school nurses and health visitors had offices. They liaised with these health professionals as needed.

There was a range of specialist midwives who provided support for different needs. These included safeguarding, Rochdale and Oldham midwifery enhanced service (ROMES), specialist team for younger mothers (YAP), perinatal mental health, fetal monitoring, infant feeding, bereavement, smoking cessation and governance.

There was a designated bereavement suite (butterfly) within the labour ward. There was a dedicated entrance to the butterfly suite, for families who had experienced a loss, located away from the birthing rooms. The trust had participated in the pilot for the National Bereavement Care Pathway and had continued the pathway formally including the 9 standards such as emotional and mental health support, access to a specialist and a dedicated area.

The maternity voices partnership was positive about the provision of services for local women particularly those identified from a black, Asian or minority ethnic background. There was a concern that not all groups were being captured such as those who women from eastern European countries. There was a positive recognition for the Rainbow clinic and mental health provision. However, there was a concern that there may be a need for extra support for women with a sensory impairment or learning difficulty.

The service had contacted local community leaders to discuss the findings of investigations of some stillbirths at the hospital. It was identified that some of the parents were consanguineous marriages. Consanguine marriage is marriage between individuals who are closely related. This meant there may be an increased risk of serious harm to a baby.

Access and flow

Women could access the service when they needed it and received the right care promptly.

The service monitored the number of women that had undergone an initial booking risk assessment for their pregnancy by 12 weeks and six days. Between October 2021 and June 2022 there was an average of 86.1% of women booked in. The England standard was 90% with a regional median of 90.5%. The service recorded one to one care in established labour. For the same time period there was an average of 94% of women compared to the regional average of 96.9%. All the midwives we spoke with said that women in established labour would be their priority .

The service monitored did not attend rates for antenatal clinics. Between February 2022 and July 2022, there was an average of 7.7% of women who did not attend. We requested any action plans on how the service was aiming to reduce the figure, but did not receive any.

Managers monitored that moves for women between wards or trusts were kept to a minimum. The service was part of the Greater Manchester network of maternity services. There was a process of providing mutual aid. There had been two unit closures reported in April 2022 .

The service moved women only when there was a clear medical reason or in their best interest. Staff supported women and babies when they were referred or transferred between services.

The trust included a regional neonatal unit. This meant that women and babies could be transferred in from other district general hospitals if specialised care was required. We were told that women had been admitted from a wide range of areas across England and Wales. For bonding purposes women and their babies were cared and treated together in the hospital. There was limited 'rooming in' available on the neonatal unit which meant women would be admitted to the postnatal ward.

Managers and staff started planning each woman's discharge as early as possible. Staff planned women's discharge carefully, particularly for those with complex mental health and social care needs.

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included women in the investigation of their complaint.

We saw information for women and their families to provide feedback. However there were no posters or leaflets seen in the service about how to complain or raise concerns. Staff understood the policy on complaints and knew how to handle them.

Between February 2022 and July 2022, there had been 34 complaints for the maternity service. Of these the average compliance rate for meeting the trust's response target was 80%. However, there had been 100% compliance in March and April. There were an additional 19 concerns received by the patient advice and liaison service (PALS).

We reviewed three complaint responses. These were responded to comprehensively and empathetically within appropriate time frames that reflected the complexity of the complaints.

Staff knew how to acknowledge complaints and women received feedback from managers after the investigation into their complaint. Managers investigated complaints and identified themes.

Learning from complaints was shared with staff. Themes of complaints were mainly communication related or reminders to ensure staff were aware of any changes in any processes.

Is the service well-led?

Requires Improvement

Since we last carried out a comprehensive inspection of this service, they have become part of a newly formed NHS trust. As such we cannot compare previous ratings with this one. We rated well-led as requires improvement.

Maternity

Leadership

Newly appointed leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Prior to the onsite inspection, there had been some changes in leadership. The service did not have a Director of Midwifery (DOM). Despite multiple attempts to recruit, the service had not appointed a DOM. The trust had appointed a Deputy Director of Midwifery (DDOM) with the successful candidate taking up the role in June 2022. Since undertaking the role, it was noted that there was no Head of Midwifery (HOM), with the DDOM taking on those responsibilities as the most senior midwife for the service.

The DDOM was the safety champion for the service and the trust Director of Nursing (DON) was the trust maternity safety champion. There was a non-executive director (NED) identified to support maternity services. When we spoke with staff they were not aware of who had responsibilities for these roles.

Senior leaders had carried out four walkarounds through the in-patient areas to increase visibility and awareness of senior leadership and spoke with staff about any concerns they wanted to raise. Senior leaders were in the process of completing posters in order to feedback the outcomes to staff. The senior leaders told us they valued the staff and had attended a multi-disciplinary away day to help support staff engagement.

The community lead midwife had recently joined the trust. We were told that she was visible and had located her office near to community and antenatal staff at Oldham. This was welcomed by the staff. The community lead had responsibilities for the antenatal clinic. However, an additional lead was being recruited to take on the role of antenatal lead.

Senior leaders felt supported by the executive team. There was a focus on maternity services in the trust. The maternity improvement plan was well supported by the organisation and the trust.

Vision and Strategy

The trust had a vision for what it wanted to achieve and a strategy to turn it into action. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders understood and knew how to apply them and monitor progress.

The trust's mission was saving lives and improving lives. Their vision was: “to be the safest and most effective organisation in the NHS and the place where people want to work. We are passionate about tackling inequalities and improving health outcomes and experiences in all our places.”

There had been changes in senior management, for the service, prior to the onsite visit. Staff we spoke with were not able to articulate what the trust’s vision and strategy were. We requested a copy of the vision and strategy, for the service, but did not receive this information.

Maternity had been a focus in the organisation’s development strategy. Maternity services had the strategic objective of clinical and operational excellence. There were six diagnostic workstreams of people, service users, clinical governance, data, clinical standards and assurance and digital. There were two delivery workstreams set up to support flow and safe staffing.

Maternity

Culture

Staff did not always feel respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service did not always have an open culture where patients, their families and staff could raise concerns without fear.

Staff we spoke with told us that there was good teamwork in their regular area of work. Staff enjoyed working in the service and were committed to providing the best care to women, families and babies. Staff were required to move areas at times in order to prioritise safety for women and their babies. However, we heard that staff found some areas challenging to work in, when moved. We were told that junior midwives who were rotational could be moved and they did not always feel valued. This had been recognised and, at the time of inspection, there had been an increase in support from practice education facilitators. (PEF's). A PEF team support staff with professional; development and education particularly with preceptorship midwives.

Staff we spoke with told us that senior managers had carried out 'walkabouts' in the service and spoken to staff. We were told the Director of Nursing (DON) for the hospital had an open door policy. A culture survey had taken place. This had identified some areas of concern with staff referring to a blame culture where behaviours needed to be addressed and a lack of cohesiveness across the department. A number of focus groups had taken place to explore the outcome of the survey and work had started to resolve some issues. One point identified was that opportunities were limited to certain people. The selection process has been reviewed to demonstrate fairness with an obstetrician and midwife on the recruitment panel for all posts.

The birth centre had been linked with the labour ward. Staff told us that if labour ward was busy they were asked to support there. This meant the birth centre would need to close and any labouring woman who had planned to go to the birth centre would need to give birth in the labour ward. Staff told us that they did not always feel valued and were being utilised as 'floaters'. At the time of inspection changes were being implemented that meant the birth centre was linked with community. Staff we spoke with felt this was a positive step.

There was a kindness collaboration prior to COVID and there were plans to re-visit this. An external independent investigation body had identified a theme of staff not feeling supported following serious incidents. The service had responded by introducing 'hot' and 'cold' briefs.

The staff survey response rate was 28.3%. This was the lowest for the care organisation and also included gynaecology. Many of the responses were below the trust average. Of the 92 questions, seven were better than the trust average. 93.4% of respondents said they 'Feel trusted to do my job'. The trust average was 90.4%. 90.1% said they: 'Feel my role makes a difference to patients/service users'. The trust average was 85.3%. There were 8% of respondents who said: 'Never/rarely find work emotionally exhausting'. The trust average was 21.3%

Governance

Newly appointed leaders operated effective governance processes throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities but not all had regular opportunities to meet, discuss and learn from the performance of the service.

The service had been part of the women and children's division. Services were reorganised so that maternity and gynaecology were stand-alone rather than included with all the services in the division. Some processes were in

transition such as the review of risk registers. There was a maternity improvement plan in progress. We reviewed a copy of the plan and saw that it involved a number of workstreams that included listening to communities, people and culture, governance, data, standards, staffing and training. Information from the trust had shown that compliance with appraisal rates and training requirements were below trust targets.

We requested copies of the action plans following the Ockenden review. We were told that the action plans were due to go to board in September and we did not receive this information.

The trust shared the feedback from an insight visit, completed in May 2022 to provide assurances in the progress of the action plan following the Ockenden report. A number of recommendations were highlighted that the trust was addressing.

Prior to the onsite inspection, there had been a restructuring of governance arrangements with two full time governance midwives with dedicated areas of responsibilities although supporting each other. Incidents were reviewed daily on the trusts electronic reporting system, any considered urgent were managed immediately. The governance team attended the daily huddle on the labour ward so were sighted on any incidents from the previous day.

There were multidisciplinary reviews of incidents graded as moderate or above twice weekly with updates requested from investigators.

Governance meetings were held weekly with agenda items that included any serious incidents, application of duty of candour, complaints, lessons learned, guidelines, audit and patient feedback. We reviewed copies of meeting minutes and noted that an agenda template was used to show attendees, apologies and any previous actions and minutes agreed.

The service linked with another neighbouring trust with the perinatal mortality review tool (PMRT). Mothers and Babies: Reducing Risk through Audits (MBRRACE-UK) has an online reporting form and is a data collection tool for national surveillance. The PMRT has been designed as a review tool to assist services in completing a structured, standardised and thorough review.

The service was part of the Greater Manchester network of maternity services and the dashboard was benchmarked across the network. There was a process of providing mutual aid. There had been no diverts prior to the inspection.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

The service maintained a risk register. Senior leaders told us their biggest risks on risk register were staffing, meeting Ockenden action plans and clinical negligence scheme for trusts (CNST) requirements for training compliance. We reviewed the service's risk register; each risk had controls in place with any gaps identified. Risks were scored including significant, serious, moderate or minor risk and had dates when last reviewed.

The service had been reviewing historical incidents and had identified a theme of missed histology samples, that had been reviewed and a process was put in place with a fridge on labour ward. Other themes were being reviewed including

appropriate antenatal pathways. The service had identified themes from serious incidents and were in the process of reviewing pathways to ensure they were robust and also ensure that any learning was shared and understood by clinicians. Themes included appropriate escalation when the risk level changed such as raised blood pressure or correct identification of growth anomalies.

Perinatal morbidity and mortality meetings were held monthly and were well attended by a multidisciplinary team of professionals. These were now focused on driving improvement. Outcomes for women and babies were discussed along with processes to support families through the pathway. Case studies were presented where lessons learned were highlighted.

In the July 2022 the learning form deaths report to the board, highlighted maternity services. It was reported that the trust was expecting to be highlighted as an outlier in the MBRRACE-UK Perinatal Mortality Report for 2020 births that is expected to be published in October 2022.

The trust noted a 60% increase in stillbirths in 2020 and completed a deep dive exercise. There were 20 in 2019 and this number had increased to 32 in 2020 but then reduced to 25 in 2021. The stillbirth rate per 1,000 births in 2020 for Greater Manchester was at 4.55 per 1,000 births. However, the trust was at 7.47. The data for 2019 included a neighbouring hospital that is no longer part of the trust. A thematic review of perinatal mortality via the perinatal mortality review tool (PMRT) from 2017 to 2022 was undertaken. Similar themes had been identified with 75% of stillbirths coded as unknown cause of death. The PMRT aims to support objective, robust and standardised reviews of deaths of babies (up to 28 days post birth) to provide answers for bereaved parents about why their baby died. The report highlighted the relevance of ethnicity, growth restrictions in babies and surveillance, smoking, maternal infections, medical complications, and babies with abnormalities.

Information Management

The service collected data and analysed it. However, some staff were not confident the data was always accurate. In addition, staff could not always find the data they needed in accessible formats to help them understand performance, make decisions and drive improvements. Data was not recorded or presented uniformly across the trust and some important data was not captured.

The information systems were secure. However, they were not always reliable or integrated well. On 18 May 2022 the trust experienced a major failure of some of its key information systems which affected Bury, Rochdale and Oldham care organisations. As a result, a critical IT incident was declared. The trust announced the issues were fully resolved on 20 June 2022. The failure disrupted diagnostic, pathology and pharmacy services, and referral pathways from GPs and primary care services.

The service completed a maternity dashboard. There was a local dashboard that benchmarked against other similar services across the region. The service had a requirement to submit data to the national maternity dashboard that was publicly accessible.

Staff accessed electronic records systems in the hospital and in the community. There were different processes in place that were changing with the introduction of the electronic record system. This was being introduced initially in the community and antenatally from November 2022, followed by the inpatient areas in January 2023. This system will ensure that records are stored in one location and available at each stage of the woman's pathway.

Staff were required to complete an information governance and data security module as part of mandatory training requirements. The target compliance level was 95%. For midwives, compliance was 89% and 90% for medical staff.

The trust told us that in the six months prior to inspection there had not been any information governance incidents that were reportable.

As part of the inspection process, data was requested and received from the trust. This was found to be not always timely or concisely presented.

Engagement

Leaders and staff actively and openly engaged with patients, staff, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Due to staffing challenges, we were told that staff often missed breaks or worked over their allocated shift times. On the postnatal ward staff could attend the 'ten at ten'. This was an opportunity for staff from across the service to meet up and share any specific concerns. Staff could speak with others but also enjoy tea and toast at that time.

The service included team meetings. We requested copies of minutes from the meetings, but did not receive this information.

Following the recent changes in management and the leadership team, 'walkarounds' had been completed in order to capture any feedback from staff either as a group or one to one. The leaders were cited on concerns of staff and focused on improving engagement with them.

Staff could access trustwide publications such as the weekly newsletter 'connect' and the seasonal magazine. The latest summer edition included news regarding the planned upcoming changes to maternity records systems and also referenced the response to the latest national maternity review. There were notice boards in staff areas to share information.

A maternity dashboard was in place. However, this was not shared with staff or women to view. There were plans for governance boards to be placed in all areas to show how the service was performing.

In many areas visited we viewed individual artwork that had been completed by a midwife, with contributions from families and was for any families, staff or visitors to view. We noted art and posters aimed at 'dads matter' including signposting to peer support. A number of knitted items had been donated by members of the public.

Parentcraft classes had stopped prior to COVID-19. There were plans to re-introduce but this was dependent on the capacity of staff.

The service had been engaging with the maternity voices partnership (MVP) with quarterly meetings via teleconference facilities. These had been well attended by a range of people that included midwives, medical staff, external stakeholders, charitable organisations and advocates for the service. There was a two-way dialogue of information sharing where any issues highlighted to the MVP could be raised with the service. We were told that going forward there will be monthly meetings with the chairperson and director of midwifery.

Learning, continuous improvement and innovation

Maternity

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The monthly trustwide 'Team brief' that was circulated to staff included any new processes such as referenced quality improvement programmes.

We noted posters displayed in all areas regarding national trials such as surfactant and GBS3. Surfactant is a mixture of fat and proteins made in the lungs. It coats the alveoli (the air sacs in the lungs where oxygen enters the body). This prevents the alveoli from sticking together when a baby breathes out. GBS3 trial is looking at whether testing pregnant women for Group B Streptococcus reduces the risk of infection in newborn babies.

Rochdale Infirmary

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www.northerncarealliance.nhs.uk

Description of this hospital

Northern Care Alliance NHS Foundation Trust was formed on 1 October 2021 when Salford Royal Hospital NHS Foundation Trust legally acquired Pennine Acute Hospitals NHS Foundation Trust.

The trust has four hospitals – Salford Royal Hospital, Royal Oldham Hospital, Fairfield General Hospital and Rochdale Infirmary which provide a full range of acute services, including acute medicine, urgent and emergency care, acute frailty units, rehabilitation services, dental services and surgical services, to a population of approximately 1 million people. The trusts had been working in partnership from 2016 until the acquisition. This included a shared executive leadership team.

When a trust acquires another trust in order to improve the quality and safety of care we do not aggregate ratings from the previously separate trust at trust level for up to two years. The ratings for the trust in this report are therefore based only on the ratings for Salford Royal Hospital and our rating of leadership at the trust level.

Our normal practice following an acquisition would be to inspect all services run by the enlarged trust. However, our usual inspection work has been curtailed by the COVID-19 pandemic.

At Northern Care Alliance we inspected only those services where we were aware of current risks. We did not rate the hospital overall.

In our ratings tables starting on page 30 we show all ratings for services run by the trust, including those from earlier inspections and from those hospitals we did not inspect this time.

Maternity and midwifery services for the Northern Care Alliance were managed from the Royal Oldham Hospital. Rochdale Infirmary provided an additional base for patients to access antenatal services and support from community midwives. The community midwives provided support with home-births as well as antenatal and postnatal care.

Rochdale Infirmary did not offer any birthing services on-site. Specialist midwives provided advice and support across both locations. These included safeguarding, perinatal mental health, enhanced needs teams, continuity teams, governance, bereavement and smoking cessation.

We carried out this focussed inspection as part of our inspection of the Northern Care Alliance in accordance with the methodology for our national maternity programme. The programme requires us to report on whether maternity services are safe and well-led only.

Our findings

- The service had not ensured that staff had all required training in key skills including resuscitation, safeguarding and Practical Obstetric Multi-Professional Training (PROMPT).
- There was equipment in all areas past scheduled maintenance check dates. There were not always enough registered midwives or care staff to care for women and babies. There was some concern about medicines management including medical gases. Care was recorded either electronically or on paper dependent on which part of the pathway was at.
- The service was not accredited with the UNICEF's baby friendly initiative. Compliance with staff appraisal completion was below the trust target. The service was an outlier for stillbirths and preterm babies.
- Staff we spoke with did not know the vision and strategy for the service. For community staff, there were no formal lone working arrangements.

However:

- Staff understood how to protect women from abuse, and managed safety well. The service controlled infection risk well. Midwives assessed risks to women and acted on them. The service managed safety incidents well.
- Staff provided good care and treatment, gave women enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service. Staff worked well together for the benefit of women, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff treated women with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to women, families and carers.
- The service planned care to meet the needs of local people, took account of women's individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Recent changes in leadership indicated plans to run services well using updated information systems and to support staff to develop their skills. The leadership team and division were the same across the two trust locations with detail included in the Royal Oldham Hospital report. Some staff had felt respected, supported and valued. They were focused on the needs of women receiving care. Staff were clear about their roles and accountabilities. The service engaged well with women and the community to plan and manage services and all staff were committed to improving services continually.

Maternity

Requires Improvement

Is the service safe?

Requires Improvement

Since we last carried out a comprehensive inspection of this service, they have become part of a newly formed NHS trust. As such we cannot compare previous ratings with this one. We rated safe as requires improvement.

Mandatory training

The service provided mandatory training in key skills to all staff, however; did not meet national guidance standards.

Please see Royal Oldham Hospital report for further detail.

Staff at the trust were required to complete mandatory training modules that were a combination of face to face and eLearning. The target for all modules was 90% except for information governance which had a target of 95%. For midwives equality, diversity and human rights compliance was 78%, fire safety was 65%, health, safety and welfare was 91%, moving and handling level one was 87% and level two 65%, NHS conflict resolution was 96%, preventing radicalisation – basic prevent awareness was 100% and prevent workshop to raise awareness about prevent (WRAP) was 57%, blood transfusion theory was 74% and competence training was 74%, falls awareness was 61% and pressure ulcer awareness training was 70%.

Training was being re-launched in September 2022. It was proposed that it would be a multidisciplinary approach for skills and drills and Practical Obstetric Multi-Professional Training (PROMPT) with simulations and community specific elements. The PROMPT course covers the management of a range of obstetric emergency situations. It contributes to the training standards for the Clinical Negligence Scheme for Trusts (CNST) in England. At the time of inspection, the compliance with PROMPT training was 57% for midwives.

Staff were required to complete training in cardiotocography. The machine used to perform the monitoring is called a cardiotocograph. At the time of inspection, the compliance with CTG training was 38% for midwives.

From 1 July 2022, all registered health care providers were required to ensure their staff received training in learning disability and autism, including how to interact appropriately with autistic people and people who have a learning disability. This training should be at a level appropriate to their role. At the time of the inspection, the NCA had not made completion of this training mandatory, and staff had not completed the necessary programme of learning as required. This meant staff may not have had the skills and knowledge to communicate effectively and provide safe care to these patient groups.

Safeguarding

Staff understood how to protect women from abuse and the service worked well with other agencies to do so. Not all staff had received current training on how to recognise and report abuse but knew the processes in place.

Please see Royal Oldham Hospital report for further detail.

Midwifery staff received training specific for their role on how to recognise and report abuse. Compliance levels varied across departments. Staff were required to complete safeguarding level three for adults and level three for children with trust targets of 90%. For midwives safeguarding adults levels one compliance was 96%, two was 96% and three was 78%. Compliance for safeguarding children level one was 91%, two was 91% and three was 74%.

Environment and equipment

The design and use of facilities, premises kept people safe, however; we observed equipment that was either missing a date when last maintained or with stickers showing they were passed their date for a maintenance check. Staff managed clinical waste well.

Please see Royal Oldham Hospital report for further detail.

There was equipment in use in the antenatal clinic and community room that displayed dates to indicate the equipment was passed their dates for routine maintenance checks. These included the defibrillator and suction machine on the resuscitation trolley.

A cardiotocography (CTG) machine had a due date for a check of June 2020. Cardiotocography is a technique used to monitor the fetal heartbeat and the uterine contractions during pregnancy and labour. There were sonicaids with service due dates of February 2022 and June 2022. A thermometer was due its service in January 2020, a carbon monoxide machine was due its service in January 2022, two sets of weighing scales were due to be serviced in July 2022 and two sphygmomanometers (blood pressure machines) were due their service in April 2022 and May 2022.

Details of resuscitation trolleys was received from the trust; however, there were none provided for this location. On the day of inspection staff were shared an updated checklist for staff to complete. These included photographs of required equipment to assist with checks.

Daily checks of the equipment on top of the trolley were checked daily. A security tag was in place. This was broken for monthly checks of the trolley. We found that blood bottles had expired in the time between checks.

Community staff accessed consumables in dedicated locked storage cupboards when needed.

Assessing and responding to patient risk

Midwives completed and updated risk assessments for each woman and took action to remove or minimise risks.

Please see Royal Oldham Hospital report for further detail.

Risk assessments were completed at antenatal clinic appointments. Clinics were both midwifery led and consultant led. This meant that women assessed as low or high risk could be seen at the hospital. In the event of an obstetric emergency, the woman would need to be transferred to the Royal Oldham Hospital for on-going care and treatment.

Staff completed mandatory training modules in resuscitation. For midwives, compliance with resuscitation level two adult basic life support was 61% and level two newborn basic life support was 57%.

Sepsis and VTE were included in mandatory training requirements. For midwives, compliance was 57%. Trust target for compliance was 90%. Venous thromboembolism (VTE) compliance was 87% for midwives.

Maternity

The service monitored “did not attend” rates for antenatal clinics. Between February 2022 and July 2022, there was an average of 10.97% of women who did not attend. We requested any action plans the trust had to follow up and reduce the figure but did not receive any. This meant we were not assured that women were being seen to monitor for any risks in their pregnancy pathway.

Midwifery staffing

The service had enough maternity staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank staff a full induction.

Please see Royal Oldham Hospital report for further detail.

The establishment of midwives for Rochdale antenatal and community was 16.69 whole time equivalent (WTE) midwives. There was an over establishment of 21.01 in post, at the time of inspection.

Medical staffing

The service had enough medical staff with the right qualifications, skills and experience to keep women and babies safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave locum staff a full induction.

Please see Royal Oldham Hospital report for further detail.

The medical staff were employed for both trust locations and attended as required for specific outpatient clinics.

Records

Staff kept detailed records of women’s care and treatment. Records were clear, up-to-date, stored securely however not always easily available to staff providing care as a combination of paper and electronic.

Please see Royal Oldham Hospital report for further detail.

We reviewed records for seven women in the antenatal clinic that were paper based. The records were completed in enough detail and stored securely. However, other records were managed electronically. This meant staff might not have access to the full patient record.

Medicines

The service did not always use systems and processes to store medicines safely.

Please see Royal Oldham Hospital report for further detail.

Midwives completed medicines management training. Compliance was 52% against a target of 90%.

The fridge temperature in the antenatal clinic was monitored; however, was set between two degrees and nine degrees Celsius rather than a maximum of eight degrees. Daily checks of the fridge and the environmental temperature were undertaken. There were no occasions seen where the temperature had gone outside this range; however, there were a number of gaps in checks mainly in March, April and May 2022.

Maternity

We noticed that the cupboard where medical gases were stored was close to flammable materials. This was escalated to senior leaders for the service.

Incidents

The service managed safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents although did not always ensure that shared lessons learned were understood for the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Please see Royal Oldham Hospital report for further detail.

Information provided by the trust regarding incidents was recorded by the service and not identifiable by location. This meant we could not identify which incidents related to the services provided from Rochdale Infirmary.

Is the service effective?

Inspected but not rated

Is the service caring?

Inspected but not rated

Is the service responsive?

Inspected but not rated

Is the service well-led?

Requires Improvement

Since we last carried out a comprehensive inspection of this service, they have become part of a newly formed NHS trust. As such we cannot compare previous ratings with this one. We rated well-led as requires improvement.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Please see Royal Oldham Hospital report for further details.

Maternity

The leadership team and division were the same across the two trust locations with detail included in the Royal Oldham Hospital report.

Vision

The service had a vision for what it wanted to achieve and a strategy to turn it into action. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders understood and knew how to apply them and monitor progress.

Please see Royal Oldham Hospital report for further details.

Culture

Staff did not always feel respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service did not always have an open culture where patients, their families and staff could raise concerns without fear.

Please see Royal Oldham Hospital report for further details.

We noted that leaflets to provide feedback, via the patient advice and liaison service (PALS) were readily available for women.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Please see Royal Oldham Hospital report for further details.

In the antenatal clinic there were printed versions of guidance documents. We saw that the guideline for diabetes management, that was displayed in staff areas, included a review date of August 2021. However, the version stored on the trust's electronic policy hub was for next planned review in March 2027. The guideline for thromboprophylaxis had a review date of March 2022; however, the policy hub version was dated for review in April 2027. This meant there was a risk of staff following guidance that was not current or best practice.

There was an alert document that was attached to the resuscitation trolley for the management of hypoglycaemia. This was dated 2017. It was not clear if there was a more recent version.

Management risks, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Please see Royal Oldham Hospital report for further details.

Managing information

Maternity

The service collected data and analysed it. Staff could find the data they needed to understand performance, make decisions and improvements. The information systems were secure. Data or notifications were consistently submitted to external organisations as required.

Please see Royal Oldham Hospital report for further details.

Staff were required to complete an information governance and data security module as part of mandatory training requirements. The target compliance level was 95%. For midwives, compliance was 70%.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Please see Royal Oldham Hospital report for further details.

Innovation and sustainability

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Please see Royal Oldham Hospital report for further details.

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Report to Health Scrutiny Committee

Adult Integrated Substance Misuse Treatment and Recovery Service

Portfolio Holder:
Councillor Brownridge, Cabinet Member Health and Social Care

Officer Contact: Katrina Stephens, Director of Public Health

Report Authors: Julian Guerriero, Senior Policy, Strategy and Commissioning Manager Public Health and Dr Rebecca Fletcher, Consultant in Public Health

Ext. 8748

7th March 2023

Purpose of the Report

To update the Health Scrutiny Committee on the outcome of the recent collaborative commission by Oldham Council and Rochdale Council for the provider of an Adult Integrated Substance Misuse Treatment and Recovery Service through an open competitive tendering procedure.

To introduce the new Adult Integrated Substance Misuse Treatment and Recovery Service to be delivered by Turning Point and provide an overview of the delivery model and priorities for the first 12 months – Presentation from Steve Simmons, Senior Operations Manager.

Executive Summary

Having a high functioning drug and alcohol treatment and recovery service offer is an essential component of the range of activity required to achieve better population health and reduce demand on health and social care services.

Oldham Council and Rochdale Council have worked in collaboration to jointly commission a provider for the provision of a drug and alcohol treatment and recovery service through an open competitive tendering procedure.

It was agreed at Cabinet in February 2022 to delegate authority to the Director of Public Health, in consultation with the Cabinet Member for Health and Social Care, to approve the recommendation of the evaluation panel.

In accordance with the results of the tendering exercise (based on quality, social value and financial modelling) and completion of the tender evaluation processes, the contract was awarded to Turning Point Services Limited, and as per the delegated authority agreed by Cabinet in November 2022.

The core contract term is for a period of five years up to the end of 31 March 2028 at a value of £4.4m per year (equal contributions of £2.2m from Oldham Council and Rochdale Council). There is an option to extend the contract year on year for up to a further five years.

A further £600k per year (£300k per authority) is available to support inpatient detoxification and residential rehabilitation placements.

Additional grant funding is within the scope of the contract, with clear exit strategies that can disaggregate spend away from the core specification.

Representatives from Turning Point have been invited to attend the meeting to provide an overview of the delivery model and priorities for the first 12 months of service delivery from 1st April 2023 onwards.

Recommendations

Health Scrutiny Committee are recommended to note the outcome of the recent tender exercise to procure a provider for the delivery of the Adult Integrated Substance Misuse Treatment and Recovery Service.

Health Scrutiny Committee are also asked to consider the new Adult Integrated Substance Misuse Treatment and Recovery offer which is available for residents of Oldham.

Adult Integrated Substance Misuse Treatment and Recovery Service

1 Context

1.1. Under the Health and Social Care Act 2012, local authorities have a duty to reduce health inequalities and improve the health of their local population by ensuring that there are public health services aimed at reducing drug and alcohol misuse. The Greater Manchester Drug and Alcohol Strategy sets out the collective ambition to make Greater Manchester a place where everyone can have the best start in life, live well and age well, safe from the harms caused by drugs and alcohol. Reducing these harms is central to improving the safety, wellbeing and prosperity of our residents.

1.2. As of March 2022 the number of adult drug users in treatment in Oldham was 1,197 compared to 1,046 in the previous year – an increase of 14%. The number of adult alcohol-only clients also increased significantly by 18% from 385 in March 2021 to 454 in March 2022. These increases are significantly greater than averages for Greater Manchester, the North West region and England.

1.3. The number of new presentations to adult drug treatment services in Oldham increased sharply by 28.9% from 450 to 580 which was accompanied by a rise of 18.3% amongst alcohol-only clients from 268 to 317. Estimates of unmet need, based on the proportion of people who are dependent on opiates and/or crack cocaine or alcohol not in the treatment system, show that rates amongst Oldham's population, with the exception of 'crack (only)', are lower than the national averages.

1.4. Within Oldham's adult in-treatment drug user population 72% are male. White/White British ethnicities represent 85% of this cohort, with Asian/Asian British communities being the next largest grouping at 8%. This means that while White ethnicities are over-represented in the treatment population, South Asian communities are significantly under-represented when compared to the general population. In terms of age, 30 to 49 year olds account for 63% of adults in treatment.

1.5. Almost 7% of drug users in treatment indicated 'urgent housing problems' and 13% cited other 'housing problems'. Approximately two-thirds (65.7%) had a 'mental health treatment need identified' when they presented to drug treatment services in Oldham.

1.6. In March 2022 the largest referrers to drug treatment services in Oldham were 'Self, Family & Friends' (53.1%) with the next largest proportion of referrals coming from 'criminal justice' agencies (22.6%).

1.7. The proportion of adults Oldham with opiate problems in treatment for 6 years or more is 33% compared to 27% nationally.

1.8. Amongst adult alcohol only clients in treatment in Oldham 62% are male and 38% are female. More than nine in ten (94%) are from White/White British backgrounds. Almost one in five (19.2%) are aged 30-39 years, 28.9% aged 40-49 years and almost 36% aged 50-64 years.

1.9. Almost 1.3% of alcohol only clients in treatment indicated 'urgent housing problems' and 8.2% cited other 'housing problems'. Approximately two-thirds (65.9%) had a 'mental health treatment need identified' when they presented to alcohol treatment services in Oldham.

1.10. In March 2022 the largest referrers to alcohol treatment services in Oldham were 'Self, Family & Friends' (51.7%) with the next largest proportion referral coming from 'hospital'

(12.0% up from 6.7% in the previous year). The third highest proportion was via GPs with 7.3%.

1.11. The overall caseload of the Oldham service is currently at 1651 clients at any time for alcohol & drugs. Current analysis show that clients are presenting with higher levels of complexity in relation to mental ill health, physical health and safeguarding.

1.12. A copy of Oldham Drug & Alcohol Needs Assessment 2022 is in appendices.

2 Background

2.1. The current contract for the delivery Rochdale and Oldham Active Recovery (ROAR) service, held by Turning Point, is a collaborative commission between Oldham Council and Rochdale Council and has been in place since April 2018.The contract was for 3 years with an option to extend for up to 2 years on an annual basis and terminates on 31 March 2023. An Inter-Authority Collaboration Agreement has been signed by both Councils which agrees that Oldham Council is the lead commissioner.

2.2. The annual contract value is £4.4m and is made up by equal contributions from Oldham and Rochdale. In addition, there is also a budget of £600,000 per annum for Tier 4 inpatient detoxification and rehabilitation placements with funding split equally between the two local authorities.

2.3. Oldham & Rochdale Councils also received additional funding from Office of Health Improvement & Disparities (OHID) and Department of Levelling Up Housing & Communities (DLUHC). This is to deliver key programmes in relation to increasing engagement in drug treatment and reducing drug related crime, improving support for rough sleepers and access into treatment and Individual Placement and Support (IPS) to increase treatment engagement and improve employment opportunities for clients in recovery. These additional grants are conditional on no disinvestment in our treatment and recovery services. The total value of this additional grant funding for our substance misuse services is c.£1.3m for Oldham.

2.4 The overall aim of the contract is to deliver an integrated recovery-orientated treatment system for adults (aged 18 and over), providing triage, assessment, and structured treatment. The service aims to reduce the risk of harm and support people to maintain long term recovery from their addiction. It enhances support for people with multiple or complex dependencies, working with complex dependency teams where they exist. The service enables people with problematic drug and alcohol use to make positive changes to their lives and support them to move towards a life free from dependency and criminal offending. The service provides support packages covering a range of psychosocial and clinical substitute prescribing interventions based on individual need.

2.5 The service works closely with housing providers to ensure service users have access to appropriate accommodation and support to sustain stable housing. In addition, the service recognises the importance of employment in individual recovery capital, health and wellbeing and will support clients from treatment outset to achieve their personal aims in this regard. The service is accessible, inclusive, and recovery-focused and will cater for people having problems with all substances.

3 Adult Integrated Substance Misuse Treatment and Recovery Service

3.1 The new specification sets out the requirement for the Oldham and Rochdale Integrated Adult Substance Misuse Service. Oldham and Rochdale Councils have worked collaboratively for the last 5 years to deliver a jointly commissioned service for adults needing community

treatment across both boroughs. This collaborative arrangement is to continue with an updated specification that builds on 'lessons learnt' from the previous commission.

3.2 In addition, across Greater Manchester there is a shared vision for substance misuse commissioning, supported by Greater Manchester Combined Authority (GMCA). Key to delivery of the service is understanding each areas Locality/Corporate Plan, Greater Manchester Drug & Alcohol Strategy and HM Government 10-year drugs plan to cut crime and save lives.

3.3 The overall aim of the Integrated Adult Substance Misuse Service is to provide a high quality, recovery focused treatment offer across Oldham and Rochdale, that will support people to become free from dependency from substances and enable them to thrive. The service will reduce risk levels in our more complex clients and seek to embed substance misuse-related prevention and early intervention as key priorities across our system.

3.4 The service will adopt a holistic, and whole family, approach to service delivery to ensure that the wider determinants of health are supported within care plans along with treatment specific objectives. Establishing effective partnerships with wider stakeholders is crucial to providing a comprehensive service offer. The service is also expected to act as an 'expert' resource within the boroughs in relation to substance misuse. This will empower the wider system and communities to deliver substance misuse preventative interventions and address identified gaps, provide shared preventative messages and connect people to support that meets their needs.

The priority outcomes the service will be expected to achieve are:

- A reduction in levels of drug and alcohol related harm
- A reduction in drug and alcohol related offending.
- An increase in the number of people in and sustaining recovery.
- A reduction in drug and alcohol related deaths.
- Contribute to the reduction in demand for other services linked to complex drug and alcohol issues (e.g., reduction in the number of emergency department attendances and admissions by those who have multiple attendances and repeat presentations to adult social care).

The wider outcomes the service will be expected to achieve are:

- Reducing health inequalities
- Improving mental wellbeing
- Increasing volunteering opportunities
- Increasing the uptake of other preventative services (e.g. NHS Health Checks, screenings, flu vaccination etc.)
- Improved community engagement and reduced isolation
- Support people to access employment, education or volunteering opportunities
- Support people to improve their housing conditions and money management

This will be achieved by:

- Delivery of an accessible, inclusive and recovery-focused service that supports people having problems with all substances.
- Provision of accessible digital resources that support access to referral information, guidance and self-care advice.
- Providing evidence based, one to one and group interventions to individuals, in line with clinical standards and best practice guidelines.
- Providing support packages covering a range of psychosocial and clinical substitute prescribing interventions based on individual need.
- Embedding harm minimisation advice and guidance within the offer, supported by blood borne virus screening and treatment, wound care, and a needle exchange service.

- Providing bespoke and targeted interventions that reach out to parts of the borough which are high risk of poor health outcomes.
- Recognising the importance of employment in individual recovery capital and health and wellbeing and will support clients from treatment outset to achieve their personal aims in this regard
- Delivery of a comprehensive recovery offer that supports sustained outcomes for clients. This will also extend into the community and ensure clients are linked to wider support that isn't necessarily delivered by the service.
- Being an outwardly facing service that ensures that support offered to clients is done in meaningful partnership with other services e.g. primary care, social care, housing etc.
- Positioning the service as a system leader in relation to substance misuse and the delivery of a comprehensive training package to the wider system re: substance misuse

3.5 This is an integrated service model across Oldham for adult substance misuse treatment and recovery. The model will provide support with all substances (including prescribed medication) and incorporate a neighbourhood delivery model in order to create better links within locality hubs.

3.6 The model will be delivered in line with the national drug strategy and forthcoming commissioning standards, and the principles of trauma informed delivery and Good Help will run throughout.

3.7 The service will be outwardly facing and ensure that support offered to clients is provided in meaningful partnership with other services i.e. primary care, social care, dual diagnosis, acute provider, mental health trust, housing, children's services and young people's substance misuse services. The service will also be expected to.

I. further develop and enhance existing partnerships and pathways
II. problem solve and suggest positive ways of working to move forward and engage with residents and partner agencies
III. deliver a structured training programme for partners and establishing a key dialogue with the recovering community within both boroughs.

4 Adult Integrated Substance Misuse Treatment and Recovery Service

4.1 Turning Point Services Ltd will commence delivery of Adult Integrated Substance Misuse Treatment and Recovery Service from 1st April 2023, following completion of a successful procurement process and mobilisation period.

4.2 Representatives from Turning Point Services Limited will present an overview of the delivery model and the service priorities for the first 12 months to the Health Scrutiny committee.

5 Key Issues for Health Scrutiny to Discuss

5.1 Health Scrutiny Committee are recommended to note the outcome of the recent tender exercise to procure a provider for the delivery of Adult Integrated Substance Misuse Treatment and Recovery Service.

5.2 Health Scrutiny Committee are also asked to consider the new Adult Integrated Substance Misuse Treatment and Recovery offer which is available for residents of Oldham.

6 Key Questions for Health Scrutiny to Consider

6.1 Health Scrutiny Committee is asked to consider whether an update on the first 12 months of delivery of the Adult Integrated Substance Misuse Treatment and Recovery Service, including relevant performance management information and contributions towards health outcomes, would be useful.

7 Links to Corporate Outcomes

7.1 Adult Integrated Substance Misuse Treatment and Recovery Service, as with all Public Health commissioned services, fully supports the Council's cooperative agenda as it promotes the active engagement of Oldham residents and providers delivering in Oldham in Thriving Communities, Co-operative Services and an Inclusive Economy. The commissioning of the service and the award of the contract to Turning Point Services Limited is consistent with the commitment within the Oldham Plan to take a person and community centred approach, that places prevention at the heart of our delivery model.

8 Consultation

8.1 A comprehensive consultation process was undertaken as part of the development of the specification and included engagement with residents and the market, as well as key stakeholders.

8.2 Officers from Procurement, Finance and Legal were part of the project team for the procurement exercise and were consulted throughout the process for any implications relevant to their respective specialisms. Procurement, finance and legal implications were included in the delegated decision for the award of the contract.

8.3 The Director of Public Health, as the key relevant statutory officer, was briefed throughout the process.

8.4 The Cabinet Member for Health and Social Care has been briefed prior to and throughout the procurement process.

9 Appendices

9.1 Oldham Drug & Alcohol Needs Assessment 2022

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HEALTH SCRUTINY COMMITTEE

WORK PROGRAMME 2022/23 DRAFT

Tuesday 5th July 2022	Infant Mortality	An update report on some of the activity happening to address issues of infant mortality, with particular reference to smoking and safe sleeping.	Portfolio - Health and Social Care. Director of Public Health. Rebecca Fletcher, Consultant in Public Health	Further report on smoking and safe sleeping required by Committee, 6th July 2021
	Healthy Child Programme	To report on changes to health visiting and school nursing services in the coming year	Portfolio - Health and Social Care. Director of Public Health. Rebecca Fletcher, Consultant in Public Health.	Update report on the transformation and ongoing actions to further develop the integrated model for 0-19 services in Oldham required by the Committee 7th September 2021.
	Health Inequalities Plan	Opportunity for consideration of actions proposed in the Plan.	Portfolio – Health and Social Care Director of Public Health	
	Public Health Annual Report	To review the Annual Report which has the theme of Covid-19 and Health Inequalities.	Portfolio – Health and Social Care Director of Public Health	NOTE – submission subject to progression of this item through other bodies/ committees
	Thriving Communities Programme - Evaluation	To receive the final Thriving Communities Programme evaluation report.	Portfolio - Health and Social Care. EMT ?? Rachel Dyson, Thriving Communities Hub Lead	The item was requested by the former Overview and Scrutiny Board at their meeting held in March 2021.
Tuesday 6th September 2022	Elective Care		Mike Barker	
	New structures etc		Mike Barker	

Tuesday 18th October 2022	Northern Care Alliance / Royal Oldham Hospital - update	To receive an update on services and related matters in respect of the Northern Care Alliance and the Royal Oldham Hospital.	David Jago, Chief Officer, Oldham Care Organisation, Northern Care Alliance NHS Trust	Follow-on updates following completion of the Pennine Acute Trust/Northern Care Alliance Transaction
	Health Protection Update	To receive an update/progress report on key health protection issues including plans for the 2022 Flu Programme	Portfolio - Health and Social Care. Director of Public Health. Charlotte Stevenson, Consultant in Public Health	
Tuesday 6th December 2022				
Tuesday 17th January 2023	Health Improvement and Weight Management Service	To receive an update/progress report on the new service that commenced in January 2021	Portfolio - Health and Social Care. Katrina Stephens, Director of Public Health. Andrea Entwistle, Public Health Business and Strategy Manager. Rebecca Fletcher, Acting Consultant in Public Health	Update report to consider progress in relation in relation to high-level outcomes (ref 2.2 and 2.3 of submitted report). Report required by Committee, 18th January 2022, with a request for representatives of ABL Health Limited to attend and report.
	Integrated Sexual Health Service	To receive an update/progress report on the new service that commenced in April 2022	Portfolio - Health and Social Care. Katrina Stephens, Director of Public Health.	Update report/presentation to detail progress of the new enhanced Integrated Sexual Health Service offer. Report

			Andrea Entwistle, Public Health Business and Strategy Manager.	required) by Committee, 18th January 2022.
Tuesday 7th March 2022	Northern Care Alliance / Royal Oldham Hospital - update	To receive an update on services and related matters in respect of the Northern Care Alliance and the Royal Oldham Hospital.	David Jago, Chief Officer, Oldham Care Organisation, Northern Care Alliance NHS Trust	Follow-on updates following completion of the Pennine Acute Trust/Northern Care Alliance Transaction
	Drugs and alcohol service	To receive an update/ progress report on the re-tendering of services, and the plans for the newly commissioned service starting 1st April 2023.	Portfolio - Health and Social Care. Katrina Stephens, Director of Public Health.	Update report/presentation to detail progress and outcome of the re-tendering exercise.

BUSINESS TO BE PROGRAMMED

Reporting arrangements in respect on integrated commissioning under Section 75 Agreements, to include periodic updates and budget performance, from the Chief Operating Officer/Strategic Director and the Director of Finance respectively, remain to be programmed.

An update from the Chief Operating Officer/Strategic Director on the Urgent Care Review, last reported to the Committee in September 2020 at which the intentions for further developments and the involvement of the public were advised, remains to be programmed.

Integrated sexual health service – January 22

The Committee resolved to consider, early in the 2022/23 Municipal Year, the establishment of a 'task and finish group', comprising Committee members and relevant partners and stakeholders from across the Reproductive and Sexual Health system to carry out an in-depth study around the adoption of a collaborative approach to improving sexual health outcomes across the Oldham Borough. The Director of Public Health has clarified the intent as being for Committee to consider inviting the providers of sexual health services in the Borough to a future Committee to discuss their current offer

and the work they are doing – this might be one of the big providers such as the hospital, or possibly from some of the other service providers that are commissioned.
RECOMMENDATION – That the Committee determine whether to receive presentations from individual provider(s) of sexual health services in the Borough, in addition to the programmed progress report.

KEY DECISION DOCUMENT – COVERING DECISIONS TO BE TAKEN FROM 20TH FEBRUARY 2023

Key Decision Reference	Subject Area For Decision	Led By	Decision Date	Decision Taker
	Wrigley Head Solar Farm	Executive Director for Place & Economic Growth - Emma Barton		Cabinet
Description: Update report on the Wrigley Head Solar Farm project and options for taking the project forward. Document(s) to be considered in public or private:				
	Backlog Maintenance 2022/2025	Executive Director for Place & Economic Growth - Emma Barton	February 2023	Cabinet
Description: Backlog Maintenance Priorities for the Council Corporate Property Portfolio Document(s) to be considered in public or private: Private - NOT FOR PUBLICATION by virtue of Paragraph(s) 3 of Part 1 of Schedule 12A of the Local Government Act 1972 and it is not in the public interest to disclose the information because it relates to the financial or business affairs of the Council.				
	LA Policy on Academy Conversion and Guidance for Schools		February 2023	Cabinet
Description: Document(s) to be considered in public or private:				
	Strategic Housing Land Availability Assessment	Executive Director for Place & Economic Growth - Emma Barton	February 2023	

KEY DECISION DOCUMENT – COVERING DECISIONS TO BE TAKEN FROM 20TH FEBRUARY 2023

Key Decision Reference	Subject Area For Decision	Led By	Decision Date	Decision Taker
Description: To seek approval for the publication of Oldham Council's Strategic Housing Land Availability Assessment (SHLAA) as of 1 April 2022. Document(s) to be considered in public or private:				
	Grant Acceptance: City Region Sustainable Transport Settlement (CRSTS) – Manchester Street Viaduct Refurbishment	Director of Environment - Nasir Dad	February 2023	Cabinet
Description: Oldham Council has secured additional funding for the refurbishment of Manchester Street Viaduct, via: City Region Sustainable Transport Settlement (CRSTS) Decision is required to confirm the value of the grant available to Oldham and notify Cabinet of the intention to bring this additional resource into the transport capital programme to design and undertake refurbishment works to Manchester Street Viaduct. The report will also outline the steps that Oldham Council will need to take to procure the necessary support to develop and deliver the scheme to budget and programme. Document(s) to be considered in public or private: Cabinet Report and referred to business case				
	Approval of Temporary Accommodation Framework	Director of Economy – Paul Clifford	February 2023	Cabinet
Description: To seek approval from Cabinet to award and to enter into with each of the successful bidders for the Temporary Accommodation Framework (following on from the recent Temporary Accommodation tender). Document(s) to be considered in public or private: Private The decision relates to financial and/or business affairs of the Council and a third party.				

KEY DECISION DOCUMENT – COVERING DECISIONS TO BE TAKEN FROM 20TH FEBRUARY 2023

Key Decision Reference	Subject Area For Decision	Led By	Decision Date	Decision Taker
	Carriageway Investment Funding	Director of Environment - Nasir Dad	February 2023	Cabinet
Description: Additional funding for carriageway surfacing/treatments Document(s) to be considered in public or private:				
	Oldham Community Leisure (OCL) – Utility Benchmarking		February 2023	Cabinet
Description: Document(s) to be considered in public or private:				
	Oldham Community Leisure (OCL) – Contract Renewal		March 2023	Cabinet
Description: Document(s) to be considered in public or private:				
New!	Specialist Health & Social Care Provision at Oldham College	Executive Director for Place & Economic Growth - Emma Barton	March 2023	Cabinet
Description: Proposal for a new facility at Oldham College to accommodate specialise Health & Social Care Provision including the relocation of UCO onto the main campus. Document(s) to be considered in public or private: N/A				
New!	Local Taxation and Benefits Discretionary Policies 2023/24	Director of Finance – Anne Ryans	March 2023	Cabinet
Description: To confirm the Council's local taxation and benefits discretionary policies for 2023/24 Document(s) to be considered in public or private:				

KEY DECISION DOCUMENT – COVERING DECISIONS TO BE TAKEN FROM 20TH FEBRUARY 2023

Key Decision Reference	Subject Area For Decision	Led By	Decision Date	Decision Taker
	Report of the Director of Finance – Revenue Monitor and Capital Investment Programme 2022/23 Quarter 3	Director of Finance – Anne Ryans	March 2023	Cabinet
Description: The report provides an update on the Council's 2022/23 forecast revenue budget position and the financial position of the capital programme as at the period ending 31 December 2022 (Quarter 3) Document(s) to be considered in public or private: Proposed Report Title: Report of the Director of Finance – Revenue Monitor and Capital Investment Programme 2022/23 Quarter 3 Background Documents: Appendices – Various Report to be considered in Public				
	Wrigley Head Solar Farm – delivery options	Director of Economy – Paul Clifford	March 2023	Cabinet
Description: To provide a decision on the recommended delivery option for Wrigley Head Solar Farm Document(s) to be considered in public or private: Public				
New!	Approval of Grant Funding Agreement with Greater Manchester Combined Authority	Executive Director for Place & Economic Growth - Emma Barton	March 2023	Cabinet

KEY DECISION DOCUMENT – COVERING DECISIONS TO BE TAKEN FROM 20TH FEBRUARY 2023

Key Decision Reference	Subject Area For Decision	Led By	Decision Date	Decision Taker
Description: The report seeks approval to enter into a grant agreement with Greater Manchester Combined Authority. Under the proposed grant agreement, Oldham have been allocated grants funding that will enable the expansion and continued delivery of three services dedicated to supporting residents who are homeless or at risk of homelessness between 2022-25. Document(s) to be considered in public or private: NOT FOR PUBLICATION by virtue of Paragraph(s) <> of Part 1 of Schedule 12A of the Local Government Act 1972 and it is not in the public interest to disclose the information because affairs of specific individuals or groups of individuals (including the Council)				
New!	Enhancement of Community Sports	Executive Director for Place & Economic Growth - Emma Barton	March 2023	Cabinet
Description: Proposal to consider investment in community sports Document(s) to be considered in public or private: N/A				
New!	Acceptance of Adult Education Budget funding	Director of Education, Skills & Early Years - Richard Lynch	March 2023	Cabinet
Description: The report details funding offer received from the Education & Skills Funding Agency (ESFA) and Greater Manchester Combined Authority (GMCA) funding allocations of the Adult Education Budget grant for the 2022-2023 academic year and highlights how this funding will be used to meet the ESFA's, GMCA's and Council's key priorities. Document(s) to be considered in public or private:				
New!	Grant acceptance - Levelling up	Director of Economy – Paul Clifford, Executive Director for Place & Economic Growth - Emma Barton	March 2023	Cabinet

KEY DECISION DOCUMENT – COVERING DECISIONS TO BE TAKEN FROM 20TH FEBRUARY 2023

Key Decision Reference	Subject Area For Decision	Led By	Decision Date	Decision Taker
Description: The Council submitted two bids to the second round of the Levelling Up Fund in August 2022. In January the HM Government announced that the Council had secured £20m to deliver the Green Technology and Innovation Network proposal. The report seeks acceptance of the grant. Document(s) to be considered in public or private: n/a				
New!	Contract Novation – Green Square Accord to Allied Health Services Ltd (Care At Home)			Cabinet
Description: Document(s) to be considered in public or private:				
New!	Establishment of the Greater Manchester Integrated Care Partnership Board			Cabinet
Description: Document(s) to be considered in public or private:				
HSC-12-22	CPB approval to jointly procure two contracts with Tameside Metropolitan Borough Council and to seek approval for Delegated Authority for the Cabinet Member for Health and Social Care to approve the tender procedure	Director of Adult Social Care (DASS) – Jayne Ratcliffe	March 2023	Commissioning Partnership Board
Description: Approval to jointly procure the following two Contracts with Tameside Metropolitan Borough Council: A. Life of Client Contract (LOC): for the provision of stairlifts, ceiling track hoists, vertical and step lifts and gantry hoists in domestic properties where residents have disabilities. B. Service and Maintenance Contract (City Lifts): for the provision of inspection, servicing, maintenance and repair of stairlifts, through floor lifts, step lifts and track hoists installed in domestic properties where residents have disabilities To seek approval for Delegated Authority for the Cabinet Member for Health and Social Care to approve the tender procedure Document(s) to be considered in public or private: Public				

KEY DECISION DOCUMENT – COVERING DECISIONS TO BE TAKEN FROM 20TH FEBRUARY 2023

Key Decision Reference	Subject Area For Decision	Led By	Decision Date	Decision Taker
New!	Northern Roots VC and LC PCSA Award	Director of Economy – Paul Clifford	April 2023	Cabinet Member - Regeneration and Housing (Leader - Councillor Amanda Chadderton)
Description: The purpose of the report would be to award a contract to the successful bidder in respect to the Construction of a Visitor Centre and External Works and a Learning Centre Document(s) to be considered in public or private:				

Key:

New! - indicates an item that has been added this month

Notes:

1. The procedure for requesting details of documents listed to be submitted to decision takers for consideration is to contact the Contact Officer contained within the Key Decision Sheet for that item. The contact address for documents is Oldham Council, Civic Centre, West Street, Oldham, OL1 1UH. Other documents relevant to those matters may be submitted to the decision maker.
2. Where on a Key Decision Sheet the Decision Taker is Cabinet, the list of its Members are as follows: Councillors Amanda Chadderton (Leader of the Council), Abdul Jabbar MBE (Statutory Deputy Leader), Elaine Taylor (Deputy Leader), Mohan Ali, Shaid Mushtaq, Eddie Moores, Shoab Akhtar, Barbara Brownridge and Hannah Roberts.

KEY DECISION DOCUMENT – COVERING DECISIONS TO BE TAKEN FROM 20TH FEBRUARY 2023

Key Decision Reference	Subject Area For Decision	Led By	Decision Date	Decision Taker

3. Full Key Decision details (including documents to be submitted to the decision maker for consideration, specific contact officer details and notification on if a report if likely to be considered in private) can be found via the online published plan at: http://committees.oldham.gov.uk/mgListPlans.aspx?RPId=144&RD=0