East Cheshire NHS Trust

Evidence appendix

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

Facts and data about this trust

East Cheshire NHS Trust provides a comprehensive range of acute and community-based services, including emergency care and emergency surgery; elective surgery in many specialties; maternity and cancer services. The community health services include; community nursing, intermediate care, occupational and physiotherapy, community dental services, speech and language therapy and palliative care. They also provide several hospital services in partnership with other local trusts and private providers, including pathology, urology and renal dialysis services.

Inpatient services are provided from two hospital sites – Macclesfield District General Hospital (main site) and Congleton War Memorial Hospital. Outpatient services are provided in Macclesfield District General Hospital and community bases in Congleton, Handforth, Knutsford, Wilmslow and Poynton.

(Source: Trust Website / Acute RPIR – Context acute tab)

Is this organisation well-led?

Leadership

The trust board had the skills, knowledge and experience that they needed. They had a high level of understanding of the challenges to quality and sustainability. They demonstrated a commitment to meeting the needs of the local population. There was evidence of compassionate, inclusive and effective leadership throughout the organisation. Most staff reported that the leaders were visible and approachable.

There was a stable and experienced executive team. All the executive posts were filled and most of the team, including the chief executive, had been in post for a number of years. There had been one change to the executive team since the previous inspection in 2018. This was an additional post of chief operating officer. This role had been introduced to enable the director of nursing to have more capacity for strategy development work. The director of nursing had previously undertaken the operational role in addition to the director of nursing role.

The chair, executive and non-executive directors, that we spoke with during the inspection, demonstrated a high level of understanding of the challenges to quality and sustainability across the organisation. The executive team were delivering good operational performance despite significant financial challenges.

There was a board development programme in place that was collectively agreed.

There was evidence of compassionate, inclusive and effective leadership throughout the organisation. The trust was led through three operational divisions and the corporate division. The operational divisions were clinically led with managerial support.

Most staff reported that the leaders were visible and approachable. Directors and non-executive directors undertook a programme of walkabouts and reported these at board meetings. However, some staff within community children, young people and families services felt less engaged with the leadership team.

The trust met the Fit and Proper Persons Requirement (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014). This regulation ensures that directors of NHS providers are fit and proper to carry out this important role.

The trust had a strategy for leadership and talent management as part of the organisational development and workforce strategy. There were succession plans in place for the executive team and other senior posts. The trust had adopted the leadership academy talent management approach. Leadership and development programmes were available to staff. These included internal programmes, such as aspiring and inspiring leaders programmes and a consultant development programme, and support for external programmes, such as the Mary Seacole programme. In the previous 12 months to end of March 2019, 96 staff at the trust had attended internal leadership programmes.

Of the executive board members at the trust, none were Black and Minority Ethnic (BME) and 57% were female. Of the non-executive board members 0% were BME and 33% were female. The trust board had recognised the need for a more diverse membership. Two non-executive directors were coming to the end of their term and the trust were proactively recruiting their replacements to strengthen the diversity and skills of the board.

Staff group	**BME %**	**Female %**
Executive directors	0%	57.0%
Non-executive directors	0%	33.0%
All board members	0%	46.0%

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

Vision and strategy

Meeting the needs of the people of Cheshire East was the primary focus of the trust board's vision. The trust had not yet been able to develop a comprehensive service strategy and was dependent on working with relevant stakeholders within the wider health economy. The vision and strategy development were focused on sustainability; it was clearly understood that the trust was not currently sustainable and wider economy reform was still needed. Whilst the trust board was actively pursuing sustainable options, some of the required decision making was outwith the trust.

The trust had a vision which was to ensure patients received the best care in the right place and to work in partnership to provide high quality affordable integrated services. The trust board recognised that transformation and strategic realignment of clinical care services was required so they met the needs of the local population.

At the time of the previous inspection in early 2018, the trust was an integral part of the systemwide development of 'Caring Together.' This was a multiagency programme, which aimed to transform the way that health and social care was provided in Eastern Cheshire. At this inspection, there had been some strategic changes. The trust were now part of the strategic development within the 'place' of Cheshire East. This involved working in partnership with other stakeholders including the local authority. This was in development and the trust board recognised the need for a greater pace of change across the system. Trust board members were leading some of the workstreams across the Cheshire East partnership. Whilst the trust board was actively pursuing sustainable options, some of the required decision making was outwith the trust.

The trust board also recognised the need to work in partnership across the wider NHS system to enable them to respond to the NHS 10 year plan. They were actively developing partner relationships with other organisations, including other NHS trusts, and had developed joint executive and board to board meetings with one trust and were developing relationships further with other NHS organisations informed by patient pathways. A specialist NHS trust had recently announced plans to develop and deliver a radiotherapy service on the Macclesfield General Hospital site.

The trust board recognised the importance of the strategic work. To support this and ensure they maintained the balance with operational demands, the executive management team had rearranged their weekly meetings so there was a dedicated strategic executive management team meeting which was separate from the operational meeting. Capacity for executive directors to undertake strategic development work had been increased.

In September 2015, the trust board stated that the organisation was not sustainable and wider economy reform was needed. At this inspection, the trust board confirmed this remained the case.

Whilst there was no organisational strategy in place, the service provision was underpinned by key internal strategies including the clinical strategy, quality strategy and workforce and organisational development strategy. We saw updates on progress against strategic objectives had been was presented to the board. For example, in July 2019 an update on the workforce and organisational

development strategy was presented which was explicitly linked to the risks on the board assurance framework and risk register.

The medicines optimisation strategy, which incorporated working with other organisations, was being ratified by the board. The strategy included improving retention of staff by a variety of developmental incentives. This included encouragement of pharmacists to complete the nonmedical prescriber course. However, the oversight of some of the areas within the trust could be improved, particularly around patient group directives. The strategy included a business case for a seven-day working in place along with a roaming pharmacy discharge team.

Members of the trust board spoke positively about the strategic changes within the community setting. Although, we did not inspect community adults services at this inspection, we were informed that community nursing and social care staff were organised in teams around five care communities and this was working well.

Culture

The trust board were committed and focused on the needs of patients and people of Cheshire East. The trust promoted equality and diversity and provided opportunities for career development. Staff felt respected, supported and valued. The trust had an open culture where patients, their families and staff could raise concerns without fear.

There was a strong patient-centred culture evident across the trust. This extended to areas without direct patient contact. For example, a document had been produced that demonstrated how the library staff's role supported effective patient care and corporate staff assisted staff in clinical areas at busy times.

We saw evidence that the trust were compliant with the duty of candour requirements. This states the trust must act in an open and transparent way about the care and treatment patients receive and notify them, as soon as is reasonably practicable, after becoming aware that a notifiable safety incident has occurred, firstly in person and then in writing.

The trust had a freedom to speak up guardian. They were proactive and had used a variety of methods to increase awareness of their role. There were good monitoring arrangements in place and the freedom to speak up guardian provided reports to the board, as required. Staff in most areas we visited were aware of the freedom to speak up guardian role. For example, within the pharmacy department there were four freedom to speak up champions, in addition to an informal "listening ear" staff member who also provided an unofficial pathway for issues to be raised with senior staff.

There had been a 'spotlight' report on bullying and harassment at the trust which was presented the executive management team meeting in May 2019. This was an internally produced document that reviewed and triangulated information from a number of sources, including the staff survey results, incidents and concerns raised with the freedom to speak up guardian. Information had been analysed by directorate and staff group as well as by race, disability and gender. Actions had been put in place and further action was planned with the aim of supporting a strong,

anti-bullying compassionate culture. This included increasing the numbers of bullying and harassment ambassadors at the trust.

The trust did not have any established equality staff networks, with the exception of a disability equality group, which included employee representatives. Networks had previously been established, but interest from staff was not sustained. The workforce equality lead had implemented a quarterly staff newsletter dedicated to engagement, wellbeing and inclusion as a means of promoting its work to improve the working lives of people with protected characteristics. The trust leadership team aimed to develop an inclusive staff network with representation from staff with protected characteristics in 2019/20.

Staff Diversity

The trust provided the following breakdowns of staff groups by ethnic group.

Ethnic group	Medical and dental staff (%)	Nursing, healthvisiting and midwifery registered (%)	Qualified allied health professionals (%)
A – White – British/Irish/Any other white background	3.8%	25.3%	7.6%
B – BME - British	2.2%	1.3%	0.1%
C – BME - Non-British	0.6%	1.2%	0.3%
E – not stated	2.5%	2.2%	0.6%

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

NHS Staff Survey 2018 results – Summary scores

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

The trust's 2018 scores for the following themes were significantly lower (worse) when compared to the 2017 survey:

- Equality, diversity & inclusion

(Source: NHS Staff Survey 2018)

Although the score for equality, diversity and inclusion was worse than the score in 2017, it was above the average score for similar trusts. However, the trust board had recognised that more could be done to develop diversity and inclusion; they had recently created a new role of director of workplace and inclusion to ensure this work was taken forward.

Workforce race equality standard

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

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

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

Notes relating to the scores:

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

WRES Indicators from ESR (HR data) (*)	BME Staff	White Staff	Are there statistically significant difference between...	
			BME and White staff?	Last year and this year? (BME staff)
1a. Proportion of clinical (nursing and midwifery) staff in senior roles, band 8a+	3.2%	4.3%	●	-1.6% →
1b. Proportion of non-clinical staff in senior roles, band 8+	0.0%	9.4%	○	0.0% ○
2. Proportions of shortlisted staff being appointed to positions	48.9%	47.6%	●	36.6% ↑
3. Proportion of staff entering formal disciplinary processes	1.1%	0.8%	●	0.7% →
4. Proportion of staff accessing non-mandatory training and CPD	100.0%	98.0%	Not assessed	

WRES Indicators from the NHS staff survey (**)		Proportion of respondents answering "Yes"			Are there significant differences between...		
		BME staff	White staff	All staff	BME and white staff?	This trust and its peer group?	Last year and this year? (BME)
5. Staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	Trust	41.2%	27.4%	28.5%	●	●	7.3% →
	Peer group	*27.9%*	*25.3%*	*26.3%*			
6. Staff experiencing harassment, bullying or abuse from staff in the last 12 months	Trust	31.3%	21.0%	23.2%	●	●	5.9% →
	Peer group	*29.3%*	*23.6%*	*25.1%*			
7. Staff believing that the trust provides equal opportunities for career progression or promotion	Trust	83.0%	90.3%	88.6%	●	●	3.0% →
	Peer group	*69.5%*	*87.3%*	*84.2%*			
8. Staff experiencing discrimination at work from a manager / team leader or other colleague?	Trust	17.6%	3.6%	4.9%	●	●	6.4% →
	Peer group	*15.6%*	*5.9%*	*7.6%*			

Trust staffing numbers (*)	2018		2017	
9. [BME Voting Board Members] and Board compared to overall staff demographic	[0]	●	[0]	●

Key

- ● Statistically significant or negative finding
- ● Not statistically significant
- ● Positive finding
- ○ Statistical analysis not undertaken as less than 30 BME staff responded
- ↑ Statistically significant improvement
- → No statistically significant change
- ↓ Statistically significant deterioration

As of March 2018, none of the ESR staffing indicators (i.e. indicators 1a to 4) showed a statistically significant difference between BME and white staff.

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

- 5. 41.2% of BME staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months compared to 27.4% of white staff a change of 7.3% from last year.

- 6. 31.3% of BME staff experience harassment, bullying or abuse from staff in last 12 months compared to 21.0% of white staff a change of 5.9% from last year.

- 8 17.6% of BME staff experiencing discrimination at work from a manager/team leader or other colleague compared to 3.6% of white staff a change of 6.4% from last year.

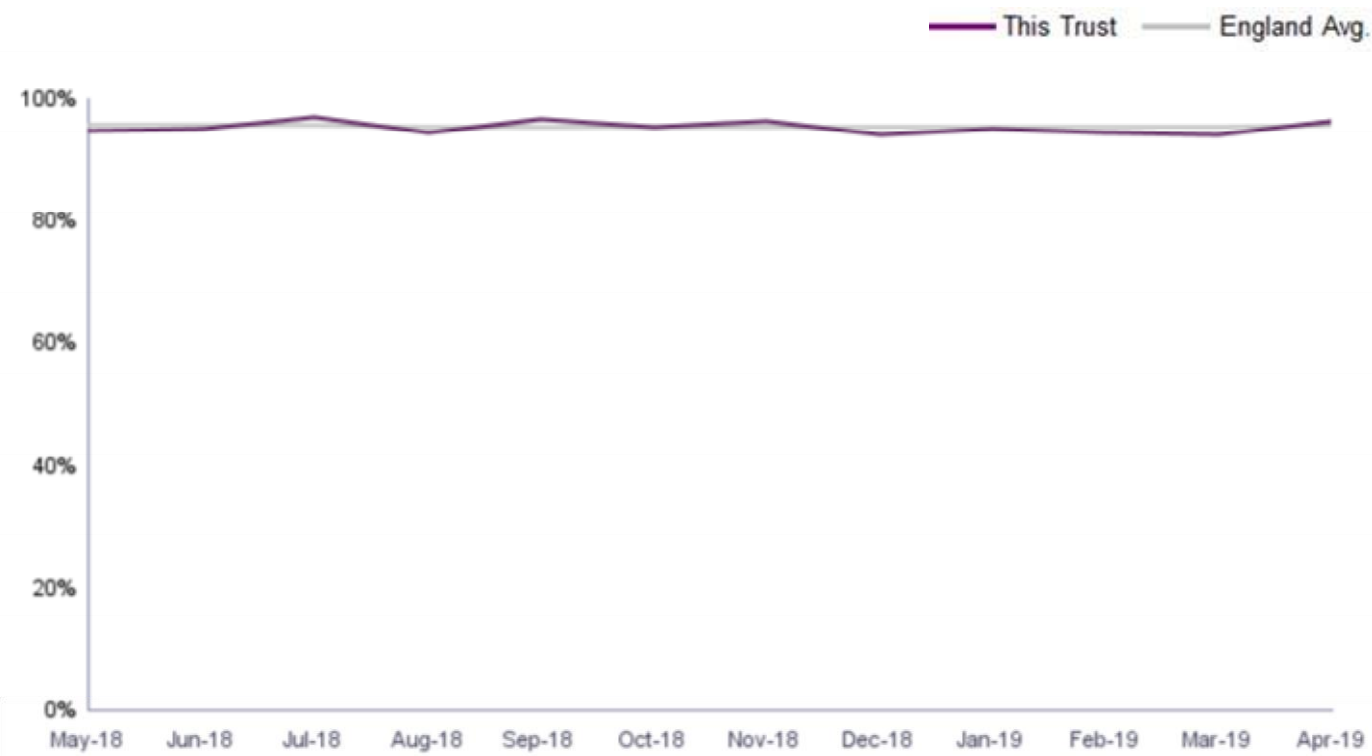
There were no BME voting board members at the trust, which was not significantly different to the number expected, based on the overall percentage of BME staff. The trust board had recognised the need for a more diverse membership.

The ‘spotlight’ report on bullying and harassment at the trust which was presented the executive management team meeting in May 2019 had analysed the data by race, disability and gender. Actions had been put in place and further action was planned.

Friends and family test

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

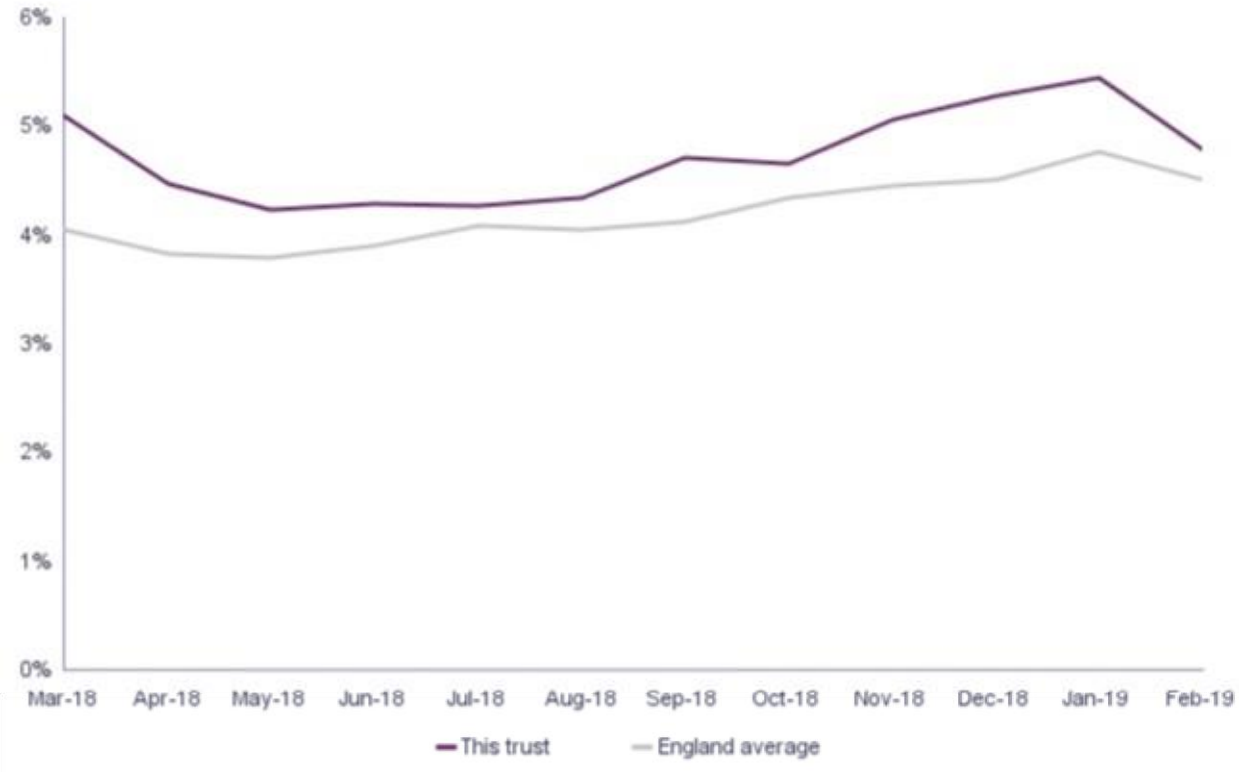
The trust scored about the same the England average for recommending the trust as a place to receive care from May 2018 to April 2019.



(Source: Friends and Family Test)

Sickness absence rates

The trust's sickness absence levels from March 2018 to February 2019 were higher than the England average. Over the same time period, the trust's performance followed a similar pattern to the England average.



(Source: NHS Digital)

The trust leadership were aware of the sickness rate. They had mandated stress risk assessments for all staff and this was being audited. They had also invested in well-being work and reported seeing incremental changes as a result.

General Medical Council – National Training Scheme Survey

In the 2018 General Medical Council Survey the trust performed the same as expected for all 18 indicators.

(Source: General Medical Council National Training Scheme Survey)

Governance

The trust leadership team operated effective governance processes across the trust and with partner organisations. Staff were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the services.

Structures, processes and systems of accountability were in place to support the delivery of good quality services. There were four sub-committees of the board, each chaired by a non-executive director. These were the safety, quality and standards committee, finance, performance and workforce committee, audit committee and the remuneration committee. In addition, the chief executive held monthly clinical management boards and separate weekly executive management meetings for operational and strategic issues.

Operationally each service area had a safety, quality and standards sub-committee which mirrored the content of the trust's main safety, quality and standards committee. These meetings took place on a regular basis and reported upwards by exception and to provide assurance.

The trust used a process to 'spotlight' areas of concern or good practice. This involved an indepth review of an issue or area, that was presented to the relevant committee, including the subcommittees of the board. The executive team were able to provide examples of when the 'spotlight' reports had been undertaken and how they had provided assurance to the board.

There was an established quality impact assessment process that was led by the medical director and director of nursing.

Arrangements were in place to review any issues arising from the Aston Community hospital to allow close monitoring following the Gosport Report.

The electronic copies of the patient group directives were uploaded onto the 'Info net' by the trust. These were the signed and authorised copies. This did not include the 'live' used documents which were used by the wards and teams. There was no record of these documents held by the pharmacy department.

Board Assurance Framework

The trust provided their Board Assurance Framework, which details five strategic risks. A summary of these is below.

1. Leadership of strategic transformation
2. Quality & compliance: patient safety, patient experience and effectiveness
3. Financial stability
4. People
5. Infrastructure

(Source: Trust Board Assurance Framework – March 2019)

The board assurance framework was clear. It was up to date and there was clear evidence that is was reviewed and updated. There was evidence it was scrutinised by the board and board subcommittees and used to drive the agenda, manage risk and prioritise assurance requirements. The board assurance framework focussed on strategic risks and also expanded to provide risk treatment and assurances. As a result, the document was lengthy and summary documents were also produced. Some assurances may have benefitted from being updated in in a more timely way, such as reliance on Monitor well-led self-assessment from October 2017.

The board assurance framework demonstrated that anticipatory risks had been considered to identify future risks at an organisational and a system-wide level. The trust board had adapted and implemented a model of assurance and used this to inform decisions on risk treatment and risk exposure. The trust demonstrated a high level of understanding of inter-organisational risk arising out of the strategic options open to the board.

Organisational objectives and risks to achieving these, were well-articulated and understood. There was a strong emphasis on collective ownership and responsibility for strategic risk. The board assurance framework was formally reviewed annually. The last internal audit had reported high assurance.

The trust board had developed an action plan following the last inspection. This was monitored through the safety, quality and standards committee of the board. We saw evidence that plans had been effective.

Management of risk, issues and performance

There were comprehensive assurance systems and performance issues were escalated appropriately through clear structures and processes. Processes to manage current and future performance were in place. There was a systematic programme of clinical and internal audit to monitor quality, operational and financial processes, and systems to identify where action should be taken. There were robust arrangements for identifying, recording and managing risks, issues and mitigating actions. Potential risks were taken into account when planning services and managing services.

The trust board were fully sighted on the challenges regarding performance. This was particularly evident with the standard for patients to be admitted, transferred or discharged within four hours within the emergency department, referral to treatment times particularly in cardiology and some

cancer waiting times and the financial challenges. Comprehensive plans were in place to manage and mitigate the risk and minimise impact on patients.

The trust board had identified risk areas including the provision of single-handed services where the quality or service was not sustainable. Where this was the case, the trust planned to stop providing these. Consequently, oral surgery and orthodontics was no longer provided.

There were embedded processes and procedures underpinning the identification and management of financial risk. Internal auditors had given the board significant assurance about the operation of internal controls in the trust in 2018-9. The trust had a track record of delivering its annual financial control total. Non-executive directors recognised that the director of finance controlled financial flexibilities to allow the trust to meet unplanned costs. There was clear accountability exercised through the audit and finance and performance committees and internal governance boards.
However, processes for managing wider health system risks affecting the Cheshire East “place” were not fully developed and were not yet effective in driving resolution of the financial and service sustainability issues affecting the trust.

A robust process for internal audits was in place. The terms of reference for internal audits were agreed by the trust board. Non-executive directors appropriately challenged, for example, enquiring what additional audits had not made the final list, so they were aware of these issues and could challenge their exclusion.

The medical director had delegated accountability for mortality at board level and had responsibility to monitor, review and receive assurance on the effective implementation of national and local strategies targeted at reducing preventable mortality in accordance with patient choice, reducing adverse events, improving outcomes and quality of care for patients. The trust monitored their risk adjusted mortality index which was lower than expected at 88. The trust had a policy for learning from deaths which was aligned with national guidance.

The trust had previously reviewed all deaths but had made a conscious decision to review 20% of all deaths. These were selected based on clear, criteria-led eligibility which was being followed. The medical director explained the change in practice had been made as the mortality was lower than expected, the reviews were criteria led, lessons to be learned were consistent and there was a view that there was limited value to be gained by reviewing a higher percentage of cases. themes emerging from the reviews were consistent, such as incomplete documentation.

The trust were using a two-stage review process in line with good practice. This included a primary mortality review and also a structured judgement review. The reviews had identified opportunities for improving the diagnosis of pneumonia and opportunities to make the bereavement booklet less hospital centric. We saw evidence was provided to the board to demonstrated action had been taken in these areas. The medical director provided a quarterly mortality report to the trust board.

We reviewed a sample of serious incident reports during the inspection. The investigation reports were comprehensive, collaborative, people focused and including learning from the incident. The trust produced a ‘learning into practice’ bulletin to support learning across the trust.

Within the emergency department, there were two monthly audits on medicine management completed. Any issues identified were fed back to the matron, who sat on the trust's safe medicines group. However, medical gases and the sepsis trolley were not included as part of the medicine's management audits.

Finances Overview

Financial metrics	Historical data		Projections	
	Previous Financial Year (2016/17)	Last Financial Year (2017/18)	This Financial Year (2018/19)	Next Financial Year (2019/20)
Income	£165,589	£152,526	£150,928	£165,628
Surplus (deficit)	-£15,149	-£16,189	-£17,932	-£5,100
Full Costs	£180,738	£168,715	£168,860	£170,728
Budget (or budget deficit)	-£19,600	-£20,200	-£17,932	-£5,100

Projections for 2018/19 indicate that the deficit will decrease compared to 2017/18.

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

Trust corporate risk register

There was a high level corporate risk register which was actively used to monitor and manage risks in the organisation. Board members could articulate the trust's risk appetite. We were informed there was a low appetite for clinical risk.

The trust provided their corporate risk register detailing 35 open risks. A summary of their highest scoring risks which scored 15 or above (out of 25) is below.

ID	Date Risk Reported	Description	Rating (current)	Rating (Target)
1406	01/04/2017	If there are inadequate core staffing levels on acute inpatient wards it will compromise the delivery of high quality care impacting ability to maintain patient safety and staff resilience, with associated impact on agency utilisation and financial control.	16	12
2726	29/01/2018	If we are unable to achieve our 2018/19 financial control total then there is a risk to the reputation and sustainability of the organisation	20	10

2727	29/01/2018	If we are unable to identify and deliver adequate QIPP schemes within the 2018-19 financial year then there is a possibility that the financial plan will not be achieved	20	12
2745	20/03/2018	If clinicians are not fully engaged in delivery of the operational plan this could have an impact on cost reduction, maximising productivity; and plans for transformation.	20	15
2834	18/07/2018	IF there is no planning in place for the replacement of end of life hardware THEN devices may not be fit for purpose and direct patient care will be affected.	16	9
2860	07/09/2018	If the level of trained nurse vacancies within planned care wards (1,2 and 10) continues to increase then there may be a risk that failure to provide appropriately trained and experienced staff may impact on the quality of care patients receive, the flow of patients through the organisation and the satisfaction of patients and their families in the care they have received whilst an inpatient.	16	12
2773	12/05/2018	If the directorate does not have sufficient capacity to deliver the annual plan then this may result in a backlog of patients waiting to be treated including clinic appointments and those requiring surgery.	16	12
2788	28/05/2018	If the out of hours rotas for FY2 doctors continue to cover across Surgery and Orthopaedics, then there is a risk that during busy shifts the doctors may be stretched too thinly and unable to provide safe care, resulting in a clinical incident or omission of care.	16	12
2794	05/06/2018	Orthodontic is a single handed consultant led service. Service has recently closed to new referrals due to demand. Issues with frequency of follow up appointments raised by Consultant	16	12

2681	06/12/2017	If the Endoscopy and Treatment Unit are not able to offer dates for required procedures within the recommended timeframes there may be a clinical risk to some patients which could mean a poor outcome due to the delayed diagnostic procedure. A number of surgical patients who have been referred to ETU for diagnostic tests on an urgent basis have not been offered procedures within the recommended 4 week timescale and may have waited a number of months.	15	9
2806	02/04/2018	If the Planned Care Directorate is unable to operate within the financial plan and achieve the relevant income and QIPP, there is a risk that the trust will not achieve the financial target for 2018/19.	16	12
2817	02/07/2018	If the inpatient 18 week backlog for ENT continues to increase, then there may be an impact on patient safety & experience due to delays in treatment.	16	12
2732	14/02/2018	If there is insufficient capacity to see all ophthalmology patients waiting a follow up appointment then there is a risk of patient harm and poor patient experience.	16	6
2663	03/04/2017	If the inpatient 18-week backlog continues to increase, there may be an impact on patient safety due to delays in treatment (potential 52 week breaches), the NHS constitutional standard will not be achieved with associated reputational risk and potential financial impact due to loss of income or penalties.	16	12
2463	15/02/2017	If the HSDU Autoclaves, Washer Disinfectors (the R.O. equipment or the Clean Steam Generators) are not replaced, they will become increasingly unreliable and if they were to fail may not be able to be repaired.	16	4
1766	17/03/2015	If the HSDU Reverse Osmosis Water Plant goes out of service then HSDU will not be able to provide a decontamination service to the Trust. The RO plant feeds the steam generation plant for the sterilisers and provides the final rinse water for the washers. The RO Plant is at the end of their expected service life. In addition, the plant currently cannot provide RO water fully compliant with the chemical purity required.	16	4
2610	23/08/2017	If the Trust does not meet the diagnostic target standard of <1% of patients waiting more than 6 weeks (ie 99% of patients are seen within 6 weeks), then this may impact on patient care, patient experience and Trust reputation	16	6

2660	16/11/2017	If AER (Automated Endoscopy Reprocessers) - ETU washers - fail completely the unit will be unable fully function affecting patient care, safety and reducing capacity. N.B. JAG requirements are that AERs should be replaced every 10,000 cycles - currently all bays are beyond 10,000 cycles. Current issue with tracking system and getting to work to allow electronic tracking of scopes.	20	9

2666	03/04/2017	If the A&E 4 hour performance standard is not met then there will be a financial impact to the Trust i.e. loss of 400k per quarter 18-19	16	12
2742	02/03/2018	If we do not have the required specialist staff in Rheumatology we will be unable to sustain levels of service and achieve expected quality and performance standards. Patient care may be significantly compromised by delays in treatment.	16	12
2269	20/07/2016	If there is no commissioned diabetes specialist nursing service for Eastern Cheshire then there is a significant clinical risk that pregnant women that require support with optimising their glyceamic control will not be managed appropriately.	16	8
2272	21/07/2016	If inpatient flow is not maintained effectively then AAU may be used to accommodate inpatients, additional beds may be placed in ward bays and ED may become overcrowded with patients on corridors, which will impact the delivery of safe care leading to patient harm, due to: - environment not suitably equipped for the number and casemix of patients - lack of skilled staff to provide timely care and treatment for backlog of patients in ED - challenges in maintaining privacy & dignity in these areas - inability to implement an effective care & treatment plan	15	10
2389	18/11/2016	If the Trust does not have plans in place to upgrade the Intensive Care Unit, this will impact on the ability to comply with Health Building Note (HBN) 04-02	16	2
2427	30/12/2016	If the Trust does not have the required specialist consultant support within its diabetes/endocrinology service (single-handed consultant model), then the Trust will not be able to offer patients senior specialist assessment and treatment and patient care may be compromised.	16	8
2512	03/05/2017	If the Cardio Respiratory Department are unable to increase staffing levels and offer more echocardiography appointments there is a risk that the 6/52 diagnostics access standard will not be achieved, leading to delays in treatment that may result in patient harm. Staff resilience is also impacted by an unsustainable workload, perceived risk to patients and inability to recruit new staff to vacant posts.	16	12

2536	25/05/2017	If the environmental upkeep of Minor Injuries Unit and Congleton War Memorial Hospital is not repaired / updated there is a potential risk of poor patient experience and patient safety	16	8
2548	12/06/2017	If the level of trained nurse vacancies within acute medical wards (3,4,7 and CCU)continues to increase then there may be a risk that failure to provide appropriately trained and experienced staff may impact on the quality of care patients receive, the flow	16	12
		of patients through the organisation and the satisfaction of patients and their families in the care they have received whilst an inpatient.		
2820	05/07/2018	If the Acute & Integrated Care Directorate is unable to operate within the 2018/19 financial plan and achieve the relevant income and QIPP, there is a risk that the trust will not achieve the financial target	20	12
2797	07/06/2018	If staff do not have the competence to manage long lines (internally or from an external source) (Midline/PICC/CVC) in line with clinical standards, then patient outcome will be affected. This Risk covers all clinical areas from ED to wards clinics, and discharged patients with long lines.	16	12
2801	08/06/2018	If the current cardiology back log of new and follow up patients cannot be managed within current job planned capacity there is a significant clinical risk to delivery of patient care due to increasing patient backlog and longer waiting times.	20	16
2877	01/10/2018	A Serious Incident relating to an Unexpected Death of an Inpatient on HCU / ICU has been reported on the Strategic Executive Information System (2018/22826 Web-55377).	20	5
2878	01/10/2018	A Serious Incident relating to a Medication Incident on A&E has been reported on the Strategic Executive Information System (2018/23052 Web-55509).	20	5
2915	26/11/2018	A Serious Incident relating to an Unexpected Death on Ward 3 has been reported on the Strategic Executive Information System (2018/27668 Web56627).	20	5
2917	28/11/2018	If there is a failure to recruit Middle grade Paediatricians it will mean that it will be difficult to cover the oncall rota and will necessitate a large amount of locum doctor use and jeopardise high quality care and patient experience.	16	12
186	29/07/2011	If there is a lack of a diabetes inreach service this may result in delayed/unsafe discharges, unsatisfactory patient experience, and increased workload for ward staff	16	4

(Source: Trust Board assurance framework – March 2019)

Information management

The trust leadership teams had an holistic understanding of performance, which integrated people's views with information on quality, operations and finances. The information was used to measure for improvement. Although some improvements had been made to the information technology systems since the previous inspection, there remained further work needed to improve and integrate systems.

There was an holistic understanding of performance. An integrated performance report was produced and available for the board. This showed trends and targets. This was discussed at board meetings and board members we spoke with could clearly articulate the performance and challenges for the trust. Each directorate had their own scorecard which provided an overview of performance on a range of indicators.

Information was available to staff. A risk profile of departments was produced. We saw an example of the emergency department risk profile which provided detailed information on incident numbers, levels of harm, identified risk including the three highest graded risks for the service, claims, complaints, claims, external visits and changes to policy and practice.

Financial information was clear, accurate, timely and relevant. Service line "profit and loss" accounts, based on service line data, were used to explore financial sustainability analysis, and drive improvements in productivity, efficiency and, if appropriate, clinical sustainability. Quality and sustainability both receive sufficient coverage in relevant meetings.

Information technology systems still required further development to enable the trust leadership teams to efficiently monitor and improve the quality of care. Since the previous inspection, the trust had introduced 'single sign on' system for clinicians and improved wifi access across the hospital. However, there was no electronic patient record system or electronic prescribing system in place. We were informed that two bids for further resource were in place. Electronic prescribing was identified as a priority.

The pharmacy department had access to the trust's electronic bed management system. This enabled a targeted response to medicine reconciliation for patients recently admitted to the trust. The medicines team used an electronic discharge system to provide information, however this did not link to community pharmacies.

Information sharing arrangements and memorandums of understanding were developed to support the sharing of information with key stakeholders and partner organisations, where appropriate.

The trust had achieved external recognition for the quality of its data. The trust had a data quality group. The group's remit was to ensure the trust was able to give assurance that information used for management reports, clinical audit and commissioning could be monitored and the quality of information met the required standards of information governance.

An annual data quality audit outcomes report was produced which included an audit of samples of admitted, outpatient and elective patients records. An annual clinical coding audit was also undertaken by a service approved clinical coding auditor.

Engagement

There was openness about the clinical and financial sustainability of the trust. The trust leadership team were actively engaged in wider partnership working to develop proposals for future sustainable services for the benefit of the local population.
People's views and experiences were gathered and acted on to improve the current services and culture.

There was a patient experience strategy which we saw in place at our previous inspection; this strategy was planned to be reviewed in 2020. The trust continued to use several mechanisms to capture patient feedback and improve the patient experience. There were board assurance walkabouts, the trust participated in national patient survey programmes and they reviewed complaints or concerns which ensured that a more proactive approach was taken to facilitate early resolution of concerns. Patient's and staff stories were presented at each board meeting, safeguarding committee and the safety, quality and standards sub-committee.

The pharmacy team shared a web page which had a link to a patient sharing decision tool. This was intended to help patients both internally and externally with questions around their medicines.

There was patient representation on groups, including the infection prevention committee.

However, at the time of inspection and in the absence of a comprehensive service strategy, there was limited evidence that people who used services, those close to them and their representatives were actively engaged and involved in decision-making to shape services. The trust leadership team were aware of this and planned to engage with the public as part of the wider strategic plans.

Staff engagement was positive. The results of the NHS staff survey 2018 showed the trust wide engagement score had improved and was above the national average.

The trust leadership reported positive staff engagement. This was corroborated by the feedback we obtained at a number of focus groups we held with staff during the months before the inspection.

We found examples of positive staff engagement. For example, staff had been involved in planning the redevelopment in the outpatient department, there was a regular junior doctor forum, and the leadership team gave examples of positive engagement with the commissioners. There was a monthly clinical management board and we were told there was good clinical engagement with decision making. The medical director held twice yearly update days for local GPs.

Learning, continuous improvement and innovation

There were systems to support improvement and innovation work. Learning was shared effectively and used to make improvements.

During our inspection, we reviewed 10 complaints and the responses. We found the responses were detailed, included an apology where appropriate, and responded to the concerns raised. Lessons to be learned were identified and monitored.

The trust had a patient advice and liaison (PALS) outreach service. The team visited wards and departments and helped identify and resolve issues at an early stage. This was recognised externally as good practice. The trust reported a 29% fall in formal complaints since the introduction of the service.

The trust was asked to comment on their targets for responding to complaints and current performance against these targets for the last 12 months.

Question	In days	Current performance
What is your internal target for responding to complaints?	3	100%
What is your target for completing a complaint	25 & 45 days	94%
If you have a slightly longer target for complex complaints please indicate what that is here	N/A	N/A
Number of complaints resolved without formal process in the last 12 months?	1,104 (April 2018 to March 2019)	

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

The trust received 105 complaints from April 2018 to March 2019. Medical care received the most complaints with 35 (26% of all complaints received trust wide).

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

Core Service	Number of complaints	Percentage of total
AC - Surgery	32	24%
AC - Urgent and emergency services	30	22%
AC - Services for children and young people	7	5%
AC - Medical care (including older people's care)	35	26%
AC - Gynaecology	5	4%
AC - Outpatients	5	4%
CHS - Community health services for adults	4	3%
AC - Maternity	1	1%
AC - Diagnostic imaging	4	3%
CHS - Sexual Health	7	5%
Total	**105**	**100%**

The most common subject of the complaints was patient care which accounted for 68 complaints (65%).

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

From April 2018 to March 2019, the trust received a total of 7,606 compliments.

A breakdown by core service is below;

Core service	Total	Percentage
CHS - Adults Community	2146	28.2%
AC - Medical care (including older people's care)	1691	22.2%
AC - Services for children and young people	1327	17.4%
AC - Surgery	660	8.7%
AC - Outpatients	655	8.6%
AC - Maternity	315	4.1%
AC - Diagnostic imaging	292	3.8%
CHS - Community Inpatients	154	2.0%
Other	137	1.8%
AC - Critical care	122	1.6%
AC - Urgent and emergency services	107	1.4%

CHS Adults community had the highest number of compliments with 2,146 (28.2%) followed by Medical care with 1,691 (22.2%).

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

To support improvement, the trust used recognised improvement methodologies including the plan, do, study, act methodology and the 90 day improvement process.

Teams had visited other trusts and countries, to identify best practice and care models. This had been used to influence the model of care in the community teams.

Macclesfield District General Hospital was the first acute hospital in the UK to gain the National Autistic Society's Access Award. This work resulted in improved access and experience for patients with autism and their carers.

The patient advice and liaison outreach team had been identified as good practice by the Ombudsman.

The trust and its partners launched the 'Helping Flo' campaign aimed at highlighting the ways in which members of the public can help free up hospital beds for those who really need them. The campaign features a video starring local NHS and social care staff along with a fictitious patient called Flo.

As part of the workforce strategy, the trust leadership had introduced 'reconnect' sessions to improve retention of nursing staff. They had identified that most staff left within the first 12 months of being in post. The 'reconnect' sessions involved the new staff member meeting with senior staff at 30 days, 60 days and 90 days. The trust reported improvements in their turnover rate to below 10% over the last six months.

A health cadet academy programme has been developed with the local college. Students have been recruited and are due to start the programme in September.

The trust had implemented a ‘runner’ system, with corporate departments supporting clinical areas to help manage winter pressures; this work had received a national award.

Acute services

Urgent and emergency care

Facts and data about this service

The emergency department is a type one department that treats approximately 50,000 new patients per annum. The service treats children and young people and about 20% of attendances are for children.

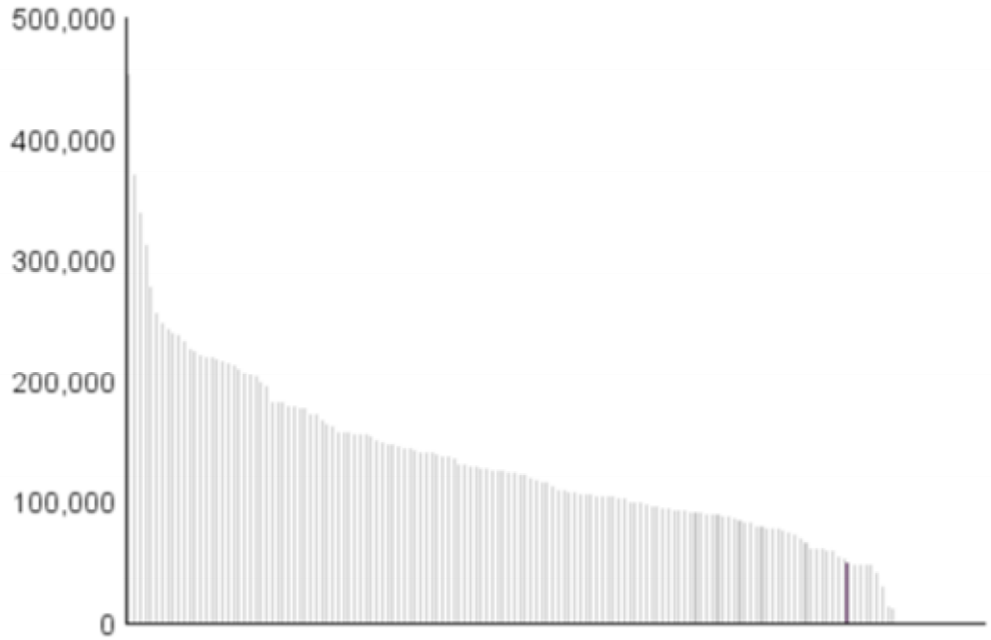
The department is consultant led, with consultants available from 09.00am until 21:00pm each week day. The department is supported by nurses and health care assistants (bands 2-7), junior doctors, emergency nurse practitioners and middle grade doctors; with a variety of services out reaching to provide specialist input. These include liaison psychiatry which is provided by a nearby mental health trust.

There is an acute assessment unit with criteria for attendance. Patients attending were GP referrals, planned treatments or referred from the hospital out-patient department.

There is a GP out of hours service which provides GP cover seven days a week, 24 hours a day. This was not inspected as part of this inspection.

Activity and patient throughput

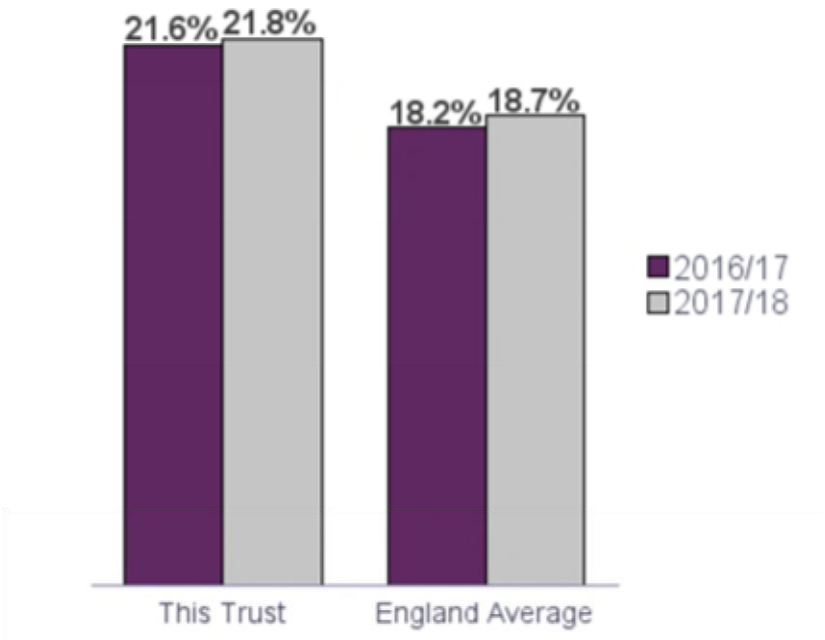
Total number of urgent and emergency care attendances at East Cheshire NHS Trust compared to all acute trusts in England, December 2017 to November 2018



From December 2017 to November 2018 there were 49,660 attendances at the trust's urgent and emergency care services as indicated in the chart above.

(Source: Hospital Episode Statistics)

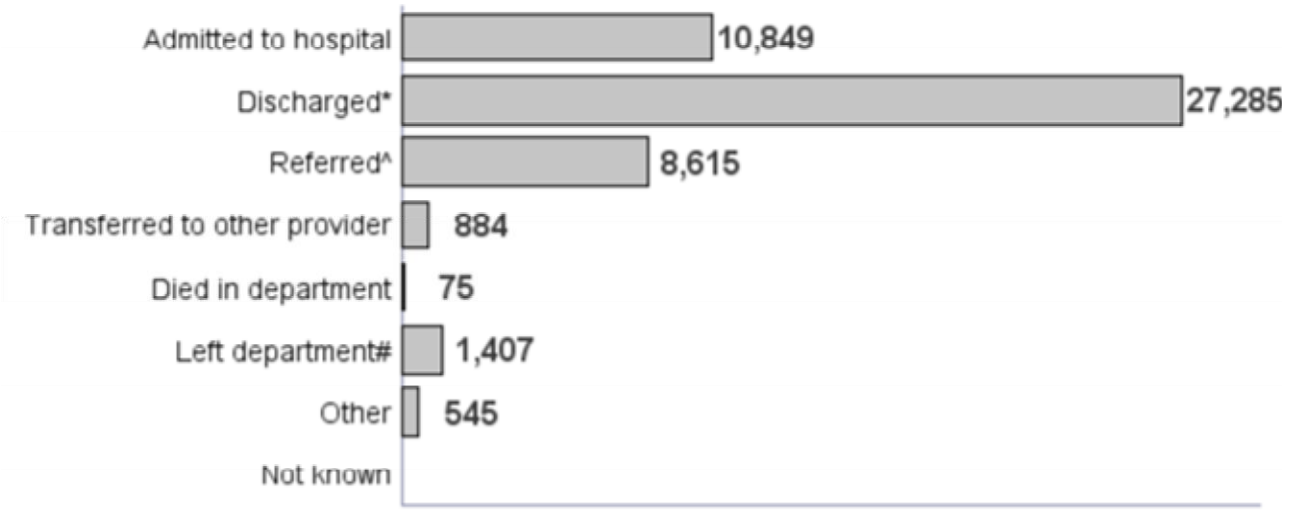
Urgent and emergency care attendances resulting in an admission



The percentage of UEC attendances at this trust that resulted in an admission remained similar in most recent year compared to previous year. In both years, the proportions were higher than the England averages.

(Source: NHS England)

Urgent and emergency care attendances by disposal method, from December 2017 to November 2018



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

(Source: Hospital Episode Statistics)

Is the service safe?

Mandatory training

Most nursing staff received and kept up to date with their mandatory training. Not all doctors were up to date with mandatory training, but the numbers included staff who were on long term sick.

All trained staff in the department completed the paediatric training day which included children's safeguarding, paediatric life support training, paediatric early warning scores, blood transfusion for children and medicines for children. Only two staff in the department had not completed this at the time of the inspection. There was also training for staff from the children's ward.

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

Core statutory and mandatory training includes health and safety, safeguarding adults and children, infection control, fire safety, equality diversity and human rights.

Core clinical eLearning includes: consent, mental capacity act, Deprivation of Liberty Safeguards, learning disabilities awareness and record keeping.

Annual clinical update sessions are bespoke (depending on role) and topics are reviewed annually - this is classed as statutory due to the inclusion of life support training appropriate to role.

The trust does not report preventing radicalisation/workshop to raise awareness of prevent (WRAP) training as a statutory or mandatory training module, however, for the purposes of the analysis this module has been included in the table below.

Trust level

A breakdown of compliance for mandatory training courses from April 2018 to February 2019 at trust level for qualified nursing staff in urgent and emergency care is shown below:

Training module name	April 2018 to February 2019				
	Staff trained	**Eligible staff**	**Completion rate**	**Trust target**	**Met (Yes/No)**
Information Governance	57	58	98.0%	95%	Yes
Prevent / WRAP	144	147	98.0%	85%	Yes
Core Clinical E-Learning	53	56	95.0%	90%	Yes
Core Stat & Mand	51	56	91.0%	90%	Yes
Annual Clinical Update	46	56	82.0%	95%	No
Grand total	351	373	94.0%	95%	No

In urgent and emergency care the training completion targets were met for four out of five mandatory training modules for which qualified nursing staff were eligible.

A breakdown of compliance for mandatory training courses from April 2018 to February 2019 at trust level for medical staff in urgent and emergency care is shown below:

Training module name	April 2018 to February 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Prevent / WRAP	44	54	81.0%	85%	No
Core Stat & Mand	14	18	78.0%	90%	No
Annual Clinical Update	13	19	68.0%	95%	No
Information Governance	11	18	61.0%	95%	No
Core Clinical E-Learning	10	18	56.0%	90%	No
Grand total	92	127	72.0%	95%	No

In urgent and emergency care the 95% target was not met for any of the mandatory training modules for which medical staff were eligible.

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

Safeguarding

All staff received safeguarding training specific for their role on how to recognise and report abuse.

There was a trust policy for safeguarding that included a checklist for child exploitation for children and young people attending the department.

Pathways and flowcharts for safeguarding adults and children were available around the department.

Staff induction on the department included all aspects of safeguarding for adults and children and included domestic violence, child sexual exploitation and female genital mutilation. The paediatric annual training for all staff also contained safeguarding training.

If staff had concerns about children that were not urgent, they completed a book which was checked every day by a health visitor. They would then follow up on concerns. There was also a domestic violence contact book which was checked daily. Staff told us that these systems had been in place for a long time and worked well.

The department worked with the trust safeguarding team and if there were incidents the safeguarding team would feed back what had gone well and what could have been done better. This information was disseminated to all staff in the department.

We were given an example of a safeguarding referral that was made by staff for a patient on the acute assessment unit. Social services had been informed as had the patient's relative. Staff were contacting the medical assessment unit to inform them of the safeguarding as the patient was due to be moved to that department.

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

Trust level

A breakdown of compliance for safeguarding training courses from April 2018 to February 2019 at trust level for qualified nursing staff in urgent and emergency care is shown below:

Training module name	April 2018 to February 2019				
	Staff trained	**Eligible staff**	**Completion rate**	**Trust target**	**Met (Yes/No)**
Safeguarding Children (Level 3)	36	36	100%	85%	Yes
Safeguarding Children (Level 2)	19	21	90%	85%	Yes

In urgent and emergency care qualified nursing staff met the 85% target for both safeguarding modules.

A breakdown of compliance for safeguarding training courses from April 2018 to February 2019 at trust level for medical staff in urgent and emergency care is shown below:

Training module name	April 2018 to February 2019				
	Staff trained	**Eligible staff**	**Completion rate**	**Trust target**	**Met (Yes/No)**

Safeguarding Children (Level 3)	13	15	87%	95%	No

In urgent and emergency care medical staff failed to meet the 95% target for safeguarding children level 3.

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

Cleanliness, infection control and hygiene

Staff followed infection control principles including the use of personal protective equipment.

The department was clean although it was cluttered. Personal, protective equipment was available across the department and we saw that staff used it. There were hand washing sinks and gel around the department.

The department did not routinely carry out handwashing audits. In the infection control committee minutes from May 2019, there was agreement that the verification hand hygiene audits would only take place in areas of the hospital where infections such as MRSA, bacteraemia and acute attributable Escherichia-coli had been identified. Verification audits would also be undertaken in outbreak situations, increased incidences of organisms or other causes for concern.

A commode audit had been completed in June 2019 with 100% compliance.

Patients records included alerts for infections such as MRSA allowing staff to take precautions as the patient was admitted to the department.

We saw that trolleys were cleaned between patients and cubicles were kept clean and tidy.

There was a dedicated housekeeper for the department who was responsive to the needs of the department.

Equipment we saw had “I am clean” stickers on it.

Sharps bins were dated and not overfilled. Clinical waste was disposed of appropriately and bins were signed for correct disposal of waste.

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 emergency department was located on the ground floor of the hospital. Patients could enter from the main corridor of the hospital or from outside the hospital into the streaming area. At night all patients from the hospital had to exit through the department. There was an entrance for ambulance patients.

There were cupboards and trolleys in the treatment areas that were well labelled with the contents. We checked equipment in various treatment areas around the department. In the critical care area, the equipment was checked. There was one item that was out of date. Trolleys were checked daily and we saw that checklists had been completed. We informed the service managers, and this was immediately addressed.

Most of the trays of equipment contained checklists, but some were missing including the thoracotomy kit checklist.

In the resuscitation room, we saw that the checklists for equipment checks were complicated and that not all checks had been recorded. All the equipment that we looked at was in date.

There was a sepsis trolley in the department which was checked daily. The blood culture bottles were out of date. Staff said they didn't always use it as it was heavy.

We checked two bays in the majors area and all equipment had been checked and replenished and was fit for purpose and ready for the next patient.

There was equipment around the department including sphygmomanometers, ultrasound machines and electro-cardiograph machines, staff told us that these were services regularly and were PAT tested (electrical safety testing).

The doctors said that there weren't always enough computers for all staff in the department.

Assessing and responding to patient risk

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a patient's mental health).

The shift co-ordinators held a safety brief at the beginning of every shift to highlight any issues including incidents, complaints, patients with infections or additional needs to staff on that shift.

There was a trust policy for the minimum standards for monitoring and recording adult in patient based physiological vital signs that was based on guidance from the National Institute of Health and Care Excellence. (NICE CG50 2007). There was an electronic package which was on the trust computers and hand-held devices which could capture clinical data in real time, analyse and record the data and provide real time analysis for staff. Vital signs were recorded by the system and the policy laid out the frequency of observations dependant on the acuity of the patient.

The service was using national early warning scores 2 (NEWS 2). This improves the detection and response to clinical deterioration in adult patients. Staff had received training, face to face, simulation and e-learning in NEWS 2. If any patient was scoring on NEWS there would always be a registered nurse in that area.

The critical care room was available for the resuscitation of adults and children and young people. There were flow charts on the walls from the Resuscitation Council (UK) for life support. There were life support trolleys for adults. There was a team that could in reach into the department from the critical care unit.

The trust had a sepsis policy based on sepsis 6 pathways. The department were using a sepsis screening and action tool for adults, one for children and young people and one for maternity. We saw the sepsis pathway on display in all areas of the department. There were sepsis stickers which were used as prompts in the patient records for red flag and amber triggers. There was a blood gas machine in the department which would support the prompt diagnosis of sepsis

Staff told us that they had received training in sepsis through e learning, simulation exercises and the Tuesday education sessions. We saw during the inspection that the department received a standby call. Staff and a treatment area were allocated, and the necessary equipment was prepared.

The department had trialled the rapid access diagnosis (RAD) system for patients so that patients for the majors department received a timely nurse assessment. This would help to eliminate unassessed patients waiting on corridors, reduce delays for ambulance handover and improve the flow of patients through the department. The pilot had run for a month in April 2019 and the results had been evaluated and used to change the service delivery. RAD was implemented in May 2019 and was now fully operational.

Patients were streamed on arrival at the hospital and any patients who met the RAD criteria were assessed by the RAD nurse who was a band six or seven. A quick set of observations was undertaken and a sepsis screen to identify any patients with signs of sepsis.

During the inspection, we saw that some patients were nursed in the corridor while waiting for a bed in the department. If a nurse was unavailable to staff the corridor then this role was taken by the critical care nurse. We saw during the inspection that a patient on the corridor deteriorated and that staff attended to them quickly and moved them to a more suitable area.

In the majors department all the bays could be observed from the central island where staff were seated and the computers were located.

We observed a medical handover. Each patient's condition was updated by their doctor so that the lead consultant had an overview of all the patients in the department. Patients pain was discussed and how it was being managed. Patients with confusion and delirium were also discussed.

The electronic board in the main department indicated if a patient was immuno-suppressed or was receiving cancer treatment so that treatment could be administered accordingly. The electronic system alerted the oncology team if one of their patients attended the department and the oncology specialist nurses would come down to the department to see the patient and advise on treatment. The system also alerted matrons in the community e.g. if a patient was admitted with an exacerbation of chronic obstructive pulmonary disease and they could start to plan the patient discharge.

We heard staff asking about patients allergies and that these were documented in patient records.

There were co-ordinators in the department for nursing and medical staff who moved staff around the different areas to meet the acuity of the patients.
A frail patient who was to be discharged was kept in the department as they were too frail for the discharge lounge. They were collected from the department by the ambulance crew.

Staff told us that staff from the children's ward helped to support the urgent and emergency care department. We saw on inspection that a paediatrician had attended the department to see a young child and had treated and discharged them.

Emergency Department Survey 2016

The trust scored better than other trusts for one of the five Emergency Department Survey questions relevant to safety. The trust scored “about the same” as other trusts for the remaining four questions. Add any commentary on specific questions.

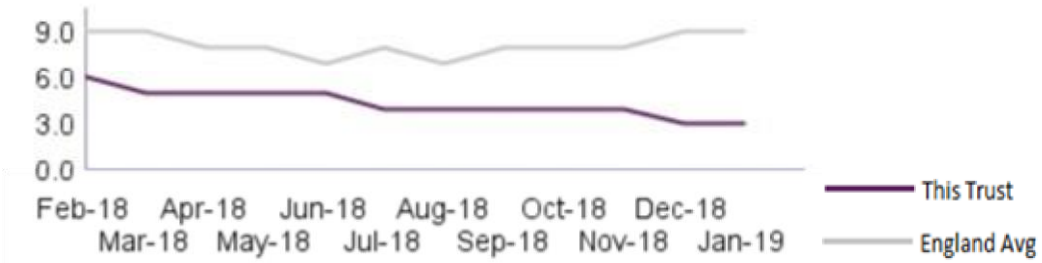
Question	Score	RAG
Q5. Once you arrived at the hospital, how long did you wait with the ambulance crew before your care was handed over to the emergency department staff?	8.9	About the same as other trusts
Q8. How long did you wait before you first spoke to a nurse or doctor?	6.9	About the same as other trusts
Q9. Sometimes, people will first talk to a nurse or doctor and be examined later. From the time you arrived, how long did you wait before being examined by a doctor or nurse?	6.7	About the same as other trusts
Q33. In your opinion, how clean was the emergency department?	8.9	About the same as other trusts
Q34. While you were in the emergency department, did you feel threatened by other patients or visitors?	9.9	Better than other trusts

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

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

The median time from arrival to initial assessment was better than the overall England median for the entire 12-month period from February 2018 to January 2019. In the latest period January 2019, the median time to initial assessment was three minutes compared to the England average of nine minutes.

Ambulance – Time to initial assessment from February 2018 to January 2019 at East Cheshire NHS Trust



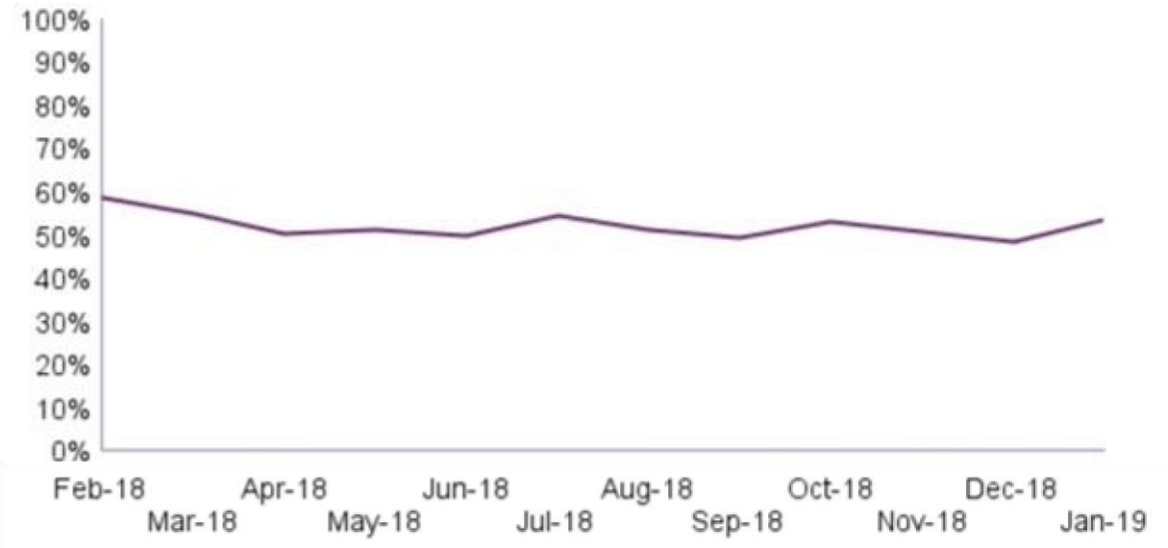
(Source: NHS Digital - A&E quality indicators)

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

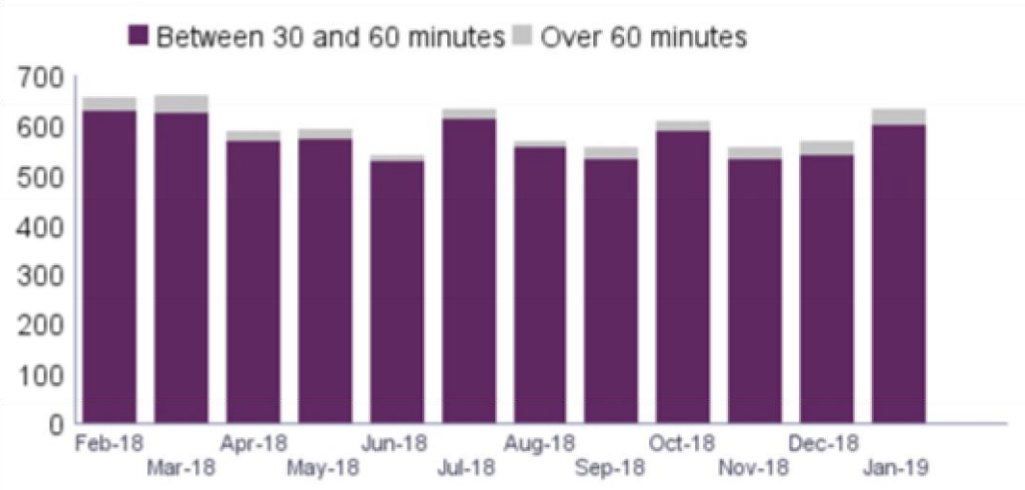
Macclesfield District General Hospital Macclesfield Cheshire

From February 2018 to January 2019 there was a stable trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes at Macclesfield District General Hospital Macclesfield Cheshire.

Ambulance: Percentage of journeys with turnaround times over 30 minutes



Ambulance: Number of journeys with turnaround times over 30 minutes - Macclesfield District General Hospital Macclesfield Cheshire

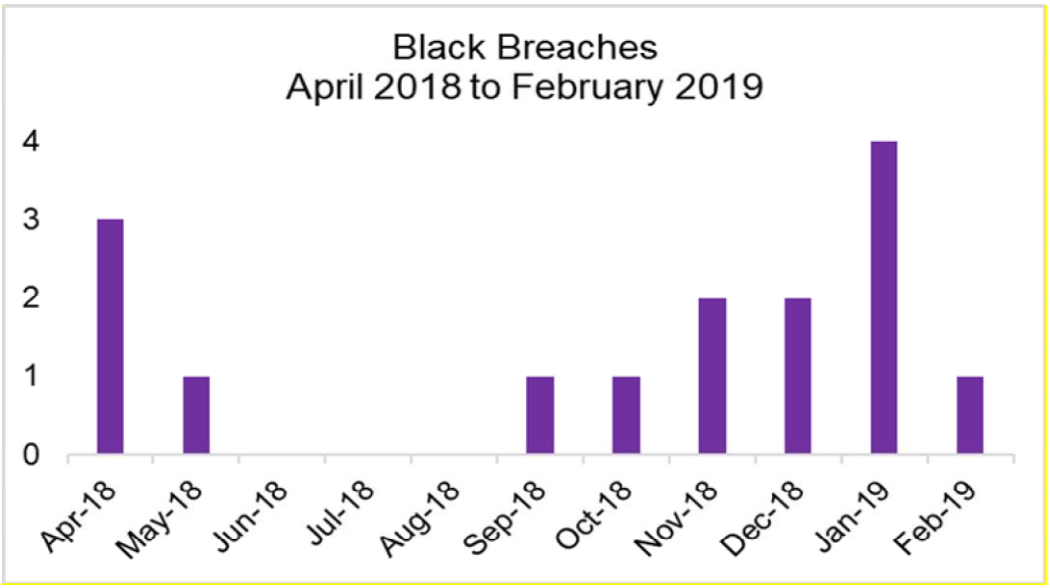


(Source: National Ambulance Information Group)

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

From April 2018 to March 2019 the trust reported 15 “black breaches” with the main reasons being:

- Multiple ambulance attendance
- No beds available
- No clinical assessment capacity



(Source: Routine Provider Information Request (RPIR) – Black breaches tab)

Nurse staffing

The service had enough 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. Managers regularly reviewed staffing levels and skill mix, and gave bank and agency staff a full induction.

The department did not use a staffing tool for the department, but they looked at capacity and acuity to plan staffing and staffing numbers and skill mix were regularly reviewed. There was also a review of staffing by the matron every year. Activity levels and acuity were used so that staffing levels matched predicted activity. This applied to the children's nurses so that at high levels of demand there would be qualified children's emergency nurse practitioners on duty, for example, at weekend.

There was a matron of the day who oversaw staffing across the hospital and scrutinised patient numbers and patient acuity and use staffing number and skill mix to reduce risk to patients across the hospital site.

There were gaps in the band five nurse staffing in the department. The department had put plans in place and the department and the trust were actively recruiting nursing staff. Senior nurses visited different venues and there had been an event at the hospital one evening during the inspection and two nurses had been recruited from this event.

The department were keen to look at skill mix in the department and had employed a paramedic for a while. They said that this had worked really well and had developed a training package to support the member of staff. They said that their skills complemented the nursing staff in the department. The paramedic had since left the hospital.

There were two registered sick children's nurses for the department; one was an emergency nurse practitioner. Staff had been sent on training but had left the department following completion of the training. Other staff were encouraged to undertake the training for adults and children. The department used the skill mix so that appropriate staff were in the department when demand was likely to be highest. There was ongoing recruitment for children's nurses.

To address the shortfall in children's nurses the urgent and emergency care staff underwent a paediatric training day every year which included advanced paediatric life support training and at the time of the inspection 92% of staff had completed this training.

There was a nursing associate for the department who was still supernumerary. Preceptorship had been put in place to support them.

There had been a pharmacist attached to the department for a trial period, but this had not been continued.

Senior staff worked hard to recruit additional staff to the department and to retain existing staff. In order to attract staff, flexible working had been offered.

The trust reported the following whole time equivalent (WTE) nurse staffing numbers for the periods below for urgent and emergency care.

The psychiatric liaison team at the hospital had no vacancies.

Trust level

Site name	Apr 17 - Mar 18			Apr 18 - Sept 18		
	Actual staff	**Planned staff**	**Staffing rate (%)**	**Actual staff**	**Planned staff**	**Staffing rate (%)**
East Cheshire NHS Trust	53.64	61.1	82%	52.94	65.73	81%

From April 2017 to March 2018, the nursing staffing rate within urgent and emergency care was 88%, compared to the 81% reported in the more recent period from April 2018 to September 2018.

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

Trust level

From April 2018 to March 2019, the trust reported a vacancy rate of 18% for nursing staff in urgent and emergency care; this was higher than the trust target of 5%.

A breakdown of vacancy rates by ward is below;

Ward / team name	Annual vacancy rate
Emergency Dept Nursing	18%
Urgent Care Management	50%
Ward 8 - MAU / EAU	15%

Urgent care management has a 50% vacancy rate, this is due to low staff numbers.

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

Turnover rates

Trust level

From April 2018 to March 2019 the trust reported a turnover rate of 13% for nursing staff in urgent and emergency care; this was higher than the trust target of 10.5%.

There was no breakdown of turnover rates by ward or site for this core service.

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

Bank and agency staff usage

Trust level

The table below shows the numbers and percentages of nursing hours in urgent and emergency care at Macclesfield District General Hospital from March 2018 to February 2019 that were covered by bank and agency staff or left unfilled.

Qualified nursing staff

Of the 137,618 total working hours available, 7% were filled by bank staff and 24% were covered by agency staff to cover sickness, absence or vacancy for qualified nurses.

In the same period, 22% of the available hours were unable to be filled by either bank or agency staff.

Non- qualified nursing staff

Of the 69,278 total working hours available, 16% were filled by bank staff and 0% were covered by agency staff to cover sickness, absence or vacancy for non-qualified nurses.

In the same period, 5% of the available hours were unable to be filled by either bank or agency staff.

Staff group	March 2018 to February 2019						
	Total hours available	Bank usage		Agency usage		Not filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
Qualified staff	137,618	9,127	7.0%	32,440	24.0%	29,695	24.00%
Non-qualified staff	69,278	11,171	16.0%	0	0.0%	3,187	0.00%

All nursing staff	206,896	20,298	10.0%	32,440	16.0%	32,882	16.00%

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

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.

Medical staffing was flexible to meet the needs of the department with more staff planned for the lunch time and tea time periods when demand was highest. The service had bank staff that they could use when the service needed additional staffing and all bank staff could access trust training.

There was consultant cover in the department from 9.00am to 21.00pm Monday to Friday though usually one consultant started earlier. There was an additional consultant in the afternoon to meet demand and consultants would stop later if necessary. There was an on-call consultant overnight.

There was a clinician who was identified as the paediatric lead (ED clinical lead). There was regular and robust clinical attendance from both paediatric and emergency care clinicians at paediatric liaison meetings.

There were some vacancies in the medical staffing and some long-term sickness, the main gaps were for middle grade doctors. The department was actively trying to recruit and retain medical staff

The department was working with the north west Deanery and had increased the numbers for the rotation of doctors into the department for training.

There were two new consultants on the bank with opportunities for these staff to become permanently employed by the trust. The clinical lead said that this was helping to build capacity in the department for the future.

The department was supporting doctors on the Certificate of Eligibility for Specialist Registration (CESR) training for entry onto the specialist register. This training required experience in other areas of medicine including anaesthetics and intensive care medicine and so doctors needed to be seconded from the urgent and emergency care department to undertake this training.

There was a paediatric middle grade doctor on site 24 hours a day seven days a week. This doctor was available to the emergency department at all times for advice and attendance if required. If a critically ill child attended the urgent and emergency care emergency department then the paediatric arrest protocol was activated so that there was senior paediatric (including consultant paediatrician) and senior anaesthetic presence in the department..

The Paediatric team were available to be bleeped 24 hours a day seven days a week to attend for paediatric alerts, standbys, child death and safeguarding concerns Fast track pathways had been developed with open access to paediatric ward if appropriate. The team provides facilitated debrief sessions as required. There was an informal agreement that paediatric nurses would help in the urgent and emergency care department if they were struggling with the treatment of a child or there was an emergency situation.

The trust reported the following whole time equivalent (WTE) medical staffing numbers for the periods below for urgent and emergency care.

Trust level

The trust reported the following whole time equivalent (WTE) medical staffing numbers for the periods below for urgent and emergency care.

Site name	Apr 17 - Mar 18			Apr 18 - Sept 18		
	Actual staff	**Planned staff**	**Staffing rate (%)**	**Actual staff**	**Planned staff**	**Staffing rate (%)**
East Cheshire NHS Trust	18.85	19.58	96%	18.25	19.53	93%

From April 2017 to March 2018, the medical staffing rate within urgent and emergency care was 96%; this was slightly higher than the 93% in the more recent period from April 2018 to

and emergency care; this was higher than the trust target of 5%. urgent
September 2018.

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

Vacancy rates

Trust level

From April 2018 to March 2019, the trust reported a vacancy rate of 9% for medical staff in urgent

A breakdown of vacancy rates by ward is below

Ward / team name	Annual vacancy rate
Emergency Dept - Medical	9%

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

Turnover rates

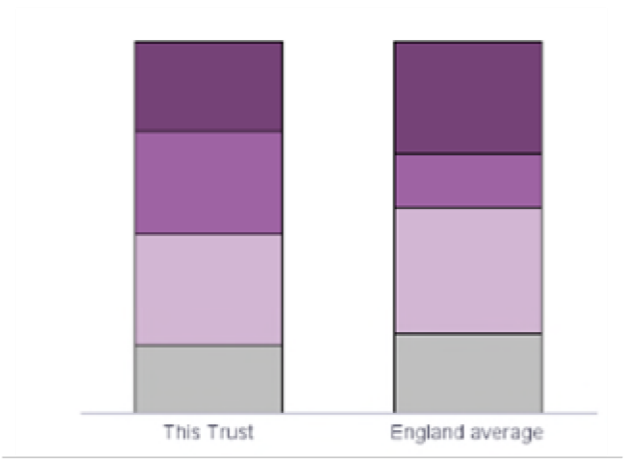
Trust level

From April 2018 to March 2019 the trust reported a turnover rate of 20% for medical staff in

Staffing skill mix

From December 2018 to December 2018, the proportion of consultant and junior (foundation year

Staffing skill mix for the 25-whole time equivalent staff working in urgent and emergency care at East Cheshire NHS Trust.



Consultant	24%	30%
Middle career^	28%	15%
Registrar group~	30%	34%
Junior*	18%	21%

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

(Source: NHS Digital Workforce Statistics)

and emergency care; this was higher than the trust target of 10.5%.

1-2) staff reported to be working at the trust were lower than the England average.

	This Trust	England average

Records

Most patient records were comprehensive, and all staff could access them easily.

The paper records were left on the main desk in trays for the staff to pick them up when treating a patient. Some of the identifiers in these records were visible, though not to patients.

We checked 15 records a mixture of electronic records and paper records.

The doctors records were electronic and were comprehensive. When the doctors made an entry into the record this populated a letter to the patients GP. There were clear times of triage, review and discharge. Dates, times, roles, signatures and bleep numbers were all present and the records were of a good standard.

The psychiatric liaison team made their records in the electronic doctors records. These were comprehensive and included full assessment details.

Nursing records were paper records and we saw that these were not always complete, there was inconsistency in the completion of the risk bundle for patients who had long stays in the department. e.g. pressure area care. However, NEWS scores had been completed and there was evidence of actions if the NEWS score increased. These were mainly on time for the one hourly and two hourly checks.

Medicines

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines.

There were electronic medicine cabinets in the department which were used for the safe storage and dispensing of medicines. There was biometric access to the system using finger prints which recorded transactions and controlled access. This allowed an audit trail of all users of the system and the system transmitted information to pharmacy for effective stock control. Stocks were replenished three times a week.

Staff told us that they really liked the system as drug cupboards were no longer necessary so staff did not have to keep looking for keys.

The urgent and emergency care department used patient group directions (PGD) to administer medicines to patients (PGD's are a legal framework that allows some registered health professionals to supply or administer specified medicines a pre-defined group of patients without them having to see a prescriber.) Patient Group Directions were in place, however the person authorising staff who could administer the medicines under the direction had signed before the staff had signed and on one there was no authorising signature and on some there was no list of staff. One had been authorised, but not dated when this had taken place.

Minutes of meetings from the medicine's management group showed that certain medicines had been approved by this group for patient group directions in the urgent and emergency care department.

Medicine errors were discussed at the trust medicines management group and trends were identified. There was a newsletter to highlight themes or incidents that had been identified or learning from alerts or single incidents that needed to be shared. There had been two of these newsletters one was "the peril of patches" and the other "drug interactions with Clarithromycin." Fridge temperature records from April had several gaps although the recent records did not include any gaps. There was a pilot so that fridge temperatures were monitored electronically from pharmacy. This meant that pharmacy knew if fridge temperatures went outside the expected ranges and could act accordingly.

In the sepsis trolley the antibiotic ampoules were not stored within their original packs.

There was a paediatric resuscitation resource folder in the critical care room with medicine doses for children of different ages.

The check on the medical gas cylinders was not documented and the daily check of the hypo box did not confirm that the contents had been checked. **Incidents**

The service managed patient safety incidents well. Staff recognised 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.

The trust had an electronic system for the reporting of incidents.

Staff told us that were confident to report incidents. Senior managers said that they thought that staff reported incidents appropriately and in a timely manner. There had been a focus on reporting pressure ulcers and staff had received training in measurement and grading of ulcers.

There was learning from incidents and we were given an example of an incident that had occurred the week before the inspection where staff had reflected on what could have been done differently and lessons learned.

Messages were disseminated through safety briefings in the department, the directorate newsletter, team meetings, and by email to all staff. Messages were put on toilet doors so that staff would see them.

Staff were aware of the duty of candour and we saw where it had been applied in the investigation of an incident.

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

From April 2018 to March 2019, the trust reported no never events for urgent and emergency care.

(Source: Strategic Executive Information System (STEIS))

Trust level

In accordance with the Serious Incident Framework 2015, the trust reported one serious incident in urgent and emergency care which met the reporting criteria set by NHS England from April 2018 to March 2019.

We reviewed a serious incident that had occurred in the department in the reporting period. A full root cause analysis of the event had been completed and the duty of candour had been applied.

There were lessons learned and additional learning for all staff in the department.

(Source: Strategic Executive Information System (STEIS))

Safety thermometer

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

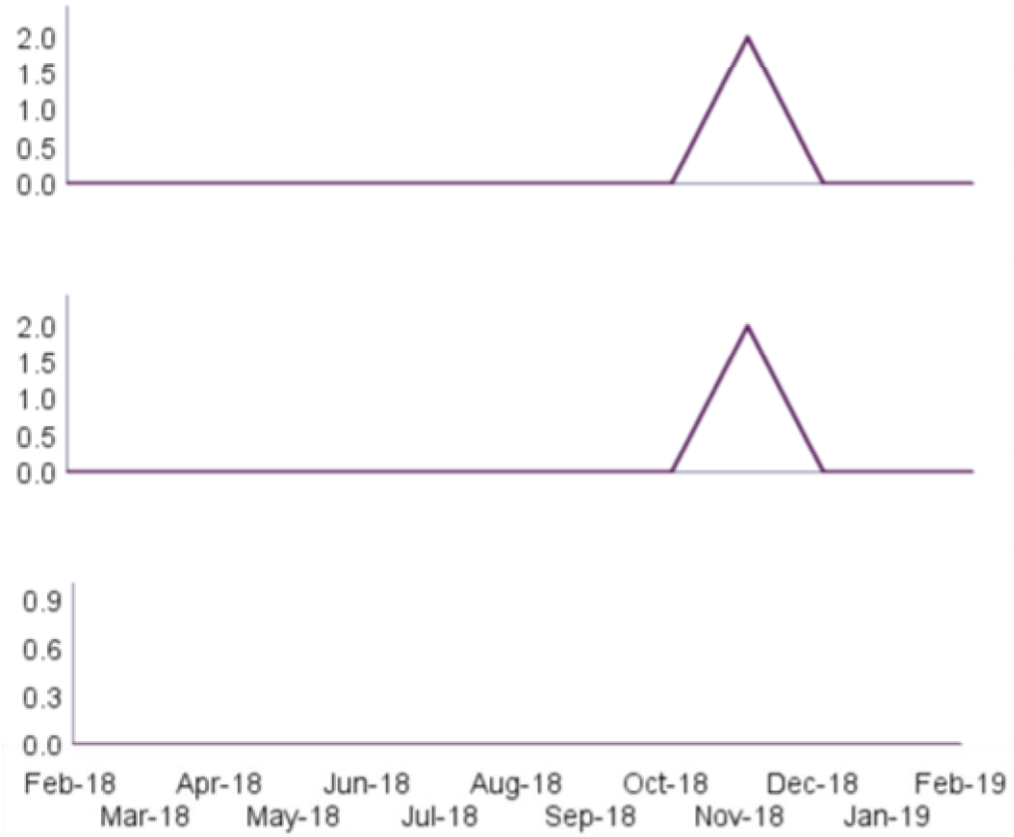
Data collection takes place one day each month. A suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of the suggested data collection date.

Data from the patient safety thermometer showed that the trust reported one new pressure ulcer, one fall with harm and zero new urinary tract infections in patients with a catheter from February 2018 to February 2019 within urgent and emergency care.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at East Cheshire NHS Trust

[1]

Total pressure ulcers (1)



[2]

Total falls (1)

[3]

Total CUTIs (0)

Insert commentary on any trends.

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

(Source: NHS Digital - Safety Thermometer)

Is the service effective?

Evidence-based care and treatment

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

Treatment was based on guidance from the National Institute for Health and Care Excellence (NICE) and the Royal Colleges. We saw in policies and pathways where there were references to NICE.

All pathways and guidance were available on the trust intranet system.

When new guidance and guidelines came out, this was reviewed by the medical director and the clinical leads. Information on the new guidance was passed to the consultants for implementation. Specialities of doctors would get together to review how the guidance was working and this would be audited

In the critical care room, there were guidelines from the North West Children's major trauma pathway and guidance from the Royal Manchester Children's hospital. There was an aide memoire from the Resuscitation Council on advanced paediatric life support.

We saw pathways for children for first febrile convulsion, a hot infant under three months and a return to the ward after attendance in the department of less than 48 hours.

For adults the Greater Manchester major trauma pathway was available in the critical care room.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health.

There were refreshments available in the department from vending machines and close to the department were a café and a shop. There was also a canteen for staff and patients on the first floor of the hospital.

Patients in the acute assessment area were provided with meals and refreshments if appropriate. The meal trolley provided meals for patients who were waiting for a bed in another part of the hospital. Sandwiches and drinks were always available for patients.

A water machine was due to be installed in the department for the use of staff and patients.

Patients we saw on inspection were given tea and toast and we saw that patients were given appropriate cups for drinking.

In the CQC emergency department survey, the trust scored 7.6 for the question “where you able to get suitable food or drinks when you were in the emergency department?” The score was about the same as other trusts.

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

Pain relief

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

Individual patients pain was discussed at medical handover with advice from senior medical staff.

The emergency nurse practitioners could administer pain relief to children and young people when they first attended the department for streaming.

We checked 10 patient records to see if pain scores had been recorded and found sometimes if patients were not in pain, this was not recorded. Where the patient was in pain, there was sometimes a gap between the recording of the pain and the time that the analgesia was administered.

There had been complaints and incidents raised in the department about the administration of analgesia.

In the CQC emergency department survey, the trust scored 7.2 for the question “how many minutes after you requested pain relief medicine did it take before you got it?” The response was about the same as other trusts.

The trust scored 8.3 for the question “do you think the hospital staff did everything they could to help control your pain?” This score was better than other trusts.

Question – Effective	Score	RAG
Q31. How many minutes after you requested pain relief medication did it take before you got it?	7.2	About the same as other trusts
Q32. Do you think the hospital staff did everything they could to help control your pain?	8.3	Better than other trusts
Q35. Were you able to get suitable food or drinks when you were in the emergency department?	7.6	About the same as other trusts

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

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The trainee doctors were all involved in the quality improvement programme and were registered with the research team in the trust. They had presented the results of their audits in the department.

There had been a Commissioning for Quality and Innovation (CQUIN) to improve services for people with mental health needs who present to the urgent and emergency care department.

RCEM Audit: Moderate and acute severe asthma 2016/17

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

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

- Standard 1a: oxygen should be given on arrival to maintain sats 94-98%. This department: 69%; UK: 19%.
- Standard 3: High dose nebulised β2 agonist bronchodilator should be given within 10 minutes of arrival at the UEC. This department: 90%; UK: 25%.

The department was in the lower UK quartile for three standards:

- Standard 2a: Vital signs should be measured and recorded on arrival at the ED. This department: 0%; UK: 26%.
- Standard 5: If not already given before arrival to the emergency department, steroids should be given as soon as possible:
- Standard 5a: within 60 minutes of arrival (acute severe). This department: 0%; UK: 19%.
- Standard 5b: within 4 hours (moderate). This department: 0%; UK: 28%.

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

- Standard 4: Add nebulised Ipratropium to nebulised β2 agonist bronchodilator therapy. This department: 86%; UK: 77%.

- Standard 9: Discharged patients should have oral prednisolone prescribed according to guidelines. This department: 52%; UK: 52%.

(Source: Royal College of Emergency Medicine)

RCEM Audit: Consultant sign-off 2016/17

Macclesfield District General Hospital did not participate in the RCEM Consultant sign-off audit 2016/17.

RCEM Audit: Severe sepsis and septic shock 2016/17

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

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

- Standard 5: blood cultures obtained within one hour of arrival. This department: 63.6%; UK: 44.9%.

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

The department's results for the remaining 7 standards were all within the middle 50% of results.

- standard 1: respiratory rate, oxygen saturations (SaO_2), supplemental oxygen requirement, temperature, blood pressure, heart rate, level of consciousness (AVPU or GCS) and capillary blood glucose recorded on arrival. This department: 55.3%; UK: 69.1%.

- standard 2: review by a senior (ST4+ or equivalent) emergency department medic or involvement of critical care medic (including the outreach team or equivalent) before leaving the emergency department. This department: 55.3%; UK: 64.6%.

- standard 3: O_2 was initiated to maintain SaO_2>94% (unless there is a documented reason not to)

within one hour of arrival. This department: 52.9%; UK: 30.4%.

- standard 4: serum lactate measured within one hour of arrival. This department: 71.4%; UK: 60.0%.

- standard 6: fluids – first intravenous crystalloid fluid bolus (up to 30 mL/Kg) given within one hour of arrival. This department: 40.6%; UK: 43.2%.

- standard 7: antibiotics administered: within one hour of arrival. This department: 44.1%; UK: 44.4%.

- standard 8: urine output measurement/fluid balance chart instituted within four hours of arrival. This department: 27.3%; UK: 18.4%.

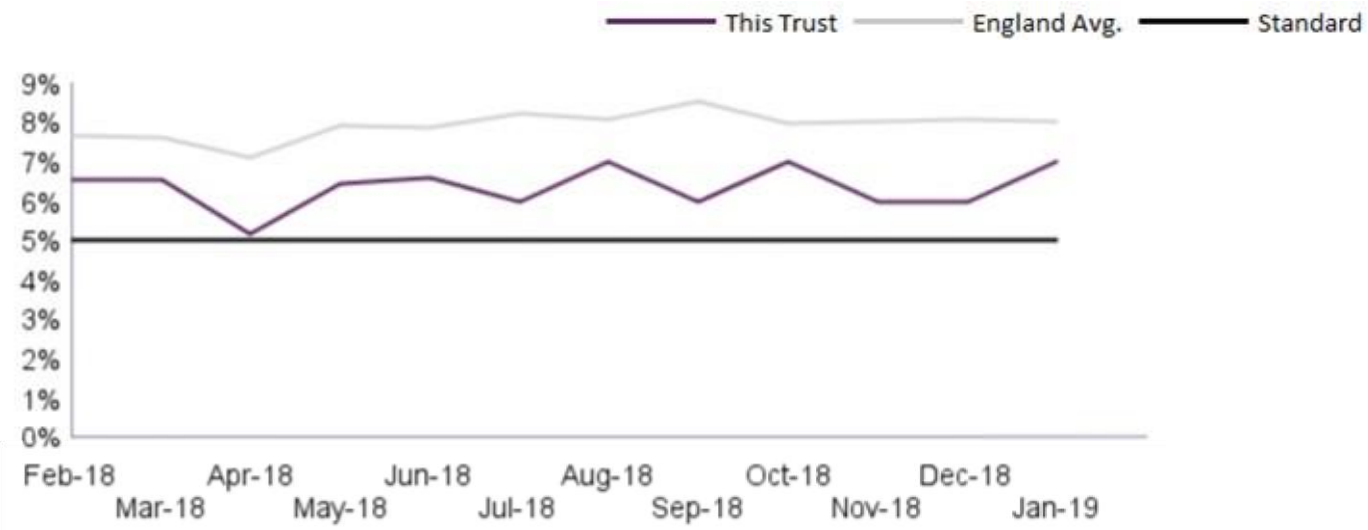
(Source: Royal College of Emergency Medicine)

The trust does not participate in the trauma audit and research network audit.

Unplanned re-attendance rate within seven days

From February 2018 to January 2019, the trust's unplanned re-attendance rate to A&E within seven days was worse than the national standard of 5% and better than the England average. In the latest month January 2019 trust performance was 7.0% compared to an England average of 8.0%.

Unplanned re-attendance rate within seven days - East Cheshire NHS Trust



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

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.

There was a strong culture of learning in the department. Training was delivered in a variety of ways to engage staff. There had been simulation exercises for mental health issues, the deteriorating patient, pressure care, trauma and the walking wounded. There had also been study sessions around non-clinical areas such as dementia, end of life and conflict resolution.

On Tuesday mornings, for a few hours, the consultant clinical lead and the nurse training educator would wear red so that they could be identified as providing training during that time. They would lead training sessions with staff but also make themselves available so that staff could ask questions. This was an initiative with Health Education England.

There were competencies for band six and seven staff and we saw that staff were working through these competencies and that some had been signed off. There was good development for band five nurses so that they could move up to band six after appropriate training and experience.

Health care assistants who worked in the department were band three and there was training for these staff. These included taking blood pressure, phlebotomy, wound dressings and applying plaster casts for patients before they could be seen in an orthopaedic clinic. Senior staff on the ward said that the health care assistant role could be further developed in the department.

The clinical lead for the department said that they had done some work with the nursing staff showing them how to suture. We saw during the inspection that an advanced nurse practitioner showing health care assistants how to plaster a patient's wrist.

There was a simulation suite with virtual reality to demonstrate to staff what it was like to be frail, staff said this training was good. This had been used by the trust board and they had actors in to act out a patient trying to leave the urgent and emergency care department who did not have mental capacity. The frailty team had done other training in the department with medical and nursing staff to raise awareness of the issues of frailty.

The nursing staff involved in the treatment of children and young people had completed their competencies and we saw that these had been signed off. There were simulations for paediatric life support and resuscitation. Some staff were signed up for course at a university, this had been part of their appraisal process. There were also paediatric ward placements for staff.

The staff in urgent and emergency care had completed their paediatric life support training and their advanced paediatric life support training to support the children's services in the department. At the time of the inspection 92% of staff had completed appropriate training.

New staff were supernumerary to the department for an average of six weeks, this could be extended if necessary. Staff completed a training needs analysis and then training could be provided to meet their needs. Some training was provided from the department and some was provided by specialist services within the hospital.

A member of staff we spoke with said that the training in the department was really good, much better than their previous hospital which was a large teaching hospital.

There were communication groups which provided informal clinical supervision in groups.

Appraisal rates

From March 2018 to February 2019, 93% of staff within urgent and emergency care department at the trust received an appraisal compared to a trust target of 90%.

There is no appraisal data for medical staff.

Trust level

Staff group	March 2018 to February 2019				
	Staff who received an appraisal	**Eligible staff**	**Completion rate**	**Trust target**	**Met (Yes/No)**
Qualified ambulance service staff	1	1	100%	90%	Yes
Support to doctors and nursing staff	44	46	96%	90%	Yes
Qualified nursing & health visiting staff (Qualified nurses)	43	48	90%	90%	Yes
Grand Total	**88**	**95**	**93%**	**90%**	**Yes**

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

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 excellent multi-disciplinary working across all areas of the department. Staff in the main department, the out of hours service and the acute assessment unit worked together to treat patients safely. During periods of severe pressure out of hours staff would support the urgent and emergency care department.

Consultants of different specialities worked together to implement, review and audit guidance. Training for doctors and consultants was across specialities to provide better outcomes for patients.

There were physiotherapists and occupational therapists in the department who worked to mobilise patients and to test mobility to see if patients could return home.

The hospital matrons shared an office in the hospital; they said that this was really useful and encouraged them to work together.

There was strong support from the children's ward for the urgent and emergency department with staff in reaching into the department from the ward. There was also a rotation of staff onto the ward to support training and development.

The psychiatric liaison team were based at the hospital and worked well with the urgent and emergency care team to support patients in the 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.

Diagnostic services were available, X-ray and computerised tomography 24 hours a day, seven days a week.

The psychiatric liaison team was available 24 hours a day, seven days a week.

Health promotion

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

There were leaflets around the department to signpost patients to well-being services.

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 agreed personal measures that limit patients' liberty.

Staff were knowledgeable about the mental capacity act and about what "best interests" meant when treating patients. This was documented in patient records.

The frailty team assessed patients for delirium, depression and dementia to understand what capacity they had at different times.

There had been simulation training in the department for staff to demonstrate how and when to use the mental capacity act.

We case tracked eight patients who had come into the hospital through the urgent and emergency care department and were under the care of the psychiatric liaison team. We saw in the patient records that the mental capacity assessments were completed in a timely manner and were well documented in the patient records. We saw that a patient was assessed by the psychiatric liaison team as requiring a Deprivation of Liberty Safeguards order and that the paperwork had already been completed.

Is the service caring?

Compassionate care

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

We heard staff introducing themselves to patients in the department. Staff were polite and patient and did not rush patients even though the department was very busy.

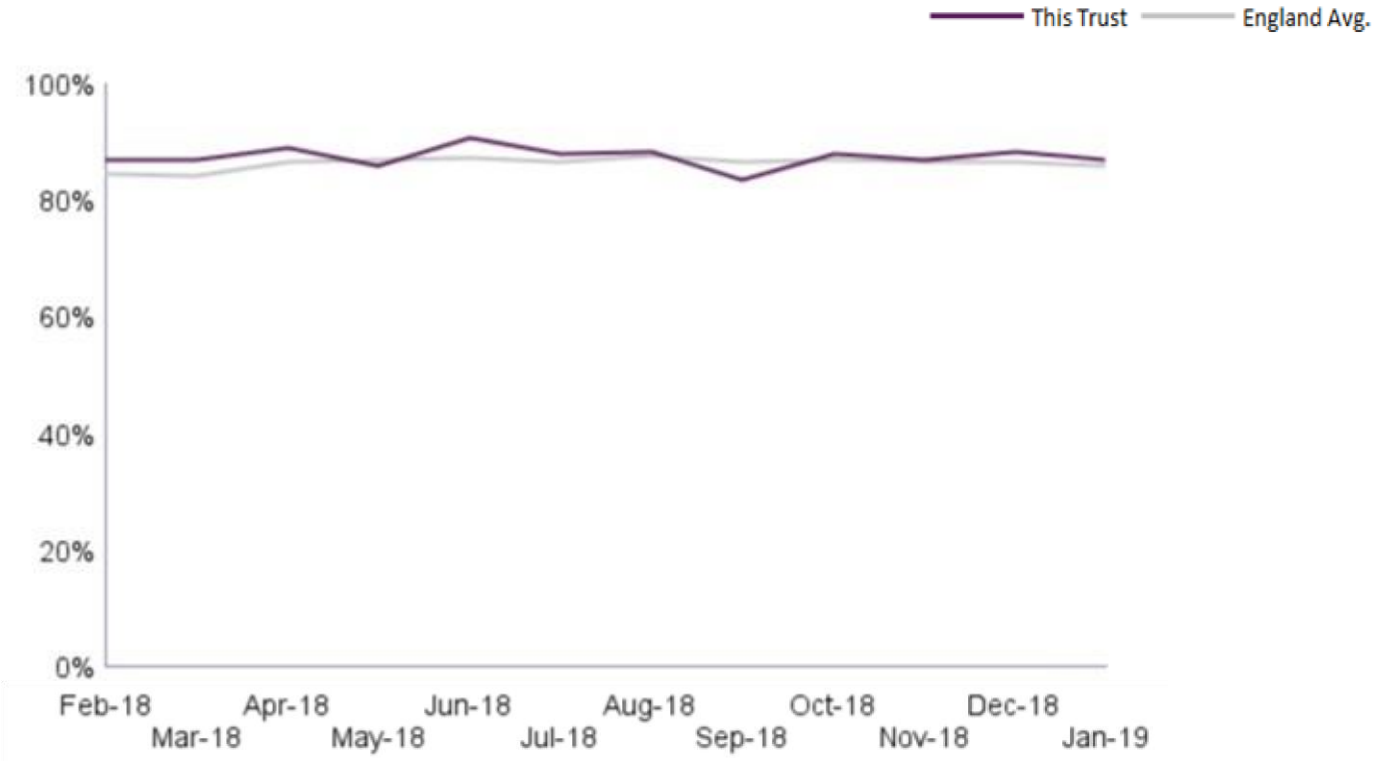
Privacy and dignity of patients was respected by the closing of the two doors on the corridor so that there was a closed off area for the exchange of information when the ambulance handover was taking place.

We saw staff asking patients if they were warm enough and offering extra blankets.

We spoke with eight patients and their relatives. Feedback about the department was very positive with patients saying, “my treatment was brilliant” and “I can’t fault the treatment that I have had” and “I was treated with respect.”

The trust’s urgent and emergency care Friends and Family Test performance (% recommended) was about the same as the England average from February 2018 to January 2019. In the latest month January 2019 trust performance was 86.9% compared to the England average of 86%.

A&E Friends and Family Test performance - East Cheshire NHS Trust



(Source: NHS England Friends and Family Test)

Emotional support

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

We saw that staff were respectful of patients and protected their privacy and dignity. Staff closed curtains if they could and if curtains needed to be left open so that patients could be observed, they ensured that patients were covered with a blanket.

We observed staff providing emotional support. During the inspection we saw that a patient's relative became upset during the streaming process and staff immediately found a private room for them and comforted the relative.

Patients told us that staff were very reassuring and that they were confident in the decisions that they made.

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.

We saw that many patients attended the department with friends and relatives. Staff involved patients and their carers in discussions about their care in the department. Many people attending the department were older people who needed a lot of support from staff and a number of these patients lacked capacity. Explanations about treatment were very thorough.

Patients told us that their families were involved in discussions about their care, one patient said that their family had attended the department they said "my family asked, and everything was explained"

We observed an example of staff understanding the social situation of patients. A patient had attended the department and they were the main carer for a relative; we saw that social workers were being involved to support both the patient and the carer.

The trust scored better than other trusts for four of the 24 emergency department survey questions relevant to the caring domain. The trust scored about the same as other trusts for the remaining 20 questions.

Question	Trust 2016	2016 RAG
Q10. Were you told how long you would have to wait to be examined?	4.0	About the same as other trusts
Q12. Did you have enough time to discuss your health or medical problem with the doctor or nurse?	9.0	Better than other trusts
Q13. While you were in the emergency department, did a doctor or nurse explain your condition and treatment in a way you could understand?	8.5	About the same as other trusts
Q14. Did the doctors and nurses listen to what you had to say?	9.2	About the same as other trusts
Q16. Did you have confidence and trust in the doctors and nurses examining and treating you?	8.9	About the same as other trusts
Q17. Did doctors or nurses talk to each other about you as if you weren't there?	9.4	Better than other trusts
Q18. If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?	8.4	Better than other trusts

Question	Trust 2016	2016 RAG
Q19. While you were in the emergency department, how much information about your condition or treatment was given to you?	9.1	About the same as other trusts
Q21. If you needed attention, were you able to get a member of medical or nursing staff to help you?	8.3	About the same as other trusts
Q22. Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you in the emergency department?	9.5	Better than other trusts
Q23. Were you involved as much as you wanted to be in decisions about your care and treatment?	8.4	About the same as other trusts
Q44. Overall, did you feel you were treated with respect and dignity while you were in the emergency department?	9.3	About the same as other trusts
Q15. If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?	7.6	About the same as other trusts
Q24. If you were feeling distressed while you were in the emergency department, did a member of staff help to reassure you?	7.3	About the same as other trusts
Q26. Did a member of staff explain why you needed these test(s) in a way you could understand?	8.6	About the same as other trusts
Q27. Before you left the emergency department, did you get the results of your tests?	8.6	About the same as other trusts
Q28. Did a member of staff explain the results of the tests in a way you could understand?	9.0	About the same as other trusts
Q38. Did a member of staff explain the purpose of the medications you were to take at home in a way you could understand?	9.4	About the same as other trusts
Q39. Did a member of staff tell you about medication side effects to watch out for?	5.2	About the same as other trusts
Q40. Did a member of staff tell you when you could resume your usual activities, such as when to go back to work or drive a car?	5.8	About the same as other trusts
Q41. Did hospital staff take your family or home situation into account when you were leaving the emergency department?	5.7	About the same as other trusts
Q42. Did a member of staff tell you about what danger signals regarding your illness or treatment to watch for after you went home?	5.9	About the same as other trusts

Q43. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left the emergency department?	7.9	About the same as other trusts
Q45. Overall... (please circle a number)	8.4	About the same as other trusts

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

Is the service responsive?

Service delivery to meet the needs of local people

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.

Patients who attended the hospital urgent and emergency care department were streamed on arrival at the hospital and directed to the area most appropriate to meet their needs. The streaming was carried out by a band 6 or 7 nurse and patients would be sent to the primary care centre, minor injuries, major injuries, resuscitation or the children's waiting areas. There was also an ambulatory assessment unit.

Patients attending the hospital were asked to take a number and they were then called for assessment, there was a screen to try to address privacy issues and we were told that the estates department were looking to install something more permanent in the department.

About 8% of patients were streamed to the primary care centre. There was an acute visiting service where GP's, who worked closely with the ambulance service, could be sent out to patients in their own homes and this supported admission avoidance. This service saw about 400 patients a month. The primary care service is not covered by this inspection.

The minor injuries area was staffed by emergency nurse practitioners (ENP) from 8.00am to midnight. There was one ENP on duty on weekdays and two at weekends. Medical cover could be provided as necessary. About 30% of attendances in the department were for minor injuries. There were three treatment rooms and one had a slit lamp for the use of patients with eye injuries.

The walking majors area was staffed from 8.00am to 8.00pm with registered nurses. Patients who were able to sit were encouraged to sit in chairs. There was an area for patients who required additional observation called the sub wait area. The majors area had 11 cubicles of which four had no oxygen or suction and were used for less poorly patients. There were two side rooms that could be used for patients who required more privacy.

The resuscitation area had three bays and there was also a critical care room which was used for the treatment of both adults and children.

There was an acute assessment unit (AAU) with an ambulatory waiting area, two treatment rooms and five assessment trolleys. This was for the treatment of patients with acute medical conditions that needed urgent investigation for conditions such as deep venous thrombosis, pulmonary embolism and pneumonia. These patients were often referred from their GP. It was open from 08.00am to midnight. The doctor overseeing the AAU was the clinical lead for acute medicine.

Some patients attended the AAU for planned treatment including intravenous antibiotics, blood transfusions and frusemide for the treatment of heart failure. Patients could be referred from the hospital out-patient departments for treatment

Medical staff told us that it was a good service and kept patients out of the main urgent and emergency care department. There was consultant cover in the department on Monday to Friday 9.00am to 17.00pm and cover from the acute physician from 17.00pm to 20.00pm. At weekend it was mainly used for planned treatments. There were two doctors covering the department with one nurse, a health care assistant and a nurse co-ordinator 10.00am till 22.00pm.

The maximum stay for a patient in the AAU was 12 hours and staff had to complete an incident form for every patient who exceeded the 12-hour maximum stay.

The service treated children and young people and about 20% of the attendances in the department were children and young people. There was a dedicated waiting room and two cubicles which were linked to the majors area. The waiting room had toys, a television and there were electronic devices for the use of children attending the department. There were toilets for children and a room for breast feeding if required.

There were link nurses in the department to encourage areas of interest for the staff. One of the link nurses had an interest in organ donation.

There was a room that could be used as a viewing room for the relatives of patients that had died. There was a relatives room that had poor décor and was not very inviting. Staff told us that this had only recently been designated as the relatives room.

Ambulance patients were handed over in the corridor in an area where doors could be closed for privacy, dignity and confidentiality. Patients could be assessed in this area.

Patients who had to stay in the department overnight were bedded down in the ambulatory assessment unit.

The urgent and emergency care department was co-located with the X-ray and computerised tomography department so that these services were immediately accessible to patients attending

the service. These services were available 24 hours a day, seven days a week. However, signage to the X-ray department was unclear for patients.

There was no surgical assessment unit at the hospital due to low numbers of unscheduled surgical admissions, there were protocols in place for patients attending who may require surgery.

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 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 department had received Autism Accreditation by the National Autistic Society with processes in place to support people with autism.

Patients with learning disabilities had passports that they could bring with them when they attended hospital with appropriate information. There were also "this is me" documentation for patients with dementia or cognitive impairment. Easy read documents were also available.

The electronic board for access and flow indicated if patients had dementia, learning disability or other cognitive issues.

These was a telephone number for carers to contact the department if they thought that the patient may present significant challenges, which allowed staff to make reasonable adjustments before the patient arrived.

There was a reasonable adjustment box in the department which contained items such as a pain chart and pictures of procedures that could be used for patients with a learning disability or cognitive impairment. There were also distraction aids to distract patients with dementia.

The department had cannula sleeves so that patients could not remove their cannula.

Door frames and clocks were dementia friendly and one of the cubicles had been painted in dementia friendly colours.

When discharged from the department any patient with a learning disability or cognitive impairment was provided with a copy of the electronic discharge record containing a summary of their treatment, medicines prescribed, investigations carried out and any follow up appointment.

There was a frailty team at the hospital which was headed up by a GP (frailty lead) with three physiotherapists and an occupational therapist. There was additional occupational therapist capacity in the winter months. The team now included a rotational band five post which helped to embed the service into the hospital. The team used the Rockwood frailty tool.

The team mainly worked between the urgent and emergency care department and the medical assessment unit. Any older person who had fallen was comprehensively assessed by the team. This included taking patient's blood pressures standing and lying down, and medicines were reviewed for polypharmacy which can increase the risk of falls. We saw that patients prescriptions had been reviewed and by the doctor to try to reduce the risk of patients falling There was also a matron who went into the community to safeguard patients and their families.

The team used the 4-item Abbreviated Mental Test (AMT4) for detecting cognitive impairment. They also assessed patients for delirium and worked with the liaison psychiatry team to identify

dementia and depression in older patients. They worked with an advanced dementia team across hospitals and community. The staff in the urgent care department said this service was good and supported their work.

In the urgent and emergency care department there was a 136 suite. (A 136 suite is a place of safety for those who have been detained under Section 136 of the Mental Health Act.). There was a panic button on the wall so that staff could summon help in an emergency and there were no ligature points in the room. There was information about chaperones on the wall. There were also other rooms in the department that could be used for interviews.

There was a psychiatric liaison team who were based at the hospital but were employed by a specialist mental health trust. They were available 24 hours a day, seven days a week. Staff in the department told us that they were responsive and usually came with in the hour of a request being made.

They could also refer patients to other teams in the trust including the older persons community mental health team.

There were signs on the walls telling patients how to book interpreters and staff told us that they had contacted interpreters when necessary.

If one of the treatment rooms was being used as a viewing room for deceased patients, a discreet sign was put on the door so that staff knew not to enter the room.

There was a box in the critical care room so that staff could collect mementoes from children who passed away in the department.

Emergency Department Survey 2016

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

Question – Responsive	Score	RAG
Q7. Were you given enough privacy when discussing your condition with the receptionist?	7.2	About the same as other trusts
Q11. Overall, how long did your visit to the emergency department last?	7.4	About the same as other trusts
Q20. Were you given enough privacy when being examined or treated?	9.2	About the same as other trusts

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

Access and flow

Patients could not always access services when needed and receive treatment within agreed timeframes and NHS constitutional standards

At the time of the inspection the department was very busy. The trust had accepted a number of ambulance diverted patients from a nearby trust overnight. Staff told us that they had capacity for about 25 patients a day and on one of the inspection days 48 patients had attended the department.

There was an electronic board in the main part of the department which had all the patients in the department on it. It showed how long patients had been waiting and if there was a breach of any targets. If patients needed investigations these were shown in yellow and turned green on completion. There was a co-ordinator who had oversight of the board and managed flow including sorting out referrals and following up diagnostic tests.

The trust had a full capacity protocol standard operating procedure which was part of the escalation policy. The trust produced a root cause analysis about any breach in the four-hour target every week.

There were three bed flow meetings every day Monday to Friday at 8.30am, midday and 15.30pm. There were also meetings at weekend. We attended two of these meetings during the inspection, the meetings had a set agenda. At the midday meeting, attendees included the senior manager on call and the manager on call; this was part of the actions set out in the full capacity protocol. The matron of the day also attended. Nursing and medical staffing levels were reviewed, and skill mix adjusted appropriately, and escalation actions were put in place to try to address the flow issues through the hospital. Other actions included reviewing delayed transfers of care, breaches, bed availability, discharges and any elective surgery. At the 15.30pm meeting we saw that all the actions had been put in place.

There were action cards for each of the four operational escalation levels (OPEL) described in the full capacity policy and these were used to review and assign the appropriate OPEL level. We saw that these were used at the bed meetings

Senior staff in the department requested additional staff to support the department; they said that these requests were never turned down though they had to justify the need for the staff. We saw during the inspection that additional qualified nurses; health care assistants and medical staff were booked from the bank to support the shifts.

We saw that patients were handed over from the ambulance crews in a timely manner and crews we spoke with said the system worked well. Ambulance crews were asked to ring a bell on arrival in the department and to ring it again if they had not been seen in five minutes. Feedback from the paramedics was very positive about handovers at the hospital.

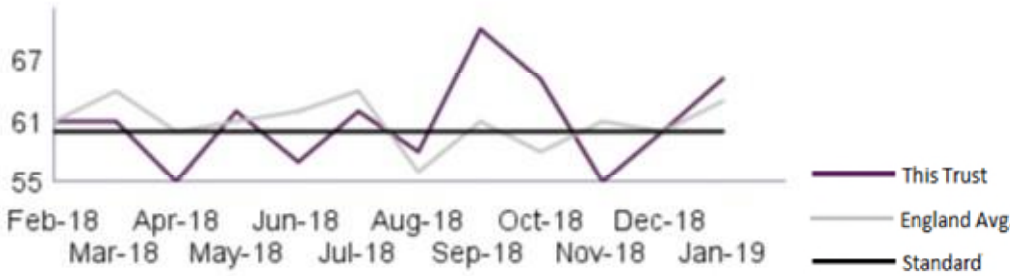
The department had put up electronic screens around the department, so they would be able to inform patients of the waits in the department. These were due to go live this month. In the acute assessment unit there was a board telling patients how long their wait would be. There was currently an intercom system so that patients could be informed of any wait and staff could be called to any part of the department.

Median time from arrival to treatment (all patients)

The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment should be no more than one hour. The trust did not meet the standard for seven months over the 12 - month period from February 2018 to January 2019.

From February 2018 to January 2019 performance against this standard showed no consistent trend.

Median time from arrival to treatment from February 2018 to January 2019 at East Cheshire NHS Trust



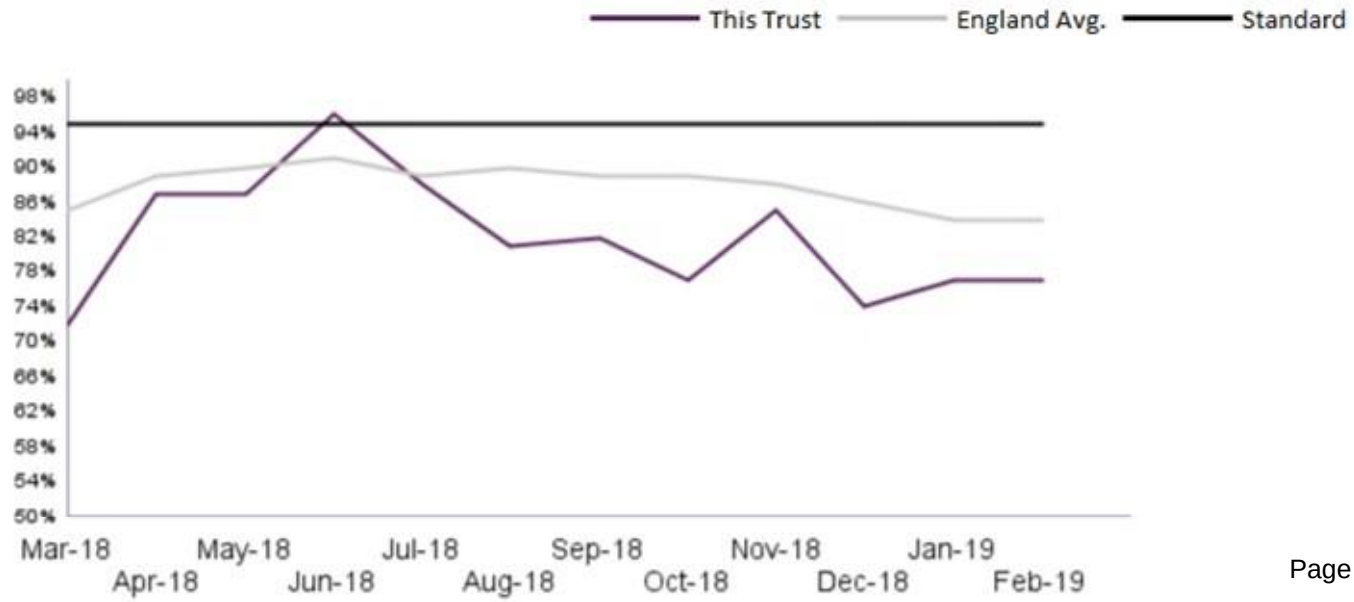
(Source: NHS Digital - A&E quality indicators)

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

The Department of Health's standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the emergency department.

From March 2018 to February 2019 the trust failed to meet the standard and performed worse than the England average aside from June 2018 when performance was 96% against the England average of 91%.

Four- hour target performance - East Cheshire NHS Trust

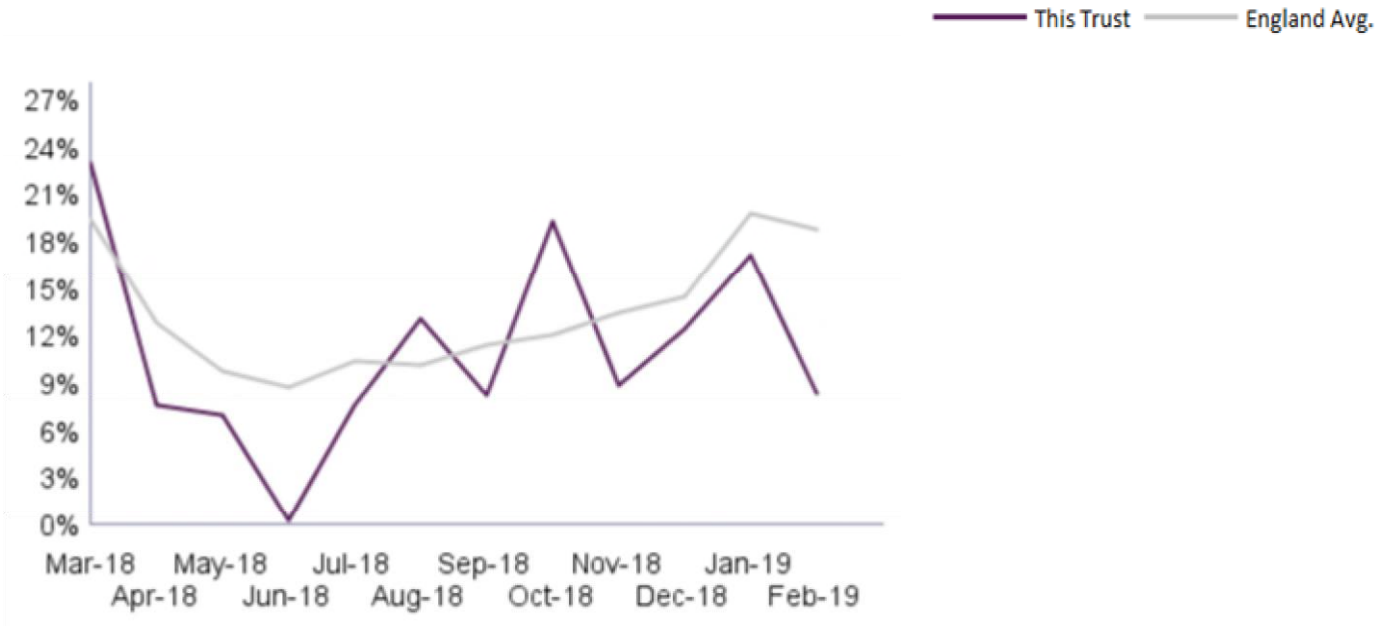


(Source: NHS England - A&E Waiting times)

Percentage of patients waiting more than four hours from the decision to admit until being admitted

From March 2018 to February 2019 the trust's monthly percentage of patients waiting over four hours from the decision to admit until being admitted was generally better than the England average.

Percentage of patients waiting more than four hours from the decision to admit until being admitted - East Cheshire NHS Trust



(Source: NHS England - A&E SitReps).

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

Over the 12 months from March 2018 to February 2019, 16 patients waited more than 12 hours from the decision to admit until being admitted. The highest numbers of patients waiting over 12 hours were in March 2018 (221), October 2018 (187) and January 2019 (179).

Month	Number of patients waiting more than four hours to admission	Number of patients waiting more than 12 hours to admission
Mar-18	221	4
Apr-18	73	0
May-18	67	0
Jun-18	3	0
Jul-18	68	0
Aug-18	120	0
Sep-18	74	0
Oct-18	187	6
Nov-18	82	1
Dec-18	125	2

Jan-19	178	3
Feb-19	79	0

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

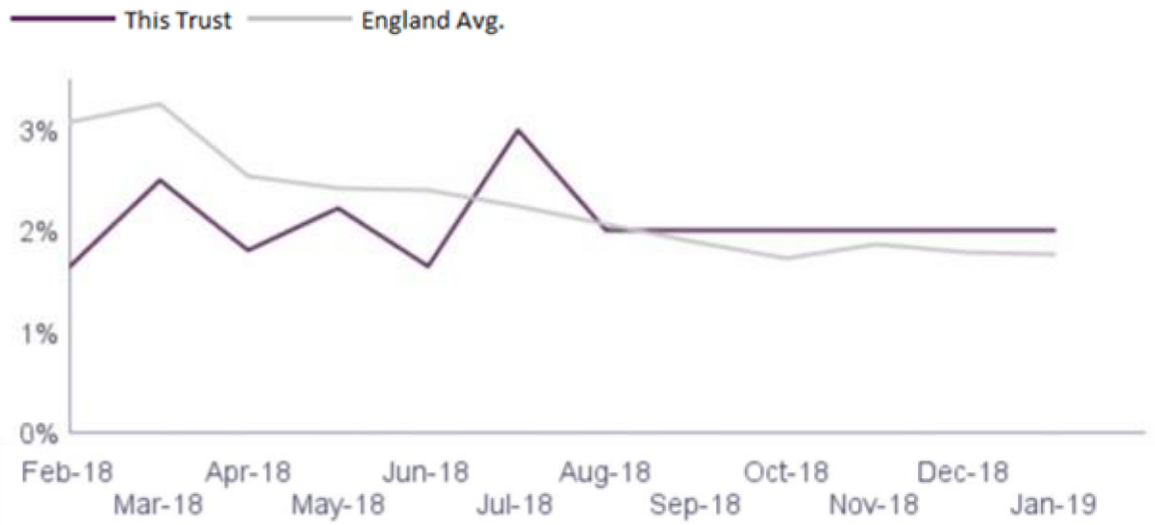
Percentage of patients that left the trust's urgent and emergency care services before

being seen for treatment

From February 2018 to June 2019 the monthly percentage of patients that left the trust's urgent and emergency care services before being seen for treatment was better than the England average. From July 2018 to January 2019 the trusts performance was similar to the England average.

In the latest month January 2019, the percentage of patients that left the trust's urgent and emergency care services before being seen for treatment was 2.0%, compared to the England average which was 1.8%.

Percentage of patient that left the trust's urgent and emergency care services without being seen - East Cheshire NHS Trust



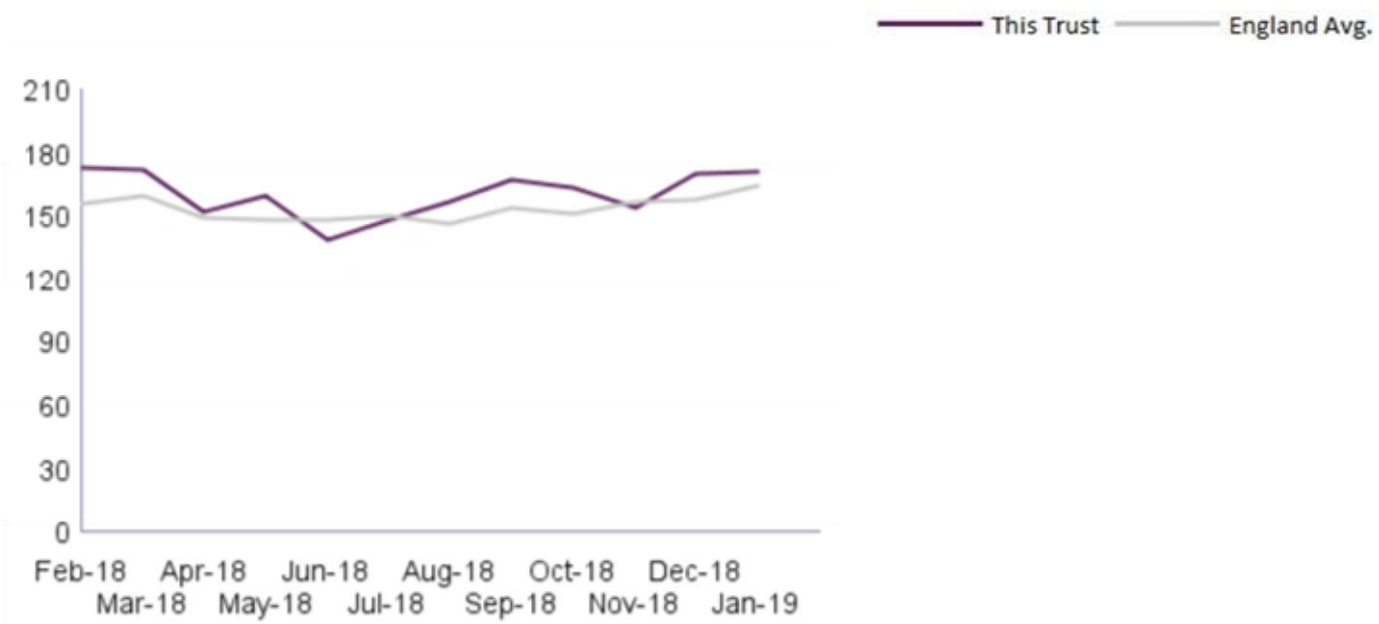
(Source: NHS Digital - A&E quality indicators)

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

From March 2018 to February 2019 the trust's monthly median total time in U and EC for all patients was worse than the England average for seven months.

In the latest month January 2019, the trust's monthly median total time in U and EC for all patients was 171 minutes compared to the England average of 164 minutes.

Median total time in A&E per patient - East Cheshire NHS Trust



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

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.

Staff told us that they would always try to address patients concerns when they were in the department and that they would apologise to patients if things had gone wrong. We saw that staff apologised to patients for keeping them waiting.

Complaints were overseen by the Safety, Quality and Standards committee which met ever three months. There was an analysis of all the complaints received in the hospital which were then broken down into directorates. The committee could identify trends in complaints in each area and any learning needs for staff. We saw there were examples of learning and improvements to practice which had been fed back to staff.

We saw that a patient complaint from the urgent and emergency care department was on the agenda for the meeting of the 6 November 2019. The complaint was about the treatment of child with sepsis and the lessons learned and actions put in place following the incident were noted in the minutes.

Trust level

From April 2018 to March 2019 the trust received 30 complaints in relation to urgent and emergency care at the trust (22% of total complaints received by the trust). The trust took an average of 33 days to investigate and close complaints, this is in line with their complaints policy,

which states complaints should be closed within 25-45 days. If there were investigations into a serious incident, then the complaint could go to 60 days.

A breakdown of complaints by type is shown below:

Type of complaint	Number of complaints	Percentage of total
Patient Care	18	60%
Values & behaviours (staff)	4	13%
Communications	2	7%
Admissions and discharges (excluding delayed discharge due to absence of care package)	2	7%
Other (specify in comments)	2	7%
Access to treatment or drugs	1	3%
Privacy, dignity & well being	1	3%

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

Number of compliments made to the trust

From April 2018 to February 2019 there were 107 compliments about urgent and emergency care at the trust. A breakdown of compliments by ward/area is below

Ward/area	Number of compliments	Percentage of total
Accident and Emergency - Emergency Medicine (A&E)	78	73%
Acute Assessment Unit (AAU)	4	4%
GP Out of Hours - East (Macclesfield)	25	23%
Total	**107**	**100.0%**

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

Is the service well-led?

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 urgent and emergency care department was part of the acute and integrated care directorate.

The leadership, both medical and nursing, was proactive and aware of the challenges of the department. One of the strengths of the department was the integrated working between doctors and nurses and other staff including allied health professionals and the health care assistants. The department also worked well with the GP out of hours service with joint meetings across both services.

To support the retention of the medical staff there was training in leadership and well -being. The clinical lead told us that this was particularly important for middle grade doctors who weren't on the consultant pathway. They said that the training had been well received.

There were leadership courses that were available through the trust and staff had accessed leadership modules at graduate level.

All the consultants had job plans. Board minutes showed that next years job plans would be better aligned to service demand and delivery ensuring that the right senior decision makers were available at the right times of the day.

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.

Work was underway to determine the services that would be delivered by the trust in the future. This was in partnership with nearby trusts. These plans had gone to the trust board for agreement.

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.

The culture of the department was very positive, and staff told us that they felt supported. They said that there was an open-door policy and that the leaders were very visible and approachable. There was a culture of learning and improvement in the department with training and development a priority for staff. Training was delivered to all members of staff and different methods of training were used to maximise training opportunities.

Staff were involved in changes that happened in the department and this was demonstrated in the work that had been undertaken in the pilot of the rapid access diagnosis service. Feedback from the staff was used to make changes in the service.

When staff started in the department they met with senior staff in the trust and were encouraged to give feedback about the hospital and the department. The initiative was called reconnect and it was hoped that this would encourage retention of staff. We spoke with a member of staff who had recently started in the department and they said that the experience had been very positive.

Staff told us that they usually got their breaks.

There was a drive in the department to reduce single use plastic.

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 was a Safety Quality and Standards (SQS) Committee which oversaw the governance of the trust. Agenda items included a patient story, mortality reports and items for assurance to the board. Each directorate fed into the committee and reporting was by exception.

There were also SQS meetings for each directorate which met monthly. There was a focus for each part of the directorate in turn. Agenda item included complaints, workforce issues and achievement of national targets. Risks were reviewed and there was feedback from committees including information governance, infection control and medicines management. The minutes of

the meeting from 26 April 2019 showed agenda items including approval of clinical guidelines, policies for approval and guidance from the National Institute of Health and Social Care Excellence for dissemination.

There were emergency department team meetings which were held every two months. There was a set agenda for the meeting. In the meeting of the 21 March 2019 there was feedback from a root cause analysis (RCA) from an attendance in the department of a patient with learning disabilities that had not gone well. The recommendations from the were discussed. The was positive feedback about improved documentation in skin assessment and the safety list. In the meeting of the 16 May 2019 complaints were discussed. Incidents and trends were discussed and complaints and compliments. Gaps in staffing for doctors and nurses were agenda items.

The emergency nurse practitioners (ENP's) had regular meetings and at the beginning of the meeting was a teaching session from one of the consultants. An agenda item included the expansion of the scope of practice for ENP's supported with training from the medical staff.

There were emergency department management meetings. At the meeting on 2 April agenda items included workforce, training and development, sepsis and performance. At the meeting on the 4 June the autism accreditation and the tissue viability training on how to photograph pressure ulcers.

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.

Senior staff in the department were aware of the risks in the department, their main concern was staffing, both medical and nursing, as this had an impact on the delivery of targets and the delivery of quality care to patients attending the department.

There was a risk register for the department. The biggest risks on the register were about achievement of national targets and maintaining quality of care with effective service delivery. There was also a risk on the register following a medicine incident in the department which had been reported to the Strategic Executive Information System (STEIS). These risks were rated as red.

Risk were an agenda item at the SQS group meetings where the risk register for the directorate were reviewed, appropriate risks could then be included on the trust risk register.

There were some amber and yellow risks including developing the workforce, recruitment and future proofing the workforce to make the department sustainable.

At the SQS meeting in November 2019 senior consultants in the department has presented information on the pressures in the department and assurances around winter planning and how the department would manage the additional pressures.

The department had undertaken a pilot on the rapid access diagnosis services and used the plan, do, study, act model. This enabled the service to test out the changes on a small scale and build on the learning in a structured way before implementation.

Performance was managed through the acute and integrated care directorate scorecard. This included waiting times in the department, the recording of a completed handover, the timeliness of a completed handover and the average time to first treatment.

Information management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

There was a hospital mortality sub-committee which met every month. This provided an overview of deaths that had occurred in the trust and evidence of learning from deaths. Deaths were discussed to identify any trends and at one of the meetings the process for people who died in the urgent and emergency care department was discussed. Sepsis was an agenda item at another meeting and the processes to quickly identify and treat sepsis starting in the urgent and emergency care department.

The department was aware of its performance through the directorate scorecard which was electronic. It was RAG (red, amber, green) rated to show achievement of targets. Other information on the scorecard included rates of statutory training, induction, information governance training, safeguarding and infection data. There was also information relevant to patients including friends and family data.

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.

We saw, in the example of the implementation of the rapid access diagnosis service (RAD), that the department had used feedback from its own staff, staff from the ambulance service and patients to change the service model as the pilot progressed.

The department had engaged with a local school and 30 children had been to look round the department. Staff said the visit had been a success.

A patient had made a suggestion to improve the department and this had been funded and implemented.

The department had excellence reporting cards so that they could thank staff for their work. They had different designs on them with “thank-you”. They would also fill a mug with chocolate and leave it on staff’s desks anonymously.

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.

We saw from the minutes of meetings that mortality reviews were used to improve services across the hospital including the urgent and emergency care department.

Learning was at the centre of the improvement and development in the department. Every opportunity was taken to develop all grades of staff with different types of learning. Staff were keen to learn and develop.

Critical care

Facts and data about this service

Facts and data about this service

The trust has six critical care beds. A breakdown of these beds by type is below.

Breakdown of critical care beds by type, East Cheshire NHS Trust and England.

This trust	England

(Source: NHS England)

The critical care unit is located on the first floor of Macclesfield District General Hospital. It is part of the acute and integrated care services directorate and has six adult beds. Neonatal critical care services were not included in this inspection. The service provides comprehensive care for patients who are critically ill through either injury or illness. The unit treats approximately 450 patients at acuity levels two and three per year.

> Level two (also known as high-dependency): May be managed within clearly identified, designated beds, resources with the required expertise and staffing level or may require transfer to a dedicated level two facility / unit.
>
> Level three (also known as intensive care): Patients needing advanced respiratory support and / or therapeutic support of multiple organs.

The critical care service is a member of the Cheshire and Mersey Critical Care Network which is committed to sharing and promoting best practice, both clinically and managerially to ensure the best possible outcomes for the critically ill patient, setting regional standards within a service specification and a peer review evaluation process.

Patients are admitted from any speciality within the hospital, occasionally planned; for example, after major surgery, but most commonly as an emergency. Occasionally the service accepts patients into intensive care from external providers who may be referred due to local capacity issues. Whilst in the unit the patient remains under the care of the admitting consultant supported by the anaesthetic team who provide 24-hour cover with a resident speciality doctor and an on-call consultant intensivist.

The critical care service provides an outreach service of advanced practice critical care staff that support the ward clinicians in the management of the acutely ill patient, in addition to leading on sepsis, acute kidney injury and central line venous access.

(Source: Trust routine provider request, acute context tab)

Is the service safe?

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

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

Mandatory training

The service provided mandatory training in key skills to staff and monitored completion of the training. Training completion rates for nursing and healthcare staff on the unit exceeded or were on trajectory to meet the trust target.

Mandatory training completion rates

The mandatory training was comprehensive and met the needs of patients and staff.

Core statutory and mandatory training included health and safety, safeguarding vulnerable adults and children, infection control, fire safety, and equality, diversity and human rights.

Core clinical e-learning training modules included, consent, mental capacity act awareness, deprivation of liberty (DoLS) awareness, learning disabilities awareness and record keeping.

Annual clinical update sessions were bespoke (dependent on role) and topics were reviewed annually; this was classed as statutory due to the inclusion of basic life support (BLS).

All nursing staff had completed advanced life support and immediate life support training, and all healthcare assistant staff had completed basic life support training.

The trust separately reported the anti-radicalisation Prevent duty training (preventing radicalisation/workshop to raise awareness of prevent (WRAP)) to its statutory and mandatory training modules. However, for the purposes of the analysis this module is included in the table below.

A breakdown of compliance for mandatory training courses from April 2018 to February 2019 at trust level for qualified nursing staff in critical care is shown below. The trust set a target of 95% for completion of mandatory training. The data that the trust's 95% target was met for two out of five mandatory training modules for which qualified nursing staff were eligible in the period.

Training module name	April 2018 to February 2019				
	Staff trained	**Eligible staff**	**Completion rate**	**Trust target**	**Met (Yes/No)**
Prevent / WRAP	129	132	98%	85%	Yes
Information governance	42	44	95%	95%	Yes
Core Statutory and mandatory	40	44	91%	90%	Yes
Core clinical e-learning	38	44	86%	90%	No
Annual clinical update	35	44	80%	95%	No

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

Nursing staff received and kept up-to-date with their mandatory training. The unit manager monitored mandatory training and alerted staff when they needed to update their training.

Compliance with mandatory training was measured in yearly cycles from April to March. We obtained up to date figures during the inspection which showed that for 2018/19, the overall mandatory training completion rate for nurses was 96% (above trust target) and as of May 2019, the completion rate was 97%.

For core clinical e-learning, 93% (just short of target) of staff had completed this training in May 2019.

For the annual clinical update, 76% (against a target of 80%) of staff had completed this in May 2019. All staff that had still to complete the update had dates booked for training.

For information governance, 94% (just short of target) of staff had completed this training in May 2019.

For Prevent / Wrap training, all staff (100%) had completed this at the time of the inspection.

Medical staff received but did not always keep up-to-date with their mandatory training. Between April 2018 and February 2019, 84% of medical staff providing care on the unit had completed core statutory and mandatory training. This was below the trust's target. For the same period, 57% of medical staff had completed their annual clinical update, while 53% had completed the core clinical e-learning. For information governance, 37% of medical staff had completed the training, and 28% had completed training in the Prevent duty.

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 knew how to identify adults and children at risk of, or suffering, significant harm. Staff could give examples of how to protect patients from harassment and discrimination.

Staff we spoke with understood their roles and responsibilities to protect vulnerable adults and children. This included awareness of female genital mutilation and child sexual exploitation, which was included in their mandatory and statutory training.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Staff, including healthcare assistants, were described examples of the types of concerns they would seek advice on, or report; for example, any patient that demonstrated evidence of selfharming. Staff were aware of how to report referrals

Nursing staff received training specific for their role on how to recognise and report abuse.

We obtained up-to-date figures for safeguarding training during the inspection. All nursing staff (100%) had completed level two safeguarding vulnerable adults and level two safeguarding vulnerable children training at the time of the inspection.

The unit did not provide care to children. This meant that safeguarding vulnerable children level three training was not required for the majority of staff on the unit. However, seven staff on the unit were eligible for safeguarding vulnerable children level three training.

A breakdown of compliance for safeguarding vulnerable children level three training completion between April 2018 and February 2019 at trust level for qualified nursing staff in critical care services is shown below. The trust set a target of 85% for completion of safeguarding training.

Training module name	April 2018 to February 2019				
	Staff trained	**Eligible staff**	**Completion rate**	**Trust target**	**Met (Yes/No)**
Safeguarding Children (Level 3)	6	7	86%	85%	Yes

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

Qualified nursing staff in critical care met the 85% target for safeguarding children level three.

Medical staff received training specific for their role on how to recognise and report abuse. Between April 2018 and February 2019, an average of 80% of medical staff working on the unit had completed safeguarding vulnerable adults level two training, and an average of 73% of medical staff had completed safeguarding vulnerable children level two training.

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.

All areas of the unit were clean and had suitable furnishings which were clean and well maintained.

All areas of the unit including public, staff and treatment areas were visibly clean. Handwashing sinks were positioned at either side of the nursing station, and we observed staff washing their hands between patients. This was in line with the NICE QS61 statement three: “People receive healthcare from healthcare workers who decontaminate their hands immediately before and after every episode of direct contact or care”.

A handwashing sink was located in the corridor outside the unit and visitors were reminded to wash their hands before entering the unit.

Sufficient supplies of antibacterial gel were located throughout the unit.

Staff followed infection control principles including the use of personal protective equipment (PPE).

There were sufficient supplies of personal protective equipment, such as disposable gloves and aprons throughout the unit. We observed staff changing these between patients. Staff followed the ‘arms bare below the elbow protocol’.

The unit had one side-room which could be used for patients who had an infection. The room did not have negative air-flow ventilation or an ante-room for robing.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly, with a full ‘scrub’ clean undertaken monthly. This was completed when there were limited numbers of patients on the unit to minimise any disruption to patients.

Equipment, such as chairs, were wipeable and we observed staff cleaning these. ‘I am clean’ stickers were in use to identify items of equipment that were clean and ready for use. Environmental cleaning was carried by housekeeping staff. A process was in place to review cleaning standards.

Infection control was given a high priority in the service. There had been no cases of hospital acquired methicillin resistant Staphylococcus aureus, methicillin sensitive Staphylococcus aureus or clostridium difficile identified on the unit in the twelve months prior to the inspection. Daily flushing of water taps, to reduce the risk of bacterial colonisations such as legionella was undertaken by the healthcare assistants or the housekeeper.

The unit used fabric curtains, which were changed on a monthly basis, or when soiled. This was a recognised risk that was included on the unit’s risk register for environmental improvements with a view to changing to disposable curtains.

Data from the Intensive Care National Audit and Research Centre (ICNARC) for the period April to December 2018 showed a rate of just 1.7 units of acquired blood infection per 1000 patient bed days. This was about the same for all critical care services and marginally worse than average for similar services.

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 unit was located on the ground floor of the hospital and was accessible to people living with mobility difficulties. Access to the unit was via a secure intercom system. The unit was commissioned for four level three beds (one of which was in a side room) and two level two beds, but had capacity for eight beds.

The unit's layout was retained from the legacy design of the unit and, as such, was not required to meet the Department of Health's published Health Building Note 04-02 (HBN 04-02) for critical care units. For example, the space around each bed varied from $10m^2$ to $16m^2$ in comparison with the current recommended $25m^2$; and only four of the beds were served by ceiling mounted pendants for equipment.

Although the bed spaces on the unit were small, we observed staff providing care to patients and using equipment safely within the confines of the bed spaces. There was a separate power supply available at each bedside that could be used in the event of a power failure, although this required staff to plug equipment into the separate electrical outlet socket.

We discussed the environmental layout with the unit manager, who acknowledged the concerns and noted that the environment was on the unit's risk register. We reviewed the risk register, which showed the need for environmental improvement was the top risk. Funding requests had been submitted to the trust's space utilisation group for improvements to the unit; however, at the time of the inspection, funding had not been approved for commencement of improvement works in this financial year.

A full programme was in place for staff training on equipment used within the service. The programme commenced at staff induction and continued throughout the year. Staff competencies were reviewed as part of staff annual appraisals.

Rooms throughout the unit, including in staff areas, were secured by the use of coded locks; this reduced the risk of unauthorised persons gaining access to these rooms.

A point of care blood gas machine meant that staff were able to test patient samples on the unit.

A maintenance and planned replacement log was held for all equipment used in the service, which included the replacement plans for three of the unit's ventilators in 2020. Servicing contracts were in place for equipment such as beds. We reviewed a range of portable electrical equipment throughout the unit; this demonstrated that equipment had been appropriately safety tested. The unit manager and leaders were able to describe plans for replacement of older ventilation equipment in 2020. This was included in the unit's risk register.

Staff disposed of clinical waste safely. Waste was collected in foot operated bins through the unit. Clinical waste was appropriately segregated, bagged and stored awaiting disposal. The unit had introduced a recycling scheme for relevant non-clinical waste items.

Storage was a recognised issue for the unit and was included on the risk register as part of the environmental risk. However, we viewed the stock rooms which were tidy and demonstrated an appropriate stock rotation system to ensure that the oldest items were used first. The unit manager had implemented a cost reduction scheme by displaying the cost of individual items of stock on the shelves; this encouraged staff to use the most cost effective suitable item for the purpose needed.

Staff carried out daily safety checks of specialist equipment. We checked a range of equipment held on the resuscitation trolley, which were within their manufacturer's recommended expiry dates. We saw evidence of appropriate trolley equipment checks being carried out.

The service had suitable facilities to meet the needs of patients' families. The unit had two relatives' rooms, one of which was equipped with a foldable bed, kitchenette, and television. This enabled relatives to stay overnight on the unit if needed.

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 used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Staff received mandatory e-learning training in sepsis, the sepsis six bundle, the use of the national early warning score system (NEWS2), and the departments dependency tool. NEWS2 aggregates physiological parameters such as blood pressure, heart rate, temperature, respiratory rate, neurological status and oxygen saturation to determine if escalation of care was needed. The early warning system was incorporated into the patient record and triggered staff to escalate care when appropriate. Staff continually assessed patients and recorded all these observations on the bedside monitoring record.

Staff completed risk assessments for each patient on admission and updated them when necessary and used recognised tools. All five records we reviewed indicated that comprehensive risk assessments were carried out for patients within the unit. These included assessments of patients' risks relating to falls, the development of pressure ulcers, and the development of venous thromboembolism (blood clots). Where risks were identified, appropriate adjustments were made to mitigate the risk. All patients had been screened for delirium using the confusion assessment method for intensive care units (CAM-ICU).

The records showed that nursing staff escalated care to the unit's doctors appropriately and that prompt multidisciplinary team assessment of patients was carried out if a patient showed signs of deterioration or of developing sepsis.

Shift changes and handovers included all necessary key information to keep patients safe. Staff safety briefings were carried out prior to the commencement of each shift, followed by individual patient handovers between staff. These were effective in sharing relevant high-level information about each individual patient to the individual staff member caring for that patient. A handover sheet was used to ensure all relevant information was communicated, including the patient's current dependency level (red, amber, green).

Staff shared key information to keep patients safe when handing over their care to others. Staff knew about and dealt with any specific risk issues; for example, patient allergies; patients receiving cytotoxic medicines (a group of medicines that contain chemicals which are toxic to cells, preventing their replication or growth); patients with active do not attempt resuscitation orders in place; and, incidents and near miss incidents. A process was in place for the nurse in charge to ensure any bank staff commencing duty after the safety briefing had taken place received all the relevant handover information.

Twice daily consultant led multidisciplinary team ward rounds were carried out; these included anaesthetist, nursing, therapist, and pharmacy input. The microbiologist attended the unit five days a week, although not always as part of the multidisciplinary ward rounds. This enabled the consultant microbiologist to plan targeted antibiotic therapy, prescribe anticipatory antibiotics, and

to review existing prescriptions. This was in line with the Faculty of Intensive Care Medicine's guidelines for the provision of intensive care services core standards 2013 (the core standards).

The critical care outreach team supported the wards to review any patients that were at risk of deteriorating. The team were able to remotely review patient vital sign observations on electronic tablets. The system automatically calculated patients' early warning scores; this enabled the team to prioritise their care and advice appropriate to patients' needs.

The service had a tracheostomy emergency algorithm flowchart available, and a skin inspection assessment decision tree, which supported the clinical practice guide for skin health.

The service collaborated closely with the accident and emergency department enabling 'in reach' to transfer appropriate patients into the critical care unit direct from the emergency department. In additional the emergency department practice based educator joined any training sessions delivered to staff on the unit.

The service participated in the trust's quarterly deteriorating patient response group. This included supporting training in acute kidney injury, sepsis and vital sign recording.

Nurse staffing

The service had enough nursing 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 and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service had enough nursing staff of all grades to keep patients safe. 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.

The unit manager adjusted staffing levels daily according to the needs of patients. The unit used a staffing tool to calculate daily staffing levels that ensured patients were treated safely. The tool took into account patient acuity levels as well as dependency levels. This meant staffing could be focused on patients that required the greater level of support or intervention, while maintaining safe staffing levels in line with their acuity. For example, a level two patient (normally a one nurse to two patients staffing ratio) may require a greater level of support than a stable level three patient (normally a one nurse to one patient staffing ratio).

During the inspection, the number of nurses and healthcare assistants on all shifts on the unit matched the planned numbers.

Planned vs actual

The trust reported the following whole time equivalent (WTE) nurse staffing numbers for the periods below for critical care.

Site name	Apr 17 - Mar 18			Apr 18 - Sept 18		
	Actual staff	**Planned staff**	**Staffing rate (%)**	**Actual staff**	**Planned staff**	**Staffing rate (%)**
East Cheshire NHS Trust	33.6	36.3	93%	38.7	38.2	101%

From April 2017 to March 2018, the nurse staffing rate within critical care was 93%. This was lower than the 101% in the more recent period from April 2018 to September 2018. They were over 100% due to having 0.5 WTE more than planned.

The planned staffing rate has increased from 36.3 to 38.7 in the latest period.

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

Vacancy rates

From April 2018 to March 2019, the trust reported a vacancy rate of 6% for nursing staff in critical care; this was higher than the trust target of 5%.

However, at the time of the inspection the unit had 1.53 whole-time equivalent vacancies for band six nurses (recruitment adverts were published) and 5.72 whole-time equivalent band five nurses (three of which had already been recruited).

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

Turnover rates

From April 2018 to March 2019 the trust reported a turnover rate of 5% for nursing staff in critical care; this was lower than the trust target of 10.5%.

There is no breakdown of turnover rates by ward or site for this core service.

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

Sickness rates

In May 2019, nursing staff sickness rates on the unit were 2.9%.

Bank and agency staff usage

The unit manager limited their use of bank and agency staff and requested staff familiar with the service. The use of any agency staff required trust board approval, and any usage higher than one agency staff in five nurses required the unit manager to report an incident.

Bank staff were provided with a full induction to the unit on their arrival. The induction checklist was included on the relevant staff member's time-sheet.

The table below shows the numbers and percentages of nursing hours in critical care at the trust from March 2018 to February 2019 that were covered by bank and agency staff or left unfilled.

Of the 63,960 total working hours available, 1% were filled by bank staff and 6% were covered by agency staff to cover sickness, absence or vacancy for qualified nurses.

The trust stated that in some situations additional hours are rostered over and above the set establishment and this is the reason for a negative value for unfilled hours for qualified nursing staff. From March 2018 to February 2019, 723 hours (% over establishment) were rostered in this way.

Qualified staff

	Total hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
Ward		Hrs	%	Hrs	%	Hrs	%
ICU	51,055	822	2%	4,080	8%	1,232	2%

ICU Outreach	12,905	25	0%	0	0%	-1,955	-15%

Of the 7,802 total working hours available, 1% were filled by bank staff and 0% were covered by agency staff to cover sickness, absence or vacancy for non-qualified nurses.

From March 2018 to February 2019, 20 hours (0.3% over establishment) were rostered in this way.

Non- qualified staff

	Total hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
Ward		Hrs	0%	Hrs	%	Hrs	0%
ICU	7,802	62	1%	0	0%	-20	-0.3%
ICU Outreach	0	0	0%	0	0	0	0%

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

Allied health professional staffing

The service had enough allied health professionals with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The unit was supported by a dedicated respiratory physiotherapist five days a week, and a non-dedicated rehabilitation physiotherapist. This meant there was sufficient, suitably qualified therapy staff to meet the core standards requirement of 45 minutes of therapy per patient five days a week.

Although the unit did not have a dedicated occupational therapist, staff told us they were able to access occupational therapy support for patients when needed.

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.

The service had enough medical staff to keep patients safe. The unit was medical led by a consultant anaesthetist. In total the unit had nine anaesthetic consultants; however, none were consultant intensivists. Consultants were supported by specialist, middle and junior grade doctors.

Between March 2018 and February 2019, the unit had an average medical staffing headcount of 32 medical staff equating to an average of 28.3 full-time equivalent medical staff members. However, this resource was shared with the maternity unit. In the same period, 2.67 full-time equivalent medical staff left the unit.

The service always had a consultant on call during evenings and weekends. We reviewed the medical rotas between 27 May 2019 and 14 July 2019. These indicated 24-hour consultant cover was available. Four rota entries indicated minimal breaks in consultant cover of up to a maximum of

approximately 90 minutes; however, on all four occasions there was a specialist registrar or doctor of grade ST3 or above on duty during this time.

Staff told us that, due to sharing medical cover with the maternity unit, the unit could on occasion 'struggle' if one doctor is carrying out a transfer while the other doctor is on the maternity unit. Staff said the skills of the nurses meant that the unit did not feel 'unsafe' in these circumstances and that the on-call consultant intensivist was always able to attend the unit within 30 minutes if needed.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. Each on-call consultant was supported on a shift by at least one and up to two specialist doctors, middle grade or junior doctor. There were 16 junior doctor positions available, and any gaps in the rota were filled by locum doctors.

Managers could access locums when they needed additional medical staff. The service had low locum staff used on the unit. Between March 2018 and February 2019, three medical shifts were covered by locum medical staff and no medical shifts were left unfilled. Managers made sure locums had a full induction to the service before they started work; however, where possible the service used regular locums who were already familiar with the service.

The service had a low vacancy rates for medical staff. In February 2019, 29.48 full-time equivalent medical staff were in post, against a budgeted establishment of 30.1 full-time equivalent staff. This equated to a vacancy rate of 2%.

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.

The critical care service predominantly used paper records with blood test results reported electronically. We reviewed five sets of patient records. All the records we reviewed were, generally, of a high standard with legible writing and entries were appropriately signed and dated.

Patient notes were comprehensive, and all staff could access them easily.

We saw evidence of clearly detailed summaries of events requiring admission to the unit, multidisciplinary input into plans for care, risk assessments, monitoring of nutrition and fluid balances, consent for treatment, and discussions with patients and their families were clearly documented.

Where we found limited evidence of required actions not being completed in the records, these actions were either not applicable for the patient, or there was a valid reason for not completing the action, such as the patient had been admitted less than 24 hours previously.

Records were stored securely. Records, when not in use, were stored securely in the unit's lockable record trolley. Staff handover and safety briefings ensured that all relevant information from patient records were communicated to the incoming staff member. When patients transferred to a new team, there were no delays in staff accessing their records.

Medicines

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

Staff stored and managed all medicines and prescribing documents in line with the provider's policy. Medicines were stored safely and securely within a clinical room in appropriate cupboards. Intravenous fluids were clearly segregated.

The room temperature and fridge temperature were monitored and recorded. A recent issue with the fridge had been actioned. Access to the clinical room was restricted as the fridge was kept unlocked to allow easy access to resus medicines which were stored within it.

Each critical care bed had its own medicine trolley which was accessed via a key code. The medicines observation chart included an intravenous handover section and a section to record the rate and amount delivered.

Staff followed current national practice to check patients had the correct medicines. Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. There was an urgent care pharmacist who provided dedicated support for the critical care unit. Our review of five patient records demonstrated that the pharmacist reconciled patients' medicines within 24 hours of admission to the unit, and regularly reviewed patients' prescriptions. Omitted or non-administered medicine doses were clearly recorded.

The records showed that antibiotics had been prescribed and reviewed appropriately.

The pharmacist undertook a safety audit every three months and a quarterly controlled drugs check.

Staff stored and managed all medicines and prescribing documents in line with the provider's policy. A dedicated controlled drug register was used to record the amount administered and wasted. A pharmacy assistant checked medicines stock levels twice a week on the unit.

We reviewed a sample of medicines held by the unit, including controlled medicines. All were within their respective manufacturer's recommended expiry dates, except for four bags of sodium chloride solution. We raised this with staff at the time, who removed the expired fluid.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. An incident with an intravenous fluid had resulted in a change in practice and the ward sisters' audit included medicines.

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 reported all incidents that they should report. Staff recognised incidents, including near misses, and reported them appropriately on the hospital's online incident reporting system. Incidents were automatically referred to the unit manager to review and to decide what level of investigation was required.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Staff had received training in, and were able to describe their responsibilities under, the duty of candour.

Between 1 June 2018 and 31 May 2019, a total of 413 incidents were recorded by staff on the unit. Of these, 84 were classified as 'near miss' incidents and 281 were classed as causing no harm to the patient or organisation. Of the remaining 48 incidents, which were classed as causing harm to the patient or organisation, all but two were classed as low or minimal harm incidents. The remaining two incidents were classed as moderate harm; one related to lack of evidence of review of a patient by a tissue viability nurse, and the other related to a staff fall on the unit.

The unit manager investigated incidents thoroughly. Patients and their families were involved in these investigations where appropriate. We reviewed the incident report log for the unit; this showed that full descriptions of each incident had been recorded, the immediate and longer-term actions taken, and the lessons learned from each incident.

Staff met to discuss the feedback and look at improvements to patient care. The incidents log showed evidence of incidents being added to the daily staff briefings to make staff aware of any learning. Staff we spoke with confirmed they received feedback and learning from incidents, and we observed this occurring during a staff meeting.

There were no serious incidents reported in the critical care service between 1 June 2018 and 31 May 2019 under the Serious Incident Framework 2015 that met the reporting criteria set by NHS England.

Staff were notified of safety alerts by the unit manager. We observed a staff meeting during which the unit manager informed staff of a National Patient Safety Agency alert from 2018 in relation to saturation probes.

The unit supported a study day on incidents. As part of this, staff were split into groups to review sample incident reports and were asked how and what they would investigate in relation to the sample incident, and what learning actions for individual or systemic improvement could be identified.

Never events

The service had no never events on the unit. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From April 2018 to March 2019 the trust reported zero never events for critical care.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

Staff were aware of how to report serious incidents clearly and in line with trust policy. However, in accordance with the Serious Incident Framework 2015, the trust reported zero serious incidents (SIs) in critical care which met the reporting criteria set by NHS England from April 2018 to March 2019.

(Source: Strategic Executive Information System (STEIS))

Safety thermometer

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

The NHS patient safety thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination. Data collection takes place one day each month.

The safety thermometer data showed the services achieved over 95% harm free care for the last 12 months. Data from the patient safety thermometer showed that the critical care unit reported two new pressure ulcers (grade two, three or four), one fall with harm (harm levels three to six) and zero new catheter urinary tract infections (level three only) from April 2018 to April 2019. This was better than the expected (prevalence rate) numbers for the unit of pressure ulcers, falls and catheter acquired urinary tract infections

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at East Cheshire NHS Trust

Total Pressure ulcers (2)[1]

Total Falls (1)[2]

Total CUTIs (0)[3]

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

(Source: NHS Digital)

Is the service effective?

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 followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The service used a wide range of local policies, protocols and patient pathways which were based on up-to-date evidence and best practice, guidance from the National Institute of Health and Care Excellence (NICE) and professional bodies, and the core standards for intensive care units.

For example, care was provided by all staff, including staff on the unit and the outreach team, in line with NICE clinical guidance CG83 *Rehabilitation after critical illness in adults*. Delirium was managed in line with NICE clinical guidance CG103 *Delirium: prevention, diagnosis and management*. Similarly, the resuscitation policy set out relevant roles and responsibilities and was linked to relevant legislation and guidance, including the Mental Capacity Act 2005, the Human Rights Act 1998, and guidelines from the Resuscitation Council (UK).

The use of high-flow nasal oxygen therapy on the unit had reduced the number of patients requiring level three intensive care.

The service submitted data throughout the year to the intensive care national audit and research centre (ICNARC). This meant that a range of care delivery, patient outcomes, and mortality outcomes were benchmarked against similar units nationally.

The service was part of the Cheshire and Mersey Critical Care Network, and was subject to an annual network peer review, and it was increasing its links with the Greater Manchester Critical Care Network. The critical care service had been peer reviewed by the network in 2018 and, at the time of the inspection, was making good progress against the 31 recommendations of the peer review. The recommendations covered a range of service, capacity, facilities, operational and workforce issues.

Consultant led mortality and morbidity reviews were included in the bi-monthly anaesthetic audit meeting. The meeting, which was attended by the consultant anaesthetist clinical lead and senior sister enabled the identification of any areas of improvement or learning for the service.

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 used a nationally recognised screening tool to monitor patients at risk of malnutrition. Staff used a malnutritional universal screening tool to identify patients at risk. Risk scores were recorded appropriately in the patient record.

Specialist support from staff such as dietitians and speech and language therapists were available for patients who needed it. The unit received dedicated support from a dietitian five days a week. Speech and language therapy support was not dedicated to the unit, but staff told us they could access therapists when needed, particularly for patients that had a tracheostomy (an incision in the windpipe so a tube can be inserted to help with breathing).).

Four of the five records we reviewed indicated that the patient required, and received, specialist dietetic and/or speech and language therapy assessment. The remaining patient did not require additional dietetic support.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. Four of the five records clearly recorded evidence that each patients nutritional and fluid requirement were being monitored.

The unit developed and supported the use of a nurse-led feeding protocol. The unit manager had also undertaken a nurse-led dysphagia (difficulty or discomfort in swallowing) assessment course.

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. There were processes in place to assess patient's pain. Individual care plans included pain assessments for all patients. This included observing the signs and symptoms of pain. Staff used a pain scoring tool.

Staff prescribed, administered and recorded all pain relief accurately. Pain relief was routinely prescribed as part of individual patient management, and additional pain relief was available at the patient's request. Patient controlled pain relief could be prescribed. All five patient records we reviewed indicated prescription and review of sedation medicines, and clearly recorded any reasons for omission or non-administration of a medicine.

Patient outcomes

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. The critical care service collected data across a range of patient outcome and mortality measures and submitted relevant data to the Intensive Care National Audit Research Centre (ICNARC). ICNARC reports present data cumulatively throughout each quarter of the year. A senior staff member told us there was some concern that the audit inconsistently measured data against eight beds rather than the six beds that were in use.

ICNARC Participation

The trust has one critical care unit which contributed to the Intensive Care National Audit Research Centre (ICNARC), which meant that the outcomes of care delivered, and patient mortality could be benchmarked against similar units nationwide.

(Source: Intensive Care National Audit Research Centre (ICNARC))

ICNARC results

ICNARC reports present data cumulatively throughout each quarter of the year. The table below summarises the critical care unit's ICNARC audit performance for the financial year of 2017/18.

Metrics *(Audit measures)*	Trust performance	Comparison to other Trusts	Meets national standard?

Risk-adjusted hospital mortality ratio (all patients) *(Risk-adjusted measures take into account the differences in the casemix of patients treated*)	1.0	Within expected range	No current standard
Risk-adjusted hospital mortality ratio for patients with predicted risk of death less than 20% ('lower risk' patients) *(Risk-adjusted measures take into account the differences in the case mix of patients treated*)	0.8	Within expected range	No current standard

At the time of the inspection, quarterly report data for the financial year of 2018/19 was available for May to December 2018. During this period the critical care unit had 270 patient admissions of which seven admissions were repeat admissions of a patient within the same acute hospital stay.

The results indicated there had been a marginal deterioration in performance by the service in the two comparators for risk-adjusted hospital mortality, and that the service performed worse than similar or all units; however, the performance was still within the expected range. The service performed better than similar or all units in the number of unplanned readmissions within 48 hours.

Metrics	**Trust**	**Comparison to other Trusts**	**Meets national standard?**
Risk-adjusted hospital mortality ratio (all patients) *(Risk-adjusted measures take into account the differences in the casemix of patients treated*)	1.14	Within the expected range but worse than similar units or all units in the audit.	No current standard
Risk-adjusted hospital mortality ratio for patients with predicted risk of death less than 20% ('lower risk' patients) *(Risk-adjusted measures take into account the differences in the casemix of patients treated*)	1.15	Within the expected range but worse than similar units or all units in the audit.	No current standard

Audit measures) **performance**

Unplanned readmissions within 48 hours *(Number of eligible admissions similar units or all hours of discharge)*	0	Within the expected range and better than standard *subsequently readmitted (unplanned) to the same critical care unit within 48*	No current units in the audit.

(Source: Intensive Care National Audit Research Centre (ICNARC))

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.

There were enough clinical educators to support staff learning and development. The unit was supported by a dedicated practice based educator in line with the requirements of the core standards.

The unit manager ensured all new staff received a full induction tailored to their role before they started work. The induction programme included a six to eight week supernumerary period during which staff essential competencies were assessed and signed off. The supernumerary period could be extended, or shortened, dependent on individual staff needs; for example, new staff to the department who had previous backgrounds in critical care services could be signed off earlier if appropriate. Assessments of both clinical and essential equipment competencies were undertaken during this period.

The unit applied the national critical care step competency framework. 'Step one' competencies were undertaken during the first eighteen months with supervisory support of mentors. Staff then progressed through steps two and three competencies. The unit manager had achieved the step four leadership competencies. Competencies were reviewed during staff yearly appraisals.

Sixty-five per cent of nursing staff on the unit had completed a post-registration award in critical care nursing. This was better than the 50% requirement of the core standards.

Bank or locum staff were required to undertake a service specific induction before commencing their first shift on the unit.

Staff group	March 2018 to February 2019				
	Staff who received an appraisal	**Eligible staff**	**Completion rate**	**Trust target**	**Met (Yes/No)**

Qualified nursing & health visiting staff (Qualified nurses)	33	36	92%	90%	Yes

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. The unit manager undertook individual monthly 'connect' sessions with staff on the unit. These provided staff with an opportunity to discuss their performance, and concerns or training needs, and enabled a development action plan to be monitored.

The practice based educator delivered a range of clinical scenario training to staff, with the assistance of young people from a local drama college. Scenarios delivered over the previous 12 months included anaphylaxis, blocked tracheostomy, sepsis and hypovolaemic shock (blood loss). Training was also supported by twice weekly lunchtime reminder 'turbo training' sessions.

Staff had received the ALERT course training (Acute Life-threatening Events – Recgonition and Treatmet); this was a multidisciplinary course aimed at newly qualified doctors and nurses. For healthcare assistant staff, training was provided in the AWARE course (Awareness Why Anticipating and Responding is Essential); this was a one day course providing a framework of knowledge and skills to promote early identification of patients whose condition is deteriorating. Training was also provided in the BEACH course (Bedside Emergency Assessment Course for Healthcare staff); this gave staff the basic skills and techniques to recognised a deteriorating patient.

Appraisal rates

The unit managers supported staff to develop through yearly, constructive appraisals of their work. From March 2018 to February 2019, 87% of staff within critical care at the trust received an appraisal compared to a trust target of 90%.

Support to doctors and nursing staff	9	10	90%	90%	Yes
Support to ST&T staff	11	15	73%	90%	No
Grand Total	53	61	87%	90%	No

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

Multidisciplinary working

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

All nurses and healthcare assistants attended safety huddles at the start of each shift. Information about each patient, their dependency and their needs, and any notable events in their care during the previous shift were discussed. The huddle also shared information about safety alerts, incidents, or learning.

Consultant-led ward rounds were undertaken twice a day, including at weekends, and included medical, pharmacy, nursing, pharmacist, and allied health professional staff. A microbiologist joined the ward round five days a week. We observed effective communication between staff of all groups during handovers and ward rounds. This ensured patients received appropriate and safe care for their individual needs.

The outreach team worked closely with all ward areas across the hospital to identify patients who were deteriorating, and to support those caring for them on the wards.

The service had close links with the organ donation team, and met with the specialist nurses of organ donation three times a year. Information about organ donation was included in end of life partnership study days for staff.

Seven-day services

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

The service provided care and treatment 24 hours a day, seven days a week. Nurse staffing rotas showed that nurse staffing levels were sufficient to meet the core standards during all periods including out of hours.

Staff could call for support from doctors and other disciplines, including diagnostic tests, 24 hours a day, seven days a week. Medical rotas showed that medical staff levels were sufficient to keep people safe. Consultants undertook a twice daily ward rounds.

The service had dedicated support from the urgent care pharmacist between 9am and 6pm Monday to Friday. Out of hours and weekend pharmacy support was provided by the on-call pharmacy team. However, the pharmacist also had access to remote electronic prescribing and robotic dispensing, which meant that urgent medicine requests could be fulfilled.

Health promotion

Staff assessed each patient's health when admitted and provided support for any individual needs.

There were limited opportunities for staff to undertake health promotion, due to the nature of the inpatient care provided by the unit. However, the service supported staff to promote healthy lifestyles with patients including smoking cessation at relevant opportunities during the follow-up clinics.

The practice based educator was a health ambassador and delivered talks on health subjects to local children's groups.

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.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff made sure patients consented to treatment based on all the information available.

Staff understood their duties to ensure patients had capacity to consent. Consent was obtained for care and treatment from patients who were conscious and had capacity to give it. The process ensured the patient was able to give their decision-specific informed consent.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions.

Staff made decisions about care and treatment in the best interests of the patient when the patient was unconscious or did not have the capacity to give consent. We reviewed five patient records, of which one indicated that a patient had been assessed as not having capacity to consent. Decisions to act in the patient's best interest were clearly and appropriately recorded.

All five records demonstrated that the patients had been screened for delirium.

Staff clearly recorded consent in the patients' records. All five patient records we reviewed demonstrated and recorded that staff had appropriately assessed the patient for their capacity to consent to care and treatment. One of these records indicated the patient did not have capacity consent and that care was being delivered in line with the patient's best interests. Patients' capacity to consent and best interest requirements were discussed during the staff shift handover meetings.

Staff we spoke with understood, and were aware of, their duties under the Deprivation of Liberty Safeguards. Information about any patients subject to the safeguards was discussed during staff handover.

Of the five patient records we reviewed, three included evidence of a do not attempt cardiopulmonary resuscitation order. One of the orders had not yet been reviewed as the patient had been admitted late in the evening prior to our review of the record. The second order had

been appropriately reviewed by doctors on the unit. The third order had been reviewed and subsequently revoked.

Mental Capacity Act and Deprivation of Liberty training completion

Nursing staff received training on the Mental Capacity Act and Deprivation of Liberty Safeguards. This was completed as part of staff statutory and mandatory training. At the time of the inspection 97% of nursing and healthcare staff had completed their statutory and mandatory training.

Is the service caring?

Compassionate care

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

There was a patient-centred culture in the unit from all nursing, healthcare assistant, medical and allied health professional staff. We observed all staff caring for patients with kindness, compassion and respect and providing a supporting environment to patients, their family and carers, which was encouraged by the unit's management team and leaders.

Staff were discreet and responsive when caring for patients. Staff followed policy to keep patient care and treatment confidential.

The small size and layout of the unit meant that staff were restricted in their ability to discuss care with patients privately. However, we observed staff closing privacy curtains to ensure that patients' privacy and dignity was maintained during intimate examination or sensitive discussions. Staff were respectful of patients during multidisciplinary bedside ward rounds ensuring that, where possible, discussions were not overheard.

Staff took time to interact with patients and those close to them in a respectful and considerate way. Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients' health needs.

We observed that staff spent time talking with patients including patients that were sedated or receiving treatment with ventilators. Interactions between staff and patients were calm and relaxed. This was in line the National Institute of Health and Care Excellence's Patient experience in adult NHS services quality standard QS15 statement one.

We reviewed feedback provided by patients on a questionnaire following their attendance at the intensive care follow-up clinic. Feedback was consistently positive about the support staff provided during and after patients' admission to the unit. One patient commented, "I will be forever grateful, on behalf of myself and my family who were so well supported [by staff]."

Emotional support

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

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 observed staff providing reassurance and comfort to patients and their relatives. Although the unit did not have dedicated psychological support on the unit, patients could be referred to psychological services if required.

Staff told us of an example of a patient who had been on long-term high flow oxygen therapy, which meant the patient had been restricted to the unit for a long period of time. When the patient was taken off the therapy, staff arranged to take the patient down to the on-site duck pond

All patients who were admitted to the unit for more than 48 hours were offered a follow-up clinic appointment 12 weeks after discharge, then six and 12 months after discharge as necessary (approximately 10% of patients returned for a second time). During this appointment patients were able to speak with members of the outreach team, and to review their patient diaries. This enabled patients to talk about their experience, ask questions about their care and treatment, and 'fill in' some of the gaps in their memory about their time on the unit.

Staff told us of examples where changes had been made as a result of patient feedback received in the follow-up clinic; for example, staff had replaced the metal bins with plastic as the metal bins had caused distress to patients due to the noise they made. Similarly, seating had been rearranged behind the nursing station as a patient who was sedated during their admission had recalled seeing a disembodied head circled by a green halo; staff realised this was due to staff sitting behind the station in front of a green display.

The unit had two relatives' rooms. The larger of the two rooms included kitchen facilities, seating, a television, DVD player and range of books. The smaller of the two rooms included seating and a table. Both rooms could be used to hold difficult discussions with, or when breaking bad news to, family and carers.

Staff told us of an example where they had enabled emotional support for the family of a patient who died on the unit. The patient was an organ donor, and staff recongised that the family needed to spend some brief time with the patient before they were transferred to surgery. Staff arranged to push two beds together so that the family could lie with the patient.

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. Staff talked with patients, families and carers in a way they could understand. Relationships between patients who used the service, those close to them, and staff were strong, caring, respectful and supportive. We observed staff involving patients and those close to them in decisions about their care and treatment.

Staff told us of an example where the unit manager had worked closely with a patient's parents to develop a care plan that included them. The patient had complex issues and their parents had found it difficult to 'let go'; the care plan enabled them to be involved and to work together with staff as a team to care for the patient.

Patient communication needs were recorded clearly in four out of the five patient records we reviewed. Similarly, we saw evidence of discussion between the consultant and the patient and/or

their family in four of the five records; the fifth patient had been admitted late in the evening prior to our review of their so it was unclear if the patient had yet been reviewed by the consultant. This was in line with the National Institute of Health and Care Excellence's Patient experience in adult NHS services quality standard QS15, statements two, four and five.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. The unit supported families and carers to provide feedback through its 'ICU/HDU Relative Satisfaction Survey' leaflets. These were prominently displayed throughout the unit. The results of the satisfaction survey were collated by the critical care network and benchmarked units within the network.

The service achieved 100% of respondents indicating they had been given written information that they could understand when their relative was admitted to the unit, and 95% of respondents said they were kept up to date on their relative's condition by staff.

We observed that during ward rounds there was no interaction with patients by the multidisciplinary team as they approached the bedside. This was irrespective of whether or not the patient was sedated. However, patients were subsequently given the opportunity to ask further questions, and nursing staff clearly summarised the plan of care for each patient after the discussion.

Is the service responsive?

Service delivery to meet the needs of local people

The critical care 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 unit cared for and supported critically ill level three and level two patients. Patients were accepted from the accident and emergency department; from the surgical department for post-operative support; and, from the wards when their conditions deteriorated.

The service had systems to help care for patients in need of additional support or specialist intervention. Its critical care outreach team reviewed, intervened, and supported the care of patients on the wards that were at risk of deterioration. This was with the aim of avoiding any unnecessary admissions into the critical care unit.

The service had links to other regional hospitals for patients requiring specialist care, such as cardiothoracic support, extracorporeal membrane oxygenation support, neurological support and stroke care.

Processes were in place for transferring patients to other specialist units, with three clinical transfers in 2019. Due to the specialist skills of the respiratory physiotherapist only two patients required transfer to the regional long-term ventilation unit for weaning in the previous four years.

Non-clinical transfers only occurred if the unit lacked capacity; in these cases, patients were transferred to other critical care units within the regional network, but only with the approval of the trust's chief executive.

The unit had a point of care blood gas analysis machine. This enabled staff to quickly obtain relevant blood results to assist in planning patients' care.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach.

The service supported 10am to 10pm visiting from relatives; however, facilities were available to relatives to stay overnight. The unit had two relatives' rooms, one with a foldable bed, where relatives could stay overnight and/or have refreshments.

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.

Clock, day, date and weather boards were displayed throughout the unit. This helped to orientate patients who may be living with dementia or be experiencing delirium to time and place.

Patients' care plans included information on any reasonably adjustments that were necessary; these were handed over at shift change. Similarly, carers plans were included and set out clear roles and responsibilities to for staff and carers.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. Staff could arrange for elective patients to visit the unit prior to their surgery to familiarise themselves with the surroundings.

Staff used patient diaries to record what happened each day with individual patients. The diaries were reviewed during the follow-up clinics, and feedback indicated that patients found this helpful in understanding their experiences.

Staff told us that patients living with learning disabilities at a local residential centre could be supported on the unit by their carers 24 hours a day.

The unit manager made sure staff, patients, loved ones and carers could get help from interpreters or signers when needed. Telephone interpreter services were available to supplement the range of languages spoken by staff, which included Ukrainian, Polish, Spanish, Italian and some Indian dialects. Information leaflets in languages other than English could be obtained.

Bariatric equipment, including beds and chairs were not routinely stocked on the unit. However, the unit manager told us these could be hired, and the supplier was extremely responsive to requests.

Information was available on the trust's intranet on how to meet the needs of people from different faiths and religions. Staff told us they were able to access multifaith chaplains as needed.

Access and flow

People could access the service when they needed it and received the right care promptly. The service admitted, treated and discharged patients in line with national standards.

The unit managers made sure patients could access services when needed and received treatment within agreed timeframes and national targets. The core standards recommend that admission to intensive care should occur within four hours of making the decision to admit. This standard was met in four out of the five patient records we reviewed. Although the fifth patient was not admitted to the unit within the recommended four hour period, we saw evidence of regular review of the patient in the period they were waiting to be admitted to the unit.

Bed occupancy

From April 2018 to March 2019, the critical care unit bed occupancy rate at East Cheshire NHS Trust was lower than the England average for eight months out of 12. There was no trend identified between bed occupancy performance in either the winter or summer months.

Adult critical care Bed occupancy rates, East Cheshire NHS Trust.

Data relating to the number of occupied critical care beds is a monthly snapshot taken at midnight on the last Thursday of each month.

(Source: NHS England)

Non-clinical transfers

The service moved patients only when there was a clear medical reason or in their best interest. The unit manager monitored patient moves between the unit and ward to ensure these were kept to a minimum. There were no non-clinical transfers from the unit between April and December 2018; this was an improvement on the minimally low performance of 0.1% in the previous financial year. However, the unit manager told us there had been two non-clinical transfers in January 2019.

Out of hours discharges

The unit manager monitored the number of out of hours discharges from the unit to the ward. Between April and December 2018, 2.7% of discharges from the unit to the ward occurred after 10pm. This was a deterioration in performance for the previous financial year when 1.3% of discharges occurred out of hours.

We discussed this with the unit manager who told us that out of hours discharges from the unit only occurred when there was a pressing clinical need; for example, if a bed was required on the unit for a deteriorating or critically ill patient.

Delayed discharges

The unit manager monitored the number of delayed discharges (longer than eight hours) from the unit to the ward. Between April and December 2018, 5.4% of discharges from the unit to the ward were delayed longer than eight hours. This was a deterioration in performance for the previous financial year when 3.7% of discharges were delayed longer than eight hours.

We discussed this with the unit manager. The main factor influencing performance was the availability of beds on the ward to discharge patients to. Bed availability was discussed daily at bed management meetings.

ICNARC reports present data cumulatively throughout each quarter of the year. The table below summarises the critical care unit's ICNARC audit performance for the financial year of 2017/18.

Metrics *(Audit measures)*	Trust performance	Comparison to other Trusts	Meets national standard?
Crude non-clinical transfers *(Transfers made for non-clinical reasons often relate to patient flow and capacity issues which may add to patient risk, prolong intensive care unit stay and cause distress to patients and carers)*	0.1%	Within expected range	No Standard is 0%
Crude, non-delayed, out-of-hours discharge to the ward proportion *(Discharge out-of-hours is associated with increased risk of mortality)*	1.3%	Within expected range	No Standard is 0%

Crude delayed discharge (% beddays occupied by patients with discharge delayed more than 8 hours) *(Discharge from critical care should be within four hours of decision to discharge and occur as early as possible in the day*)	3.7%	Not in the worst 5% of units	No Standard is 0%

for May to December 2018.

ort data for the

Metrics *(Audit measures)*	Trust performance	Comparison to other Trusts	Meets national standard?
Crude non-clinical transfers *(Transfers made for non-clinical reasons often relate to patient flow and capacity issues which may add to patient risk, prolong intensive care unit stay and cause distress to patients and carers)*	0%	Within expected range	Yes Standard is 0%
Crude, non-delayed, out-of-hours discharge to the ward proportion *(Discharge out-of-hours is associated with increased risk of mortality)*	2.7%	Within expected range. Worse than all units and marginally worse than similar units	No Standard is 0%
Crude delayed discharge (% beddays occupied by patients with discharge delayed more than 8 hours) *(Discharge from critical care should be within four hours of decision to discharge and occur as early as possible in the day*)	5.4%	Better than similar units but worse than all units	No Standard is 0%

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 unit manager investigated any complaints received about the unit and shared learning with staff members during team meetings and safety briefings.

Staff we spoke with understood the trust's policy on complaints and knew how to handle them. Staff confirmed they received feedback and learning about any relevant complaints and incidents. Staff were aware of the duty of candour and the need to provide open and honest explanations to patients and their carers when things went wrong.

As the unit had not received any complaints in the twelve months prior to the inspection we were unable to review any recent complaint files.

Summary of complaints

From April 2018 to March 2019 there were no complaints received by the trust that related to the critical care service. Between April 2019 and June 2019, the service received no complaints.

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

Number of compliments made to the trust

From April 2018 to March 2019 there were 122 compliments received by the trust that related to the critical care service. Between April 2019 and June 2019, the service received a further 39 compliments.

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

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 critical care service was delivered within the trust's acute and integrated care services directorate. The service was clinically led by a consultant intensivist, a band 8c consultant nurse and a band seven unit manager, which was in line with the core standards.

The leaders had appropriate skill, knowledge and experience to lead the service, and were able to describe the leadership and reporting structure for their teams. The consultant nurse was the chairperson for the Cheshire and Mersey Critical Care Network outreach group, while the practice based educator was the chair for the network's practice based educator group.

Is the service well-led?

Staff on the unit spoke positively about their local leaders, who they considered were visible on the unit, approachable and supportive. However, staff told us there was less visibility of senior hospital or executive staff on the unit.

At the time of the inspection, the unit manager was due to leave the post imminently. Appropriate succession planning was in place with interviews expected a few weeks after the inspection. The unit manager had compiled a handover action folder for the new post holder. One staff member told us the unit manager would be a “hard act to follow”.

Vision and strategy

The critical care service did not have a clear long-term vision and strategy. The vision and strategy were dependent on the sustainability of wider services in the hospital, and local plans within the wider health economy.

At the time of the inspection, the service’s long-term vision and strategy was unclear, and discussions were ongoing at executive and medical director level about the unit’s role in the trust and the wider health economy. One staff member told us there were concerns about the impact that any changes to the services offered by the hospital (for example, surgery) might have on the unit.

However, there was clear engagement between the service and the Cheshire and Mersey Critical Care Network and, to a lesser degree, the Greater Manchester Critical Care Network. The unit’s leaders were also able to describe the actions needed to achieve clinical success, including striving to become fully compliant with The Faculty of Intensive Care Medicine’s Guidelines for the provision of intensive care services and the Core Standards for Intensive Care Units; attracting, recruiting, and retaining medical and nursing staff in the unit by developing staff competencies and providing career progression, and by investing in new equipment. One staff member told us it was a “forward thinking, proactive unit”.

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.

We spoke with medical, nursing, healthcare assistant, and allied health professional staff throughout the critical care service. All staff we asked spoke positively about the culture within the service, and in their cross-team interactions with other medical and allied health professionals. Staff felt proud to work for the service.

From our observations and discussions with staff that the culture was focused on the needs of the patients. Staff at all levels were empowered to raise concerns with their line or senior managers and to request a temporary stop to procedures if they had any safety concerns. The trust had a freedom to speak up: raising concerns (whistleblowing) policy and supported the Speak Out Safely campaign. The unit had two freedom to speak up champions in place, and staff were able to report concerns anonymously through an electronic reporting system.

The open culture was encouraged by the leaders. During a ward round, we observed the consultant encouraging positive interactions between the multidisciplinary staff in the development of clear plans and expectations for the patients. The consultant actively sought additional suggestions from all members of the team on further options for the care of patients.

There was evidence of the service complying with the regulatory duty of candour in line with the joint Nursing and Midwifery Council and General Medical Council guidance, *Openness and honesty when things go wrong: the professional duty of candour*. The critical care service leaders understood the regulatory duty, while staff at lower levels recognised this in generic terms of being open and honest.

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.

Staff at all levels in the unit were clear about their roles, accountability and escalation mechanisms for governance matters.

The critical care service contributed to the monthly urgent care directorate Safety Quality Standards committee, which was attended by the directorate's matrons, clinical managers and leads, and senior managers.

The committee, which subsequently fed into the trust's quarterly Safety Quality Standards committee, reviewed standard agenda items. These included incidents, customer care items (complaints, compliments), the risk register, information governance and record management, audits, patient feedback and surveys, policies and guidelines, claims and excellence reporting.

Consultant led mortality and morbidity reviews were included in the bi-monthly anaesthetic audit meeting.

Learning from governance meetings was shared with staff during safety huddles, staff meetings and by newsletters.

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 critical care service's leaders were able to clearly describe the main risks facing the unit. These included the need for improvements to the legacy infrastructure of the unit environment and equipment, and the recruitment, retention and competency of staff. These were included on the unit's risk register.

The unit's risk register identified a total of 15 risks using a red, amber, green rating system. Of the 15 risk, 11 were rated red while the remainder were rated as amber. All the risks identified the control measures that were already in place, any gaps within these control measures, actions to reduce the resulting risk, assurance measures and gaps in assurance. All risks had a named responsible manager, accountable manager, and lead executive director.

Similarly, the leaders could demonstrate a good understanding of the unit's performance, including internal and external factors that may impact on it, such as delayed discharges and out of hours discharges.

Executive level oversight of critical care quality and performance on the unit was provided through the quarterly Safety Quality Standards committee.

Information management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The unit's audit and research facilitator managed the collection and submission of audit data for the unit.

The service submitted data on a regular basis to the Intensive Care National Audit and Research Centre (ICNARC). This ensured that the service's performance, in comparison with similar units, could be monitored and analysed. Senior leaders used the ICNARC data to monitor and improve its services.

A programme of internal unit audits was undertaken to improve services. The quality standards audit reviewed the records and care bundles for ten patients every month. This was undertaken by the unit manager and audit and research facilitator by the patient beside looking at the previous 24-hours.

The audit included review of performance against the use of the renal care bundles, nutritional care bundle, ventilation care bundle, tracheostomy care bundle, capnography care bundle, rehab care bundle, delirium care bundle, workforce care bundle, and documentation care bundle. This enabled the unit manager to review trends and to target improvement actions and reminders accordingly.

An audit was undertaken to make improvements to mouth care for patients in the unit. A noise at night audit resulted in the chairs on the unit being changed to reduce noise levels. The pharmacist undertook an intravenous medicines audit.

A monthly senior sister's audit was undertaken to 'check the checkers' and to enable consistency in audit practice and data collection.

Engagement

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

We observed supportive interactions between staff, patients and carers. Feedback from carers was encouraged by the use of feedback questionnaires. We saw a range of examples of positive feedback provided on the forms.

Feedback from patients was obtained during follow-up clinics and used to improve the services.

The unit manager made sure all staff attended the monthly team meetings or had access to full notes when they could not attend. We observed a team meeting during our visit and all members of the team were invited to contribute to the discussions. Learning, improvements, complaints, risks and alerts were reviewed during these meetings.

In the 2018 staff survey, 96% of those staff on the unit that responded said they felt supported by their manager.

The unit engaged with young people from a local drama college to assist with clinical simulations and scenario training for staff.

The unit participated in a staff engagement group looking at how to retain and recruit staff and issues affecting staff well-being. The unit manager promoted a 'go home, switch off' ethos to maintain individual's well-being.

The trust communicated and shared information with staff in a number of ways including through the urgent care team meetings, the staff matters newsletter and the learning into practice newsletter. The urgent care team brief minutes

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 were systems and process for learning and continuous improvement. Staff were supported by a strong ethos of training and mentoring in the service, which was supported by the practice educator and the unit manager. Learning was enhanced by the use of scenario training.

Feedback from patients attending the follow-up clinic was used to understand patients' experiences and perceptions while admitted to the unit. These were used to make improvements to the service, to staff behaviours and understanding, and to the environment.

The critical care service worked closely with the Cheshire and Mersey Critical Care Network and was developing closer links with the Greater Manchester Critical Care Network.

The unit participated in a number of research programmes including the Spotlight study, tissue damage from nasal tubes and the use of e-tape, fungal infections, and outcomes for patients suffering with chronic obstructive pulmonary disorder.

The lead pharmacist for urgent care, in conjunction with the consultant nurse and lead acute consultants, developed a new section for the intravenous fluids chart for the prioritisation of fluids for resuscitation. The new chart provided guidance for staff on how to prescribe in line with national guidance.

The service supported the Macclesfield College Healthcare Cadet programme. The programme aimed to provide an insight into the skills, qualities, knowledge and experience needed for careers in healthcare professions. The trust expected to support 20 cadets starting in September 2019.

The unit's respiratory physiotherapist helped to develop guidelines for the Cheshire and Mersey critical care network for weaning patients from ventilation.

A bank nurse on the unit had developed a non-invasive ventilation standard operating procedure for ventilator machines on the unit, which supported staff to manage the two different types of ventilators.

End of life care

Facts and data about this service

The trust provides end of life care. End of life care encompasses all care given to patients who are approaching the end of their life and following death. It may be given on any ward or within any service in a trust. It includes aspects of essential nursing care, specialist palliative care, and bereavement support and mortuary services.

The trust had 638 deaths from January 2018 to December 2018.

(Source: Hospital Episode Statistics)

East Cheshire NHS Trust offer an integrated acute and community specialist palliative care team which consists of two consultants, a team of specialist palliative care nurses and administrative staff to support the team. The team is based at the Macclesfield District General Hospital site and they have a coordinator role which is rotated through the team to triage and prioritise referrals. The trust aim to support those patients with palliative care needs to enable them to reach their preferred place of death and support staff in delivering palliative care.

The teams working hours are 9am to 5pm, Monday to Friday excluding weekends and bank holidays. The team receive referrals from all ward areas including the emergency department via telephone, fax or email and aim to see the patients within 24 hours, if possible, unless it is an urgent request. One member of the team carries a bleep so that ward staff can access urgent advice as necessary.

There is a consultant led clinic every Monday at the Cancer Resource Centre (CRC) and facilities available at the CRC to see patients at other times. The team have a board round every morning and patients are scheduled and triaged accordingly. Assessments are documented in the clinical case notes as well as electronically. The team work in close collaboration with the local hospice and attend a weekly integrated multidisciplinary team meeting which is held at the hospice.

(Source: Routine Provider Information Request (RPIR) – Context acute tab)

Is the service safe?

Mandatory training

The service provided mandatory training in key skills to all staff, however, compliance rates were low.

The service provided mandatory training in end of life care to all registered nurses and care staff.

Core statutory and mandatory training included health and safety, infection control, fire safety, equality diversity and human rights modules.

Core Clinical eLearning training included consent, Mental Capacity Act, Deprivation of Liberty Safeguards, learning disabilities awareness and record keeping.

Annual Clinical Update sessions during 2018 included basic life support, infection prevention and control, care of the critically ill patient, end of life, pressure ulcer care, falls and conflict resolution. The programme is reviewed annually and from April 2019, blood transfusion replaced falls and conflict resolution.

Mandatory training completion rates

	February 2019
Information governance	87.5%
Prevent	66.7%
Annual clinical update (classroom)	64.3%
Annual clinical update (eLearn)	69.2%
Core statutory & mandatory	85.7%

Targets for completion were between 85% and 95% depending on the module. Trust targets were not achieved for any of the mandatory training, although there were only six nurses in the team.

Since the last inspection, a practice educator for end of life had been recruited and provided greater training opportunities. The end of life training delivered to all nursing staff has been redeveloped to include details about the five priorities of care for the dying person, the end of life care plan, ambitions for palliative and end of life care (2015 – 2020), advance care planning, rapid discharge and where to find information in the trust.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Safeguarding adults and children was part of core statutory and mandatory training at the trust. The palliative care team worked with adults only. At the time of inspection, staff did not complete safeguarding adults level three.

Safeguarding training completion rates

	February 2019
Safeguarding adults level 2	84.6%
Safeguarding children level 2	76.9%

Cleanliness, infection control and hygiene

Staff used infection control measures when visiting patients on wards and transporting patients after death.

All ward areas, where end of life patients were being cared for, were visibly clean. We observed staff adhering to 'arms bare below the elbows' guidance and washing hands prior to patient contact.

There were wall mounted hand washing solutions at 'hands free' clinical sinks with handwashing instructions.

Infection control was included in mandatory training.

We observed personal protective equipment available for use in the mortuary. The mortuary environment was visibly clean, particularly in the post-mortem room with scheduled deep cleaning.

There was no separate dedicated area for storage of bodies with known infections, either from the wards or in the community. Staff tried to store bodies with infections either in the bottom of a cabinet or together. Porters were aware of an infection risk when transporting a deceased patient as body bags were used to easily identify them.

Some bodies needed storing for attention of the Coroner; there were dedicated units that included clear instructions for staff to follow regarding managing the body.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them.

There was no dedicated palliative care ward. Patients, in the hospital, deemed to be in the last days of life were nursed on general wards. The palliative care team monitored the location of any patients daily.

Since the last inspection, syringe drivers, for the administration of end of life medicines, were stored centrally in an equipment library. Of those we sampled, all had been maintained within the last 12 months. Data provided by the trust showed that there was a process for recording the maintenance of syringe drivers and these had been serviced within the 12 months prior to inspection.

The mortuary had facilities for post-mortems as well as a body store area. This included five units for the storage of bodies; one unit with four compartments, two units with three compartments and

two units with one compartment. One of the four units was wider to accommodate bariatric patients (for larger patients). Each unit was floor to ceiling in height and could store four patients, on trays, one above the other.

There was a single freezer unit. It was floor to ceiling in height and could store three patients, on trays, one above the other.

Temperatures of fridges were monitored daily electronically. The probes were linked to an external system so that if the alarm sounded when the mortuary was not staffed, such as overnight, the nearby pathology laboratory (in office hours) and the hospital switchboard were alerted and they would contact the on-call staff to investigate. The system indicated if any prolonged temperature out of range.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Risk assessments considered patients who were deteriorating and in the last days or hours of their life.

Assessments were carried out for end of life patients as part of the care in the last days of life. This documentation was available to be completed by all hospital clinical staff including doctors and nurses.

The trust used a national early warning score system (NEWS) when monitoring patients. NEWS is a system to allow early recognition of physical deterioration by close monitoring of vital signs of patients receiving hospital care. For patients identified as in the last days of life, we were told that the frequency of NEWS monitoring was either reduced or stopped depending on individual patient need.

The specialist palliative care nurses and the palliative consultant told us they reviewed patients, in the last days of care daily, during weekdays.

There were processes in place for the mortuary, aligned to the neighbouring NHS Trust, including documentation to record the identity of the deceased and procedures to follow in the event of a major incident.

Nurse staffing

The service had enough nursing 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 palliative care team consisted of six palliative care nurses. Since the last inspection the nurses now worked in teams rather than geographical area. They worked in teams of three and worked both in the hospital and in the community. One of the senior specialist palliative care nurses was designated the co-ordinator and carried a bleep for easy access to advice.

A team of three specialist respiratory nurses were employed to support respiratory patients form a diagnosis of a cancer or life-limiting condition through to end of life.

A role had been created, funded by a partner provider, at the trust, where it was planned they would be based in the urgent and emergency services department to support patients, their families and staff with end of life care. This role had not started at the time of inspection.

Vacancy rates

At the time of inspection there was a nurse vacancy. This position was a band seven role, although; the service was recruiting a band six nurse that was cover more hours.

Bank and agency staff usage

The trust did not report any bank or locum usage for end of life care.

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.

There were two palliative care consultants that worked 0.9 whole time equivalent. At the time of the last inspection, there was one consultant which meant there was no palliative cover during times of absence. The consultants provided an integrated service in the hospital and community.

Vacancy rates

There were no vacancies at the time of inspection.

Turnover rates

There were no medical staff changes in the twelve months prior to inspection.

Sickness rates

There was no medical sickness in the twelve months prior to inspection.

Bank and locum staff usage

The trust did not report any bank or locum usage for end of life 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.

Paper records for patients receiving end of life care were stored securely in trolleys located near nurse's stations. Patients records included a sticker to direct health professionals that the patient had an end of life care plan.

The trusts documentation for end of life patients in the last days of life was available on all wards visited. At the time of inspection there was an end of life care plan in use, although a revised version of the care plan documentation was being prepared for use on the wards. The new version had been developed by a working group that included the end of life practice educator, palliative care consultants, palliative care nurses and nurse representatives from the wards. The document had been reviewed following the results of the latest National Audit of Care at the End of Life. There was a plan for cascading to the wards from August 2019.

The end of life care plan consisted of details of the five priorities for caring for the dying person, multidisciplinary team assessment, advance care planning, assessment of mental capacity, medicines and hydration. The document was designed for all staff to complete with sections for doctors and nurses to complete daily.

We reviewed the current end of life care plan document for two patients. They both showed discussions with patients and those close to them and also future plans that were in place. Both included information about anticipatory medicines.

Patients' paper records included the unified do not attempt cardiopulmonary resuscitation (uDNACPR) document that were stored in the patients paper records.

At the last inspection, there were inconsistencies in the completion of do not attempt cardiopulmonary resuscitation records. We reviewed 10 records of the unified do not attempt cardiopulmonary resuscitation and found that they had all been completed appropriately.

Medicines

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

The trust had policies and procedures in place for the management of medicines for patients receiving end of life care. Anticipatory medicines are medicines that are pre- prepared and kept with the patient for administration by a doctor or nurse. They are medicines that can help with symptom control in the last days of life.

Anticipatory medicines were ordered and stored in the hospital, securely, until the patient was discharged. The trust had relaunched the blue booklet that allows anticipatory prescribing in the last days of life. At the time of inspection, one of the palliative care team was a nurse prescriber. There were plans for other members of the team to undertake the training. This meant that any medicines could be prescribed and administered promptly.

We reviewed two records for anticipatory medicines and found that all medicines had been prescribed appropriately. Anticipatory medicines were included in the National Audit of Care at the End of Life that the trust submitted to.

As part of future plans, the service was planning to review and of life prescribing in critical care in line with national guidance. **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.

In the twelve months prior to inspection, there were no incidents identified as never events or serious incidents. There was a total of seven incidents all of which were classified as either low harm, no harm or near misses.

Never Events

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

From April 2018 to March 2019, the trust reported no never events for end of life care.

(Source: Strategic Executive Information System (STEIS))

Trust level

In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents (SIs) in end of life care which met the reporting criteria set by NHS England from April 2018 to March 2019.

(Source: Strategic Executive Information System (STEIS)

Is the service effective?

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.

Care and treatment, we observed was in line with national guidance such as the National Institute for Clinical Care Excellence (NICE) NG31: Care of dying adults in the last days of life and Ambitions for palliative and end of life care: a national framework for local action 2015-2020.

Each ward could access the trust's intranet for policies and guidelines to support end of life care.

The mortuary, along with a neighbouring NHS trust, completed audits that were comprehensive and showed alignment with policies and procedures.

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 we spoke with told that patients, in the last days of life were given fluids and food dependent on individual need. This meant that depending on the condition of the patient, oral diet and fluids may be taken or fluids may be given intravenously, if a cannula was in situ or sub-cutaneously (under the skin).

Records we reviewed documented discussions, with patients and relatives including decisions about appropriate nutrition and hydration needs in the last days of life.

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 pain, using a recognised pain score tool as included in the last days of life care documentation with clear pathways.

We reviewed two anticipatory prescription records for end of life patients and saw that pain medicines had been prescribed appropriately.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

For patients who died at the trust, between June 2018 and May 2019, there were 34% identified as end of life, with an end of life care plan in place.

The trust participated in the National Audit of Care at the End of Life (NACEL). The first round was submitted in October 2018 with interim results published in October 2019. The aim of this audit is to improve the quality of care of people at the end of life. It monitors progress against the five priorities for care set out in One Chance To Get It Right and NICE Quality Standard 144, which focusses on the last days of life, within the context of NICE Quality Standard 13, which focuses on the last year of life.

	National summary score	Trust submission score
Recognising the possibility of imminent death	9.1	8.7
Communication with the dying person	6.9	5.2
Communication with families and others	6.6	6.3
Involvement in decision making	8.4	7.1
Needs of families and others	6.1	4.6
Individual plan of care	6.7	4.7
Families and others experience of care	7.1	7.8

Governance	9.5	10.0
Workforce / specialist palliative care	7.4	6.7

The National Audit of Care at the End of Life published in February 2019 included the trusts scores as compared to the England and Wales average. The trust scored worse on four of the indicators, similar for three indicators and better for two.

The proposed action plan following the results of the National Audit of Care at the End of Life was focused on the key areas of the end of life documentation, including training on completion and end of life training. This was now mandatory for nursing and medical staff with one of the palliative care consultants delivering training to new doctors. We reviewed the action plan and found that it was on target with the introduction of the purple bow boxes on wards and an on-going training programme in place. Purple bow boxes included information for families such as how to access free parking and refreshments on the ward.

The service-maintained dashboards to monitor patients accessing the service. There were 457 first appointments with the hospital specialist palliative care team between April 2018 and March 2019, with 1179 follow-up appointments for the same time period. There were 452 referrals and 8461 telephone calls made to the team. There were1912 service cancellations by the hospital team but no did not attends for this period. The trust explained that, although labelled as cancellations, they were actually re allocated appointments to meet the demands of the service into the most appropriate slot on the electronic system.

In the twelve months prior to inspection, of the patients who died at the trust, there was 14.5% of patients, seen by the palliative care team.

Two months prior to the inspection the trust changed their monitoring of referrals to capture patients identified with cancer or non-cancer patients. In April and May 2019, there were 45 referrals to the hospital palliative care team with cancer diagnoses and 10 patients with non cancer diagnoses.

The service was planning to incorporate the palliative care outcome score (POS) into their electronic system to monitor patient experiences and outcomes for end of life patients.

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.

Link nurses for end of life care were available on wards we visited. Wards aimed to have at least two nurses to cover leave. We found that staff on the wards were aware of their link nurse.

The role of the link nurse included attending trust wide end of life meetings, cascading any updates in guidance or process, identifying any concerns and support for other staff. We found that they were very passionate about providing excellent end of life care. At the time of inspection, a study day was held to share the revised end of life care plan with link nurses.

The training facilitator was passionate about staff competencies to care for end of life patients. As part of a regional network, there was a range of study days that were freely accessible to ward and palliative care staff either via the regional training network or other recognised tend of life training facilitators either as groups or bespoke to individual need.

Palliative care nurses were encouraged to attend role-specific training to enhance their role.

The end of life simulation study day was accredited by the North West Simulation Network meaning the training could be offered outside of the trust. A community pilot was planned for July 2019 in collaboration with the regional partnership for care homes and hospices. This training included advanced care planning, clinical management and rapid discharge, but also provided an opportunity to practise communication skills in a safe environment.

The palliative care consultants had both undertaken appraisals in the twelve months prior to inspection. Compliance rates for appraisals of the palliative care nurses was 92%.

The bereavement staff were not bereavement officers, although had received additional training in communication following a security audit in January 2019. **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 good multidisciplinary working both internally and externally. Patients who were transferred to the last days of life care plan were referred to the trusts palliative care team, if needed, for support and advice.

All documentation was kept together so that all health professionals completed the same paper records for patients. There was no electronic palliative care co-ordination system at the hospital; although the palliative care team, completed an electronic system when in the community.

The bereavement office was based in the general office and was open from 8.30am to 4.30pm during weekdays.

They liaised with mortuary staff daily to check who had deceased overnight. They also contacted the wards if patient records were not delivered and requested doctors to complete death certificates. A registrar visited two days a week which meant deaths could be registered at the hospital. The staff managed patient belongings including valuables and were a point of contact for the Coroner and hospital funerals.

A multidisciplinary meeting was held once a week at a local hospice that involved hospital and community staff, where patients were discussed. Details of patient care were shared for the trust, local hospice and community service for new referrals as well as any in-patients or calls to the 24 hour advice line.

Seven-day services

Key services were not available seven days a week to support timely patient care.

The ‘NHS Seven Day Clinical Standards’ (2017), standard eight states that all patients on an end of life pathway must be seen daily by a consultant. NICE guidance (quality statement 10: 2018) states that specialist palliative care and advice should be available at any time of day and night for people approaching the end of life.

The palliative care team were only available Monday to Friday between 9am and 5pm. This does not meet the recommendations outlined by NICE and was highlighted at our last inspection.

Outside of these hours, patients were directed to an advice line at the local hospice as part of the trusts integrated service.

The mortuary staff worked, 8am until 4.30pm with an on-call system to cover evenings, night, weekends and bank holidays. An appointment system was in place for viewing of patients by those close to them.

The bereavement office service, situated in the general office, was open during office hours with an appointment system for the collection of the death certificate and patient belongings.

Health promotion

Staff gave patients practical support to help them live well until they died.

There was a holistic approach to patients’ in need of in end of life care and specifically those in the last days of life. Assessments included in the patients record included physical needs such as comfort and nutrition and hydration, as well as any spiritual and psychological needs.

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.

We observed staff obtaining verbal consent from patients in the delivery of care and treatment.

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

We reviewed the unified do not attempt cardio pulmonary resuscitation (uDNACPR) forms for 10 patients and found all had been completed appropriately.

An audit of unified do not attempt cardio pulmonary resuscitation was carried out in December 2018. The audit found there was good compliance with the trust policy, but also highlighted some areas for improvement. An action plan was created with dates for completion and a plan to reaudit.

Is the service caring?

Compassionate care

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

We observed staff, of all grades, providing compassionate care to patients and those close to them.

Feedback from relatives of patients, confirmed that staff treated them well and with kindness. The trusts booklet “help and care in your loss” included a section to provide feedback, however, the service found that this was rarely completed. The practice educator was exploring ways of gaining feedback after a period of time following the loss.

We saw staff interacting appropriately with patients and those close to them.

Patients were cared for in side rooms, if available. Ward nurses completed last offices, unless family members requested otherwise due to cultural preferences.

Two porters, who had completed appropriate training, escorted patients to the mortuary and completed relevant paperwork.

Porters were conscious to transport patients in a timely manner, although due to the hospital footprint they were also sensitive to moving patients through hospital corridors out of visiting hours, if possible.

A bereavement questionnaire was provided to relatives to gain feedback about the service. Staff confirmed that response rates were low but were exploring ways to gain feedback in the weeks following the death rather than at the time of registration.

Emotional support

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

Staff, we observed, introduced themselves and communicated sensitively to ensure full understanding.

Patients, and those close to them, were encouraged to ask questions and were given time to ensure they understood what was being said to them.

We observed staff providing emotional support to patients and those close to them. Leaflets provided included signposting to support services.

There was a mental health team available if needed, from a neighbouring NHS trust located onsite.

The palliative care team were available, if and when needed, to support ward staff as well as patients.

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.

Records we reviewed showed that discussions had taken place with patients and those close to them.

Staff were clear that care was for the patient and those close to them. There was open visiting for families, with close members able to be resident overnight.

From the National Audit of Care at the End of Life, the trust scored better than the England average for families and others experience of care.

Mortuary staff and porters explained how they were respectful and caring with deceased patients and those close to them.

The service had carried out a scoping exercise, visiting end of life services across the North West specifically looking at bereavement support services.

Is the service responsive?

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.

There was no dedicated palliative care ward in the trust. Patients who required end of life care were nursed on wards throughout the hospital.

The palliative care team were based in the hospital and were only available from Monday to Friday between 9am and 5pm providing support to other health professionals as well as visiting and supporting the patients that had been referred in their last days of life.

A weekly nurse led clinic had also been introduced to support patients.

At the time of inspection, there was no dedicated bereavement office. This service was operated in the general office. This was identified at the last inspection. Signage, seen on inspection, indicated the office was the bereavement office and general office. A registrar visited two days a week and could register deaths at the hospital, if preferred by families. However, there was limited space in the office and staff expressed concern that, if more than one family were in the office, sensitive conversations may be overheard. The trust had already identified these issues and we received a copy of the action plan detailing planned changes in the environment and furniture to be more appropriate for bereaved families. Following the inspection, the office was renamed as the registration and bereavement office with instructions on the door about appointment times. This was shared with staff in the trust newsletter.

Staff were also concerned about lone working. We addressed this during the inspection. A security audit, in January 2019 directed staff to contact security if concerned.

The mortuary staff participated in post mortems for adults who died at the hospital and in the local community. For babies and children, there were arrangements with regional paediatric hospitals for these post mortems, but they would return to the trust ahead of funerals.

A charity had donated craft bags to the trust rather than using patient property bags available at the hospital. They also provided ring bags for valuable items of jewellery and syringe driver bags.

A mental health team was available, from a neighbouring NHS Trust located on-site, if the patient needed extra support. The trust did not monitor the number of referrals made.

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.

On all wards we visited, staff were clear that, whenever possible, a patient in the last days of care, would be nursed in an individual side room or quieter area of the ward. All staff we spoke with were passionate that patients at end of life were a priority and care should be the highest standard.

The end of life documentation was available for the last days of life. This included an individualised care plan that was updated by all clinical staff. The documentation had been reviewed, prior to inspection and the revised documentation was expected to be available on the wards in August 2019. Documentation had been modified so that all sections could be completed appropriately.

In the urgent and emergency department, a side room was available, away from the main treatment areas, where a patient, and those close to them, could stay if they needed to remain in the department. A discreet symbol system indicated if the room was occupied.

Open visiting was available to those close to the patient. Overnight facilities could be arranged in the form of z-beds or chairs at the bedside close to the patient. The service had introduced the purple bow scheme. Each ward, we visited, had a dedicated purple bow box that included information for families. They were able to access free parking during this period. They were encouraged to take breaks and ward staff included them with meals and refreshments available on the ward.

There was a trust wide interpreter and translation service, although staff could access other staff members in the trust, if required. For patients with hearing impairments, there was access to a sign language specialist.

Patients admitted with a learning disability were often accompanied by a family member or carer. They could be accommodated as per individual need.

There was a range of patient information leaflets on the wards, the cancer resource centre, from the palliative care nurses, in the mortuary and at the chapel including for end of life support for those close to patients. These included practical advice as well as signposting to available diverse support. Information could be sourced in alternate formats, such as Braille, large font, easy read and languages other than English if requested. A bereavement pack was provided to those close to the deceased.

The practice educator, along with ward link nurses, were exploring alternative approaches to supporting end of life patients. These included a dedicated quiet time on the wards, using electronic devices to recreate calm scenes, such as a beach setting and calming smells.

A chaplaincy service was available. It was consisted of representatives from the Church Of England and Roman Catholic with links to other faiths such as Hinduism, Islam and Sikhism. There were two Anglican ministers, two Roman Catholic priests and a Methodist minister. The chaplains worked on a part-time basis supporting patients on the wards. The chaplains were employed for between one and three sessions per week, on different days, with a session being three and a half hours. They were supported by a team of about 100 volunteers. There was also an on call service, 24 hours a day, for patients at the end of life or for people who requested extra support.

There was a chapel, where regular services were held and a quiet room. There was a multi-faith prayer room that included dedicated male and female prayer areas as well as male and female ablution rooms. This multi-faith room prayer room was locked with swipe card access. Staff provided visitors with a swipe card and recorded when used. There was clear signage to the chapel, however, the only signs for the multi-faith room were on the hospital maps.

The chaplaincy team, we were told, met five times a year for team meetings chaired by the chaplaincy co-ordinator. Minutes we reviewed included an agenda, action log, details of upcoming services, chapel requirements as well as any business that chaplains needed to discuss.

Staff in the mortuary knew who to contact for a variety of faiths and provided an understanding of religious protocol. For Muslim patients, staff positioned trolleys to point towards MECCA. Purple blankets were available but were replaced by white sheets depending on the faith of the deceased.

There were processes for patients identified with medical devices, such as pacemakers and organ donation. The mortuary was discreetly situated in the hospital, although relatives who requested viewings were required to use the main entrance. Viewings were carried out using an appointment system with families with directions given. Entry was by a secure bell entry that rang in the mortuary office. A dedicated viewing room was available although families could be close to the deceased, if preferred. Out of office hours, porters and bed managers facilitated any viewings. If there were restrictions on who could view a deceased patient, this was displayed on the fridge door.

Bariatric equipment (for larger patients) was available in the mortuary including a larger storage area and trolleys. There was a frame, collected from the mortuary by porters, that was attached to the patient's bed for transport through the hospital.

Access and flow

Waiting times from referral to achievement of preferred place of care and death were in line with good practice.

There was an integrated discharge team, for the trust, however, we were told that rapid discharges were generally facilitated by ward staff with the support of the palliative care team, if needed.

Current General Medical Council (GMC) guidance states that end of life patients are those that are likely to die within the next 12 months, or when death was imminent. We found that patients were referred to the palliative care team, following referral from a consultant, in the last days of life, and placed on the end of life care plan.

The palliative care team was an integrated hospital and community team who supported ward staff, if needed, with discharges for patients. The patients preferred place of death was shared at the weekly integrated multidisciplinary meeting. There were 320 patients who died in their preferred place of death between June 2018 and June 2019.

For patients being discharged from the hospital, we were told that they were able to organise transport and any equipment needs either the same day or the next day.

The palliative care team monitored wait times following referrals. Between June 2018 and May 2019, there were 479 referrals in the hospital. The average face to face wait, for end of life patients was 0.68 days.

The mortuary could source extra temporary storage, if needed, to fulfil any increased demand, as well as working in partnership with a neighbouring NHS trust mortuary. Staff reported good relationships with local funeral directors who were prompt in collection of the deceased.

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.

We saw that information about providing feedback to the trust was available in all wards we visited.

There were two complaints about the end of life service between June 2018 and May 2019, one of which was upheld and the other partially upheld. Both complaints were regarding communication issues. Actions were taken to improve care for patients.

The service shared learning from any complaints including by scenarios in simulations.

The service had received five compliments between June 2018 and May 2019.

Is the service well-led?

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.

There were two palliative care consultants who led the service, and since the last inspection, the trust Medical Director represented the service at executive level as board champion. There was no service improvement lead for the service.

Leaders had implemented positive changes since the last inspection such as engagement with staff and responses to national audit.

There was a non-executive director (NED) who was nominated to be responsible for end of life care.

The mortuary was led by pathology services as part of a regional service with a neighbouring trust.

The palliative care team were managed within the Allied Health Clinical Support directorate, with the practice educator employed by a third party provider.

Vision and strategy

The strategy was 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.

At the time of the last inspection, there was no strategy available, for the service. Since then, the service followed the regional network strategy; the strategic partnership executive that included a range of organisations with responsibilities for end of life care. The goal of the network was: “ ...to work together (public, patients, carers, professionals) to promote a culture of compassionate, coordinated care; to endorse leadership, partnership, education; translating knowledge and experience into practice, and to support a change in public knowledge, attitude and behaviour towards death, dying and loss.”

The priorities for 2016 – 2019 were identified as advance care planning, electronic palliative care communication systems, care co-ordination and community development. The trust attended trustwide mortality reviews and were part of the palliative quality steering group for patients in East Cheshire.

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.

In all areas we visited, we found staff to be friendly, welcoming and approachable and ensuring patient care was their priority.

We observed good teamwork and senior nurses reported being proud of all staff and the care they provided.

There was a positive culture with staff reporting feeling supported by their line managers and palliative care staff.

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.

In the National Audit of Care at the End of Life, the trust scored better than the England average for governance. An action plan was in place which included the review and relaunch of the revised end of life care plan documentation, the rollout of the purple bow boxes and evaluation of training.

Dashboards monitored outcomes for end of life care at ward level and these were reviewed by commissioners. These included number of inbound referrals, first appointments, follow-up appointments, telephone calls, service cancellations and did not attends.

Monthly governance meetings were held by the trustwide allied health and clinical support safety quality standards group. Minutes we reviewed included regular agenda items such as reviews of serious incidents, complaints, risks, compliance with national guidance, audits and patient experience.
There was a palliative quality steering group as part of the regional network. There had been no external or peer review completed in the twelve months prior to inspection.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

A risk register was in place for end of life care. Sustainable workforce was the one risk identified for the service. Controls included converting a part-time band seven nursing position to a band six, therefore creating more hours. The risk had been identified in March 2018. There was evidence that the risk had been reviewed, however, there were no further dates included.

Trustwide mortality meetings were held monthly. We reviewed minutes and found there was representation from the end of life team. Deaths in the trust were reviewed along with any learning from deaths as well as progress with actions from the National Audit of Care at the End of Life.

There were no current external reviews of the service at the trust.
There were major incident plans for the mortuary in case of an emergency regionally.

Information management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

End of life policies and procedures were available for staff to view on the trusts intranet.

Palliative care staff were integrated across the hospital and community. Password protected electronic records were maintained in the community and paper in hospital.

Patient records were paper-based including the last days of care documentation and the unified do not attempt cardiopulmonary resuscitation (uDNACPR) form. The discharge liaison team forwarded information electronically to community staff of nurses and G.P.

The mortuary completed a paper record book, although had electronic systems for monitoring purposes.

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 link nurses shared information from end of life meetings with other ward team members.

The specialist Palliative care team attended monthly meetings. We reviewed minutes that showed a range of subjects were discussed including charitable funds, vacancies, training opportunities, feedback from families and planning.

The service participated in dying matters week with a local funeral service supporting the trust with charity events. Proceeds were donated to local bereavement services.

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.

End of life care was an integrated service with staff able to provide continuity of care, using a team approach in hospital and community.

The service worked collaboratively with the regional network and had introduced a range of training opportunities including the simulations.

The service had carried out a scoping exercise, visiting end of life services across the North West specifically looking at bereavement support services.

Outpatients

Facts and data about this service

East Cheshire NHS Trust holds outpatient clinics at Macclesfield District General Hospital, and at satellite locations such as Congleton War Memorial Hospital, Knutsford District Community Hospital and several other throughout the community. The leadership team staff at Macclesfield District General Hospital retain overall responsibility for the clinics and staff at all locations.

The outpatient department is part of the allied health and clinical support services directorate. It provides a number of clinics for patients including:

- General, geriatric and thoracic medicine
- Orthopaedic
- Ophthalmology
- Gynaecology
- Plastic surgery
- Gastroenterology
- Urology
- Trauma and orthopaedics
- Ear, nose and throat
- Rheumatology Cardiology.

There are two main outpatient departments at Macclesfield hospital; the general outpatient service which is based near the main entrance of the hospital; and an orthopaedic outpatient department (which held a fracture clinic) which is based in a separate part of the hospital and has a separate entrance, reception and parking area.

The service is open from 8.30am until 5.00pm, Monday to Friday. Extra clinics can be scheduled in the evening and at weekends where appropriate.

Appointments are booked by the department's booking and scheduling team, and the use of an automated reminder service is in place to reduce the number of patients that do not attend.

Patient feedback is reviewed monthly via Friends and Family reports. In addition; a quarterly patient satisfaction questionnaire takes place from which an action plan is developed and reviewed at departmental meetings.

The trust has signed off a redesign of the outpatient department at Macclesfield District General Hospital. Work is due to start in July 2019 and is expected to be completed before the end of the year.

The trust had 188,533 first and follow up outpatient appointments from December 2017 to November 2018.

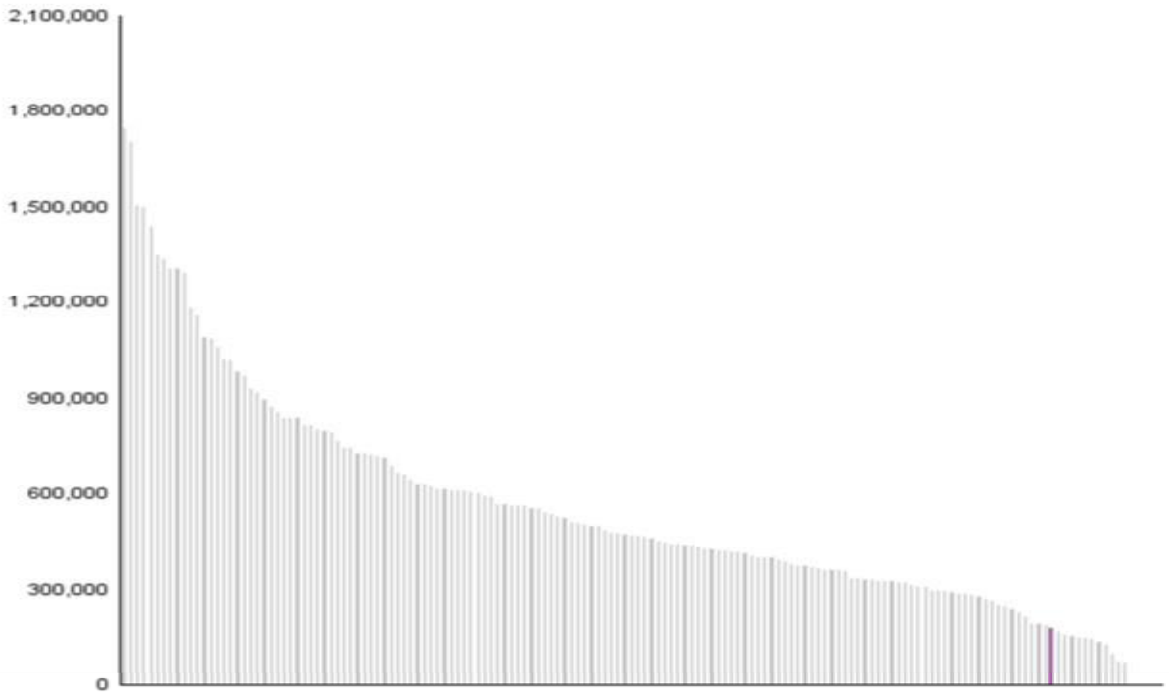
We planned our inspection based on everything we know about services including whether they appear to be getting better or worse.

We inspected the outpatient department between 2 and 4 July 2019. Our inspection was unannounced. As part of the inspection we reviewed information provided by the trust about staffing, training and monitoring of performance.

We visited the outpatient departments at Macclesfield District General Hospital. We also visited the transcription suite, the booking and scheduling team, and the medical records library.

The inspection team spoke with eight patients and carers, and 21 members of staff including managers, consultants, nurses, healthcare assistants and administrative staff. We reviewed six patient records and observed two consultations and other interactions between staff and patients.

The service was last inspected in May 2015. At the time we jointly inspected the outpatients and diagnostic services.



(Source: Hospital Episode Statistics - HES Outpatients)

Number of appointments by site

The following table shows the number of outpatient appointments by site, a total for the trust and the total for England, from December 2017 to November 2018.

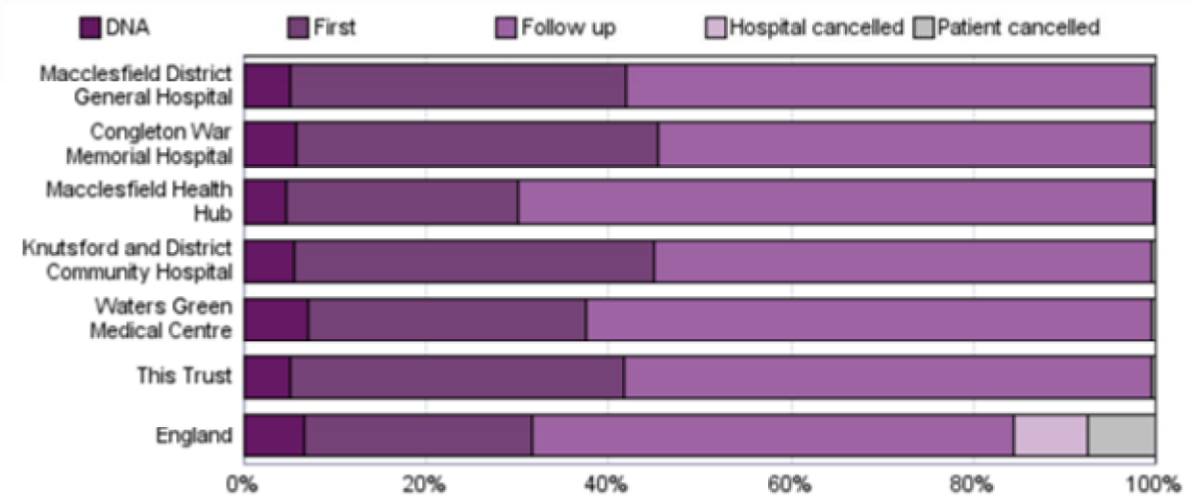
Site Name	Number of spells
Macclesfield District General Hospital	162,079
Congleton War Memorial Hospital	9,737
Macclesfield Health Hub	7,909
Knutsford and District Community Hospital	5,177
This Trust	
England	**188,533**
	108,706,318

(Source: Hospital Episode Statistics)

Type of appointments

The chart below shows the percentage breakdown of the type of outpatient appointments from December 2017 to November 2018. The percentage of these appointments by type can be found in the chart below:

Number of appointments at East Cheshire NHS Trust from December 2017 to November 2018 by site and type of appointment.



(Source: Hospital Episode Statistics)

Is the service safe?

Mandatory training

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

Staff received and kept up to date with their mandatory training. The mandatory training was comprehensive and met the needs of patients and staff. Managers monitored mandatory training and alerted staff when they needed to update their training.

The outpatient ward sisters planned staff training for the year ahead. Those staff we spoke with that had not completed it had had training booked into their diary. Staff could complete training during normal working hours.

Three members of staff had been trained in autism awareness and had been developed as link nurses. They provided additional support and advice for staff, patients and relatives.

Mandatory training completion rates

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

Core Statutory & Mandatory training includes Health & Safety, Safeguarding Adults and Children, Infection Control, Fire Safety, Equality Diversity & Human Rights.

Core Clinical eLearning includes: Consent, Mental Capacity Act, Deprivation of liberty (DoLS), Learning Disabilities Awareness and record keeping.

Annual Clinical Update sessions are bespoke (depending on role) and topics are reviewed annually - this is classed as statutory due to the inclusion of basic life support (BLS).

The trust reports Preventing radicalisation/workshop to raise awareness of prevent (WRAP) training as a statutory or mandatory training module.

Trust level

A breakdown of compliance for mandatory training courses from April 2018 to February 2019 at trust level for qualified nursing staff in outpatients is shown below:

Training module name	April 2018 to February 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Core Stat & Mand	29	32	91%	90%	Yes
Prevent / WRAP	87	96	91%	85%	Yes
Information Governance	31	33	94%	95%	No
Core Clinical E-Learning	28	32	88%	90%	No
Annual Clinical Update	25	32	78%	90%	No

Grand total	200	225	89%	95%	No

In outpatients the target was not met for four training modules for which qualified nursing staff were eligible.

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

Safeguarding

Staff received training specific for their role on how to recognise and report abuse.

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.

Those staff that had not completed safeguarding training had training scheduled into their diary. Staff were able to complete training during normal working hours.

Staff told us it was easy to contact the safeguarding leads or a manager if they required advice.

The ward sisters had developed a staff communications file that included a copy of a safeguarding report from June 2019. The report contained information from national child death enquiries.

The trust set a target of 85% for completion of safeguarding training.

Trust level

A breakdown of compliance for safeguarding training courses April 2018 to February 2019 at trust level for qualified nursing staff in outpatients is shown below:

Training module name	April 2018 to February 2019				
	Staff trained	**Eligible staff**	**Completion rate**	**Trust target**	**Met (Yes/No)**
Safeguarding Children (Level 3)	4	5	80%	85%	No

Data from the service's performance dashboard showed that at least 90% of eligible staff had completed safeguarding children and adults training level one and two, and safeguarding children's level three (data from April to December 2018).

In outpatients, qualified nursing staff failed to meet the 85% completion target for safeguarding children level 3.

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

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.

Most staff followed infection control principles including the use of personal protective equipment.

There were hand gel dispensers throughout all outpatient areas with signs reminding staff, patients and visitors to wash their hands.

The service completed monthly hand hygiene audits and sent the results to the infection prevention and control team. Audit results from April to June 2019 showed that 100% of audited staff complied with hand hygiene standards. The infection prevention and control team also carried out verification audits. The most recent audit covered 2,769 members of staff from various departments across the trust and showed 94% compliance with hand hygiene standards. The trust also had an up to date hand hygiene policy which was in line with guidance from the National Patient Safety Agency and the National Institute for Health and Care Excellence.

However, we witnessed one consultation where the doctor did not obviously wash their hands either before or after examining the patient. We observed another consultation where the doctor washed their hands after the examination, before did not obviously do so before. The trust assured us that staff had been reminded of their responsibilities regarding hygiene practices.

Staff moved infectious patients, attending clinics, to a more isolated area of the department to minimise the risk of infection to others. The area would then be deep cleaned after the consultation.

We saw that staff had placed “I am clean” stickers on equipment that had been cleaned.

Patient information leaflets in the fracture clinic contained information for patients about reducing the risk of surgical site infections.

The service had a clear pathway to follow for the decontamination of flexible endoscopes. This included a preliminary clean before being sent to the endoscopy department for more thorough decontamination. We observed that the chemicals used for the preliminary cleaning of the scopes stated that gloves and goggles should be worn for this process. A member of staff told us that they only wore gloves.

Sharps bins, whilst not overfilled, were not always labelled correctly with date, location or “locked by” information.

Environment and equipment

The design and use of facilities, premises and equipment kept people safe. Most equipment was appropriately maintained.

The main outpatient department was split into two areas with two different reception desks. A large sign had been placed on entrance to the department indicating to where patients should

check-in. Although the waiting area was busy at times, we did not see patients having to stand whilst waiting for their appointment.

The resuscitation trollies in the outpatient areas had had daily checks of the equipment. The trollies contained up to date guidance from the Resuscitation Council (UK) about in-hospital resuscitation. They also contained laminated picture cards clearly setting out what equipment should be on each shelf of the trolley. Both trollies had a tamper seal.

The reception areas had signs asking those patients waiting to book in to stand behind a line to give the person in front some privacy when checking in. As the general outpatient area was cramped, the lack of space meant that people could still hear conversation at reception. However, no clinical information was discussed.

Whilst most of the equipment we reviewed had been regularly serviced and calibrated, this was not universal. We saw two plaster saws that should have been serviced in October 2018 but had not. We spoke with the trust about this matter. They explained that equipment would either be serviced by the estates team, or the medical engineering department. They told us that this equipment did not appear on either of these departments service lists and had therefore been missed. We were told that the equipment would be serviced.

Most of the consultation rooms in the general outpatient area did not have signs on the door to say whether they were engaged or not.

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 responded promptly to any sudden deterioration in a patient's health.

Staff knew about and dealt with any specific risk issues, including sepsis.

The service had access to mental health liaison and specialist mental health support (if staff were concerned about a patient's mental health). They arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide.

The service had long waiting lists for some specialities, including cardiology and rheumatology. The service had effective systems in place to review waiting lists (a weekly meeting chaired by the chief operating officer) to ensure that those patients that required an urgent appointment could be escalated and seen quickly. The trust confirmed that no patients had come to harm whilst waiting to be seen by a doctor in the 12 months prior to the inspection,

Staff had access to the mental health liaison team during clinic times and could provide examples of when they had requested advice in the past. This included an urgent referral when a patient expressed suicidal thoughts.

Staff received training on dealing with violent and aggressive patients which was provided by the security team. There was also an up to date policy on the intranet for staff to refer to. The training highlighted de-escalation techniques rather than focusing on restraint.

Patient information leaflets in the fracture clinic contained information for patients about the steps they could take to help reduce the risk of venous thromboembolism after surgery. The leaflets also contained information about who patients should contact if they have concerns after surgery (in an emergency, patients were directed to call 999).

Staff had received training in the latest national early warning scores system that helped identify deteriorating patients, and in recognising sepsis. A healthcare assistant gave us an example of where they had escalated a patient to a staff nurse for review.

We observed two consultations. In both instances the doctor reviewed the patients' past medical history, discussed their current treatment and took account of comorbidities. One doctor assessed the patient's ongoing pain and discussed a number of management options including injections and surgery. The patient told us they were happy with the outcome of the consultation.

Staff knew what to do if a patient collapses in the department, including calling the resuscitation team. The general outpatient department was situated immediately next to the emergency department who could be called quickly to deal with an emergency. Whilst the fracture clinic was further away from the emergency department, staff could describe what to do in an emergency (and gave a recent example).

The service had introduced a referral triage system to review referrals and ensure that they had been made correctly and to the right speciality. The system was first trialled on urgent two week cancer referrals. At the time of the inspection, it was being rolled out across a number of different specialities, including cardiology and rheumatology. This allowed staff to review referrals (with support from the consultants) to check they were appropriate. Feedback could be provided to referring GPs if there were any issues identified.

The booking and scheduling team were involved in managing the additional patients the service took on for the breast service (this followed another organisation in the area closing its breast service). The team devised a tool that highlighted the patients' details, date of referral and the date they would breach national targets. The information was shared daily with the operations managers, cancer services departments and team leaders. A multidisciplinary team formed of consultants, nurses and radiologists was established, and additional clinics set up where possible.

Nurse staffing

The service had enough 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 bank, agency and locum staff a full induction.

Nurse staffing levels within the department were appropriate. Vacancy, turnover and sickness rates were low.

There was a clear induction checklist for the local and departmental induction of new staff, including bank and agency staff. This provided staff with contact details of managers and set out the philosophy of the department. The checklist detailed health and safety requirements, how to access policies, and how to manage sickness absence and annual leave. The checklist allowed new starters to highlight any gaps in their knowledge during their induction.

The service aimed to book clinics approximately six weeks in advance to give the managers time to complete staff rotas. Staffing rotas were usually completed about four weeks in advance of scheduled clinics.

The ward sisters used electronic rostering to complete rotas. Staff nurses were being trained in this to help provide support to the sisters.

There was only one plaster technician for the trust, and they only worked 7.5 hours per week due to a recent secondment to another role. However, there were mitigation plans in place to avoid delays. These included three members of staff being trained in a number of different plaster techniques, and a recruitment advert to fill the post. Doctors would undertake the plastering for more complex fractures.

The service had links with the local universities who provide student nurses on placement. Staff told us that there was good feedback from the universities about the student's experiences.

The trust reported the following whole time equivalent (WTE) nurse staffing numbers for the periods below for outpatients.

Trust level

Site name	Apr 17 - Mar 18			Apr 18 - Sept 18		
	Actual staff	**Planned staff**	**Staffing rate (%)**	**Actual staff**	**Planned staff**	**Staffing rate (%)**
East Cheshire NHS Trust	25.67	24.31	106%	25.91	26.02	100%

From April 2017 to March 2018, the nursing staffing rate within outpatients was over establishment at 106% (this meant there were more staff working at the trust than planned). This was higher than the 100% in the more recent period from April 2018 to September 2018.

Although the fill rate has decreased in the latest time period, the planned number of staff required has increased.

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

Vacancy rates

From April 2018 to March 2019, the trust reported a vacancy rate of -1% for nursing staff in outpatients, this was lower than the trust target of 5%. This means there was more staff than planned working in outpatients.

The trust's electronic staff record system does not map individual staff to core clinical services as defined by the CQC so it was unable to provide a breakdown of vacancy rates by ward or site for this core service.

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

Turnover rates

From April 2018 to March 2019 the trust reported a turnover rate of 0% for nursing staff in outpatients, this was lower than the trust target of 10.5%.

There is no breakdown of turnover rates by ward or site for this core service.

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

Sickness rates

The directorate performance dashboard showed that from April to December 2018, sickness absence was approximately 4% (this data included the allied health team and specific outpatient data could not be dis-aggregated).

Records

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

We reviewed six sets of notes during the inspection, four of which had consultation notes recorded appropriately. However, two sets of notes did not contain entries for the recent consultations, with consultants instead relying on subsequent clinical correspondence to detail patient discussions. We spoke with one doctor who told us that they did not document all of the consultation discussions in their notes as their dictations would be transcribed and the subsequent clinic letter included in the notes. However, it took time for clinic letters to be typed. Therefore, whilst the records we reviewed contained up to date information, there was a risk that up to date records would not be available to staff that needed to review the patient in the interim.

At the front of each set of patient notes was an alert page. Various alerts could be highlighted in this section including allergies, safeguarding issues, whether the patient had any hearing or visual problems, or whether they were living with dementia or had autism. However, none of the six records we reviewed indicated that there were any allergies or other patient alerts on the front cover. It was not immediately obvious from the notes whether this was because the patients did not require the alerts, or doctors had not completed the front sheet.

The service had links, via an electronic portal, to GPs in the region. Clinic letters, including discharge letters, could be shared quickly and securely.

During our previous inspection we found unsecured notes throughout the department. During this visit we found that notes we securely stored behind the outpatient reception area and could not be seen by patients or visitors. We also observed notes being moved between clinic areas in covered trolleys.

We visited the health records library where recent patient notes were stored securely. There was a clear process for staff to follow to ensure that records were ready for clinics. This included a process for preparing records for short notice additions to clinic lists. The manager told us that whilst the computer systems used to track records was old, the team were very efficient at their jobs. Urgent records could be located and prepared within two hours of a request, and routine records within five hours. There was a clear process for requesting older records held offsite.

The service used an electronic system to track notes. The manager of the health records library undertook a quarterly sampling audit to review the percentage of missing records. The audit showed that less than 1.5% of records were missing at that time (37 from a sample of 2762).

The service's transcription department had three targets to transcribe clinic letters and send to GPs. The department had been performing reasonably well against the 21 day and 28 day target, with the year to date average 89% and 93% respectively. The service struggled to meet the 14 day target with a year to date average of 77% (data for the nine months to December 2018).

The transcription department explained that staffing pressure (sick leave and the additional work from the breast clinic) had impacted on its ability to achieve its targets. At the time of the inspection there was a backlog of approximately 1.600 clinical notes and letters. The backlog had been as high as 4,000 in April 2018. To address the backlog in 2018, the service had agreed a contract with a third party company to transcribed records. There was a service level agreement in place that meant the third party would turn around transcriptions within 24 hours (this service was primarily used during time of pressure).

The transcription had a clear process for transcribing letters. The oldest were completed first, but urgent correspondence took priority and was easily identifiable.

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.

Medicines were stored safely and securely within locked wooden medicine cabinets. A limited stock of medicines was kept, and this was topped up weekly by the pharmacy team who also monitored expiry dates. No controlled drugs were stored in the department.

The prescription pads for the clinics were stored safely in a locked cupboard; there were 19 pads, one for each speciality. When we first visited the area, there was no record sheet to record when a prescription sheet had been used and which items had been issued. We raised this at the time of the inspection and the service put interim measures in place (a paper register). During the inspection period, the service developed a standard operating procedure for the "safe keeping of RJN coded FP10 prescription pads held in OPD".

A sealed hypoglycaemia box was checked weekly.

The service had printed Resuscitation Council Guidelines (UK) for anaphylactic reactions next to the medicines' cupboards.

Patient Group Directions were in place. These had been signed and authorised appropriately.

Antibiotic stewardship was the responsibility of the individual services rather than the clinics and was not monitored within outpatients.

However, Medicines fridge temperatures were not appropriately monitored with no record of minimum or maximum temperatures and no record of the room temperature. There was no pathway for staff to follow should the temperatures fall outside of the appropriate range – this included the fridge that flexible endoscopes where kept in during clinic times. In addition, there was no documented check of the medical gases and no warning sign on the door to the room they were stored in.

Incidents

The service managed patient safety incidents well. Staff recognised 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.

There were zero reported serious incidents for the service for the 12 months to March 2019.

Incidents were reported electronically and could be easily monitored.

Staff told us that any safety alerts would be emailed to them by the ward sisters.

The service used incidents to improve its service. For example, following one incident, the service ensured that privacy screens were available in all outpatient areas to provide should a patient or visitor collapse.

Whilst not all staff we spoke to understood the term Duty of Candour, they told us that they would always contact the patient if something had gone wrong. Staff also showed us the electronic incident reporting system which included a section asking whether duty of candour was applicable.

The service produced regular newsletters about incidents occurring throughout the trust. The most recent newsletter included details of an incident involving a patient in the emergency department and listed the actions staff needed to take to help prevent recurrence.

The ward sisters explained that there had been issues regarding the management of pressure ulcers. As a consequence, some staff nurses had spent time with the tissue viability team to improve their knowledge, particularly around sacral and heel sores.

Never Events

The service had no never events.

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

From April 2018 to March 2019, the trust reported zero incidents for outpatients.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

The service had no serious incidents.

Trust level

In accordance with the Serious Incident Framework 2015, the trust reported zero serious incidents (SIs) in outpatients which met the reporting criteria set by NHS England from April 2018 to March 2019.

(Source: Strategic Executive Information System (STEIS))

Safety thermometer

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

Whilst the service did not use a safety thermometer, it monitored a number of performance indicators including hand hygiene and cleanliness audits, complaints, patient experience and waiting times.

Is the service effective?

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 provided patients with information leaflets with details about MRSA and “what to expect” when visiting hospital. The leaflet reference information from Public Health England and the Department of Health and Social Care.

The ward sisters had a communication file in their room that included copies of up to date policies that staff could access. These policies reflected national guidance, including from the National Institute for Health and Care Excellence.

The trust had a standing operating procedure for compliance with Mental Health Act 1983.

Nutrition and hydration

The department offered a coaster system (an electronic buzzer that vibrated when it was time for the patient to see a doctor) to patients who wanted to leave the department for refreshments if there was a delay in clinic. Patients were recalled back to the department as soon as the doctor of nurses was available to see them.

The fracture clinic had drinking water available for patients waiting in the clinic.

Patient outcomes

Staff monitored the effectiveness of care and treatment. Managers carried out a comprehensive audit programme and used information from the audits to improve care and treatment. Managers shared and made sure staff understood information from the audits.

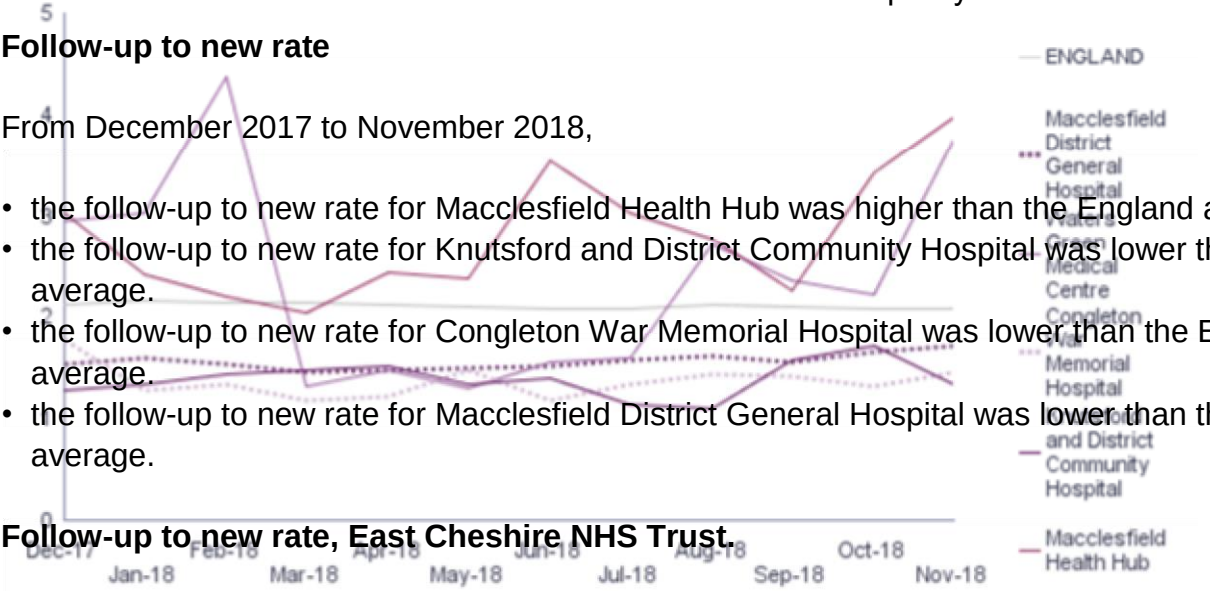
The service had a clinical dashboard it used to monitor referral to treatment times, ‘did not attend’ rates, and clinic cancellations. These were discussed at monthly meetings. The service also monitored medical record availability and clinical correspondence transcription times. This

performance data was discussed at monthly departmental meeting. Information was cascade to individual teams and was also submitted to the trust's service quality standards committee.

Follow-up to new rate

From December 2017 to November 2018,

- the follow-up to new rate for Macclesfield Health Hub was higher than the England average.
- the follow-up to new rate for Knutsford and District Community Hospital was lower the England average.
- the follow-up to new rate for Congleton War Memorial Hospital was lower than the England average.
- the follow-up to new rate for Macclesfield District General Hospital was lower than the England average.



Follow-up to new rate, East Cheshire NHS Trust.

(Source: Hospital Episode Statistics)

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.

The service managed staff competencies effectively, and those staff files we reviewed were up to date. We spoke with staff members in the plaster room that had received training in different plastering techniques and had had their competencies signed off.

We spoke with one member of staff who had visited from another site to observe different plaster techniques in the fracture clinic.

The ward sisters had developed an outpatient resuscitation training pack to help healthcare assistants identify the individual items on a resuscitation trolley.

Staff were given the opportunity to develop. We saw that a number of healthcare assistants had undertaken level two and three healthcare diplomas.

Appraisal rates

Managers supported staff to develop through yearly, constructive appraisals of their work.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

The most recent staff survey had highlighted "poor [staff] feedback" of the appraisal system. As a consequence, the department had trialled a new appraisal document, and staff were to be asked to complete a feedback form. Managers were reminded of hints and tips to conducting good appraisals.

The majority of staff at the trust had had appraisals, and those we asked told us that they found them useful. Managers could easily view a report that highlighted staff that had had appraisals, those that were due, and those that had gone past their scheduled date.

From March 2018 to February 2019, 92% of staff within outpatients at the trust received an appraisal compared to a trust target of 90%. Qualified nursing and health visiting staff did not meet the 90% appraisal target with 85%.

Trust level

Staff group	March 2018 to February 2019				
	Staff who received an appraisal	**Eligible staff**	**Completion rate**	**Trust target**	**Met (Yes/No)**
NHS infrastructure support	5	5	100%	90%	Yes
Support to doctors and nursing staff	33	34	97%	90%	Yes
Qualified nursing & health visiting staff (Qualified nurses)	23	27	85%	90%	No
Grand Total	61	66	92%	90%	Yes

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

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 referred patients for mental health assessments when they showed signs of mental ill health and depression.

Patients could see all the health professionals involved in their care at one-stop clinics. For example, patients attending the orthopaedic joint clinic were given one appointment and would be seen by a number of different specialties (for example physiotherapy, dietetics, respiratory) on the same day and in the same room. This helped reduce hospital visits.

Seven-day services

The trust did not provide a seven-day outpatient service, although clinics could be arranged for evening and weekends when appropriate.

Health promotion

Staff gave patients practical support and advice to lead healthier lives. The service had relevant information promoting healthy lifestyles and support in patient areas.

Some patient information leaflets contained information about smoking cessation programmes. Advice was also given to patients to stop smoking before surgery to help wound healing.

The fracture clinic had a large number of patient information leaflets that provided advice about the injury, and how to care for a cast after leaving hospital.

The general outpatient department had numerous leaflets that provided patients with additional information. This included, amongst other things, multiple sclerosis, thyroid problems, health eating and diabetes, and cancer research.

However, we reviewed one set of records that contained information about a patient's alcohol consumption which was above the recommended maximum weekly level. There was no evidence that the doctor gave advice to the patient about this issue.

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 agreed personal measures that limit patients' liberty.

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.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions.

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

Clinical staff completed training on the Mental Capacity Act and Deprivation of Liberty Safeguards achieving the Trust's target.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and they knew who to contact for advice.

Staff received formal training in how to appropriately obtain consent and had scenario tests they had to pass to complete the training. The service sent us data that showed that at the time of inspection 97.5% of staff had completed Mental Health Act training.

The fracture clinic had numerous information leaflets for patients to read prior to attending orthopaedic consultations which gave them information to help them to decide whether to consent to treatment.

We observed doctors and nurse obtaining verbal consent before examining patients.

We spoke with one patient who told us that the doctor took time to discuss various treatment options with them, outlining the risks and benefits of each. The patient said that they felt fully informed when consenting to treatment. We also observed a consultation where a patient was given clear information about the risks and benefits of a procedure before they consented.

Staff described an example whereby doctors took account of family member's decisions regarding patient treatment as they had legal powers to act on their relative's behalf.

The service's Mental Capacity Act policy included details of how staff could arrange independent mental capacity advocates for patients.

Is the service caring?

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 said staff treated them well and with kindness.

Staff followed policy to keep patient care and treatment confidential.

Patients we spoke with described staff as "really pleasant" and "very friendly".

The service was about to start building work to redesign the entire general outpatient area. Planned electronic checking in kiosk would allow patients to check-in within having to discuss out personal information. Receptionists would still be available for those patients that did not want to use the electronic kiosks.

Patients could request chaperones. The most recent patient experience survey also showed that of the 19 respondents who wanted a chaperone during their appointment, all had one available. However, whilst there were some signs about in waiting areas about the availability of chaperones, these were not always obvious. There were also no obvious signs in the consultation rooms we viewed. It might therefore not always be clear to patients that a chaperone service was available. Whilst staff told us that patients usually asked if they wanted a chaperone, this relied on patients being aware of the service.

We observed a patient attending a clinic who was clearly distressed. Staff responded well and with compassion, moving the patient to the quiet room which helped managed their anxiety. The doctor responded quickly and conducted the consultation in the quiet room rather than asking the patient to move.

A member of staff told us that they would usually introduce themselves to patients at the start of appointments. We did not witness this in the two consultations we observed, but staff did do this during the appointment we observed in the plaster room.

However, we observed one consultation which was interrupted by a consultant coming into the room to place some paperwork on the doctor's desk. The consultant did not acknowledge the patient or apologise for the interruption. We reported this to the trust who told us that they had reminded staff of the responsibilities.

Emotional support

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

We observed staff talking to patients in a kind and friendly manner in the plaster room when they were preparing to use an electric saw to remove a plaster cast. The patients were offered ear defenders to protect against the noise and help reduce their anxiety levels. They kept checking that the patients were happy to proceed.

There was a quiet room within the general outpatient department that patients and relatives could use if they received upsetting news. A do not disturb sign could be placed on the door to ensure that people were not interrupted.

There was a multifaith room and chapel on the trust's premises that patients and staff could use. Patients could also receive support from chaplains.

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 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.

A high proportion of patients gave positive feedback about the service in the Friends and Family Test survey.

Patients could call the hospital if they were concerned or worried after leaving their appointment. For example, patient information leaflets gave contact details for the relevant clinics, but also the emergency department.

The patients we spoke with told us that staff talked to them in a way they could understand. They told us that they had time to discuss their concerns and did not feel rushed, even if a clinic was running over time.

The service was in consultation with support staff to adjust their working hours. This was with a view to being able to speak to patients outside of usual working hours.

Patients could complete a patient experience questionnaire, commenting on the care and treatment they had received during their appointment. The results of the survey were published every three months. The most recent report (January to March 2019 – 78 patient responses) showed that 87 of patients on the waiting list felt "they were seen as soon as necessary for their appointment". 92% of patients felt involved in decisions about care and treatment. 99% of patients rated the overall level of care as either excellent or good.

Friends and Family Test data showed that from December 2018 to May 2019, at least 93% of patients recommended the service.

Is the service responsive?

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 service minimised the number of times patients needed to attend the hospital, by ensuring patients had access to the required staff and tests on one occasion.

In 2016 the trust signed up to the Disability Confident Scheme in partnership with the Department of Work and Pensions (DWP). The scheme was designed to help employers make the most of the opportunities provided by employing people with disabilities.

Posters in waiting areas highlighting that patients could obtain exemption from additional parking charges if clinics overran.

The orthopaedic outpatient department provided a joint school service. This was a 'one-stop shop' for patients to see a number of different specialities on the same day without having to have multiple appointments.

The service told us that the planned electronic check-in kiosks would give people the option of seeing information in different languages and larger print (for example).

The trust's website had a section dedicated to its outpatient service. This provided useful information to patients and those accompanying them. It explained the steps patients would follow when visiting, who the managers of the service, and the opening times.

There was a multifaith room at the entrance to the outpatient department. We observed one visitor to the area asking outpatient staff if he could use the room. However, due to poor signage staff incorrectly assumed that the room was for use by staff only. We highlighted this to the trust at the time of the inspection who agreed to make signage clearer.

Did not attend rate

From December 2017 to November 2018,

- the 'did not attend' rate for Congleton War Memorial Hospital was lower than the England average.
- the 'did not attend' rate for Knutsford and District Community Hospital was lower than the England average.
- the 'did not attend' rate for Macclesfield District General Hospital was lower than the England average.
- the 'did not attend' rate for Macclesfield Health Hub was lower than the England average.

The chart below shows the 'did not attend' rate over time.

Proportion of patients who did not attend appointment, East Cheshire NHS Trust.

(Source: Hospital Episode Statistics)

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

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.

The service adhered to NHS England's Accessible Information Standard. This was a legal requirement for services to identify, record, flag, share and meet the information and communication needs of patients and other groups with disability, impairment or sensory loss. We saw posters in all outpatient areas highlighting to patients and carers that information could be requested in braille, large print, different languages and in easy read format. Staff could also book interpreters, including sign language interpreters, for patients.

The trust had trained staff to support people with an autism (both patients and staff). There were three link nurses within the outpatient department. The nurses had their photographs displayed on the entrance to the outpatient department, so staff, patients and visitors could easily identify them if they needed advice or support. In June 2019, the trust became the first in the country to have key wards accredited by the National Autistic Society.

The general outpatient area had a quiet room for those patients that were anxious, had autism, or were living with dementia, and wanted to wait in a quieter area. The clinics usually had advanced notice of a patient with autism attending an appointment would look to prioritise these to avoid delays.

Staff in the fracture clinic provided examples of when they had closed the plaster room off to other patients (two patients could be in the area at once – separated by a screen) when patients with learning disabilities or autism attended. This helped reduce patient anxiety levels.

Both outpatient areas had bariatric chairs in the waiting rooms for patients. There were also bariatric weighing scales and examinations beds.

We observed staff offering patients the use of ear defenders to reduce the noise the plaster saw made.

We observed one doctor examining a patient on a chair as that patient who could not easily move to an examination couch.

Access and flow

People could not always access the service when they needed. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards. However, the service had taken all practicable steps to reduce waiting times, and patients requiring urgent care were treated care promptly.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. For those services with long waiting lists, managers ensured that patients requiring urgent care were treated promptly.

Managers worked to keep the number of cancelled appointments to a minimum.

Managers monitored and took action to minimise missed appointments.

Managers ensured that patients who did not attend appointments were contacted.

Data showed that, for a number of specialties, the outpatient department was below the England average for seeing patients within 18 weeks of referral. These specialities included cardiology, rheumatology and oral surgery.

The service recognised that it could not sustain the oral surgery service and this had recently been transferred to another provider.

The service had developed a number of measures to minimise patient waits and to ensure that those patients requiring an urgent review were seen quickly.

The trust's chief operating officer chaired a weekly referral to treatment trajectory group. This was attended by managers throughout different services. The group reviewed waiting lists to ensure that those patients requiring urgent appointments were given them. The group also monitored weekly clinic activity and 52 week breaches. There were discussions and recommendations around training, and emerging risks and issues.

The service had undertaken a number of waiting list initiatives including weekend and evening clinics. It ran virtual clinics were consultants could spend time reviewing patient files to see if that patient still needed to be on the waiting list, or if it would be more appropriate to refer them to other services. We saw evidence of where cardiology patients had been reviewed during a virtual clinic and been given urgent appointment.

The booking and scheduling team had undertaken a project to contact cardiology patients to see whether they still needed to be seen. A script had been developed for the team to ask patients whether their issues had cleared, or if they had been treated elsewhere in the.

The booking and scheduling team monitored patient waiting times to try and improve the percentage of patients seem within 18 weeks and referred for treatment. At ten weeks, the team checked with the individual specialities whether there are any delays in setting up clinics. Data was also sent weekly to the service and quality standards team. The booking and scheduling team said that the specialities respond well to checks carried out, and that any delays were usually to do with capacity issues.

Waiting times for the breast service clinic had been affected by the decision of another trust within the northwest to close its own service to new referrals. These referrals had instead been transferred to other trusts including East Cheshire. Additional sessions were provided in December 2018 to address the influx of new patients, but the service told us it was still under pressure.

The booking and scheduling team had weekly meeting to discuss any capacity issues and how these could be managed.

Waiting times for patients in outpatient reception areas were monitored by the service every three months. The most recent report showed that 30% of patients were seen on time and 47% within

15 minutes. 29% of patients waited between 16 minutes and an hour. 7% of patients waited between one and two and two hours, and 1% of patients waited more than two hours. During the inspection, onsite waiting times varied between about ten minutes to one hour.

The service completed a number of audits including clinic cancellations. The report had been recently revised to allow the service to review not only the number of cancellations, but also the reasons. This allowed the service to better review capacity issues within particular specialties. For the ten months to January 2019, there had been 127 cancelled clinics affecting 1,284 cancelled patients. This represented less than 1% of all outpatient appointments across the trust over a similar period.

A new referral triage system allowed the service to increase clinic utilisation by ensuring that referrals were right first time and to help avoid cancellations.

Appointments were sent out by letter. Some of the patients we spoke with told us that they had ben able to rearrange appointments for times that better suited them. Patients were also sent a text reminder in advance of the appointments to try and avoid non-attendance.

The service had developed a mobile phone application that meant that patients could receive appointment letters directly to their phone. They could also confirm, rebook or cancel appointments via the application.

Patients using the electronic referral system will be given an indicative wait time based on the previous 21 bookings for that particular service. This helps the patient to choose which hospital they wanted to attend.

The service managed “did not attend” rates well, and these were lower than the England average (approximately 5% for both first and follow-up appointments). There was a clear system whereby if a patient did not attend, their file was reviewed by a clinician who made the decision about whether the patient should be rebooked or signed off from the service. The service told us that this worked well for two week cancer referrals who could be quickly followed up.

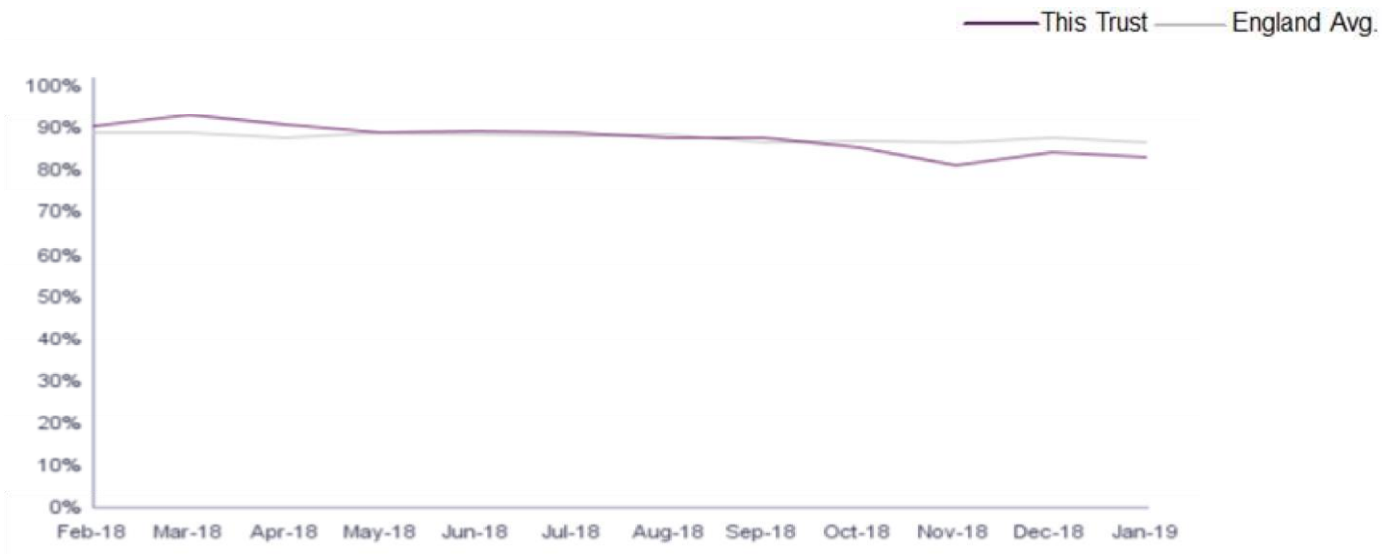
The outpatient reception areas we visited contained boards displaying clinic waiting times. However, these were not consistently updated. For example, one board had not been updated with a waiting time, but that clinic had a 20 minute delay. Another board was up to date and accurate.

We reviewed one patient where it appeared that their follow-up appointment had been lost in the system. They were seen in 2018 and it was decided that they should have a scan, which they did the following month. There was no evidence of follow-up with the patient until they were seen over six months later. This patient was not on an urgent pathway and there was no evidence in the recent notes that they had come to harm in the interim.

Referral to treatment (percentage within 18 weeks) – non-admitted pathways

From February 2018 to January 2019 the trust’s referral to treatment time (RTT) for non-admitted pathways has been similar to the England overall performance. The latest figures for January 2019, showed 83.2% of this group of patients were treated within 18 weeks versus the England average of 86.7%.

Referral to treatment rates (percentage within 18 weeks) for non-admitted pathways, East Cheshire NHS Trust.



(Source: NHS England)

Referral to treatment (percentage within 18 weeks) non-admitted performance – by specialty

Nine specialties were above the England average for non-admitted pathways RTT (percentage within 18 weeks).

Specialty grouping	Result	England average
Geriatric medicine	100.0%	95.1%
Thoracic medicine	99.4%	86.0%
Other	96.3%	90.4%
Ophthalmology	95.7%	88.7%
Gynaecology	95.6%	91.7%
General medicine	95.0%	90.8%
Plastic surgery	94.2%	90.4%
Gastroenterology	90.0%	81.9%
Urology	88.2%	85.6%

Six specialties were below the England average for non-admitted pathways RTT (percentage within 18 weeks).

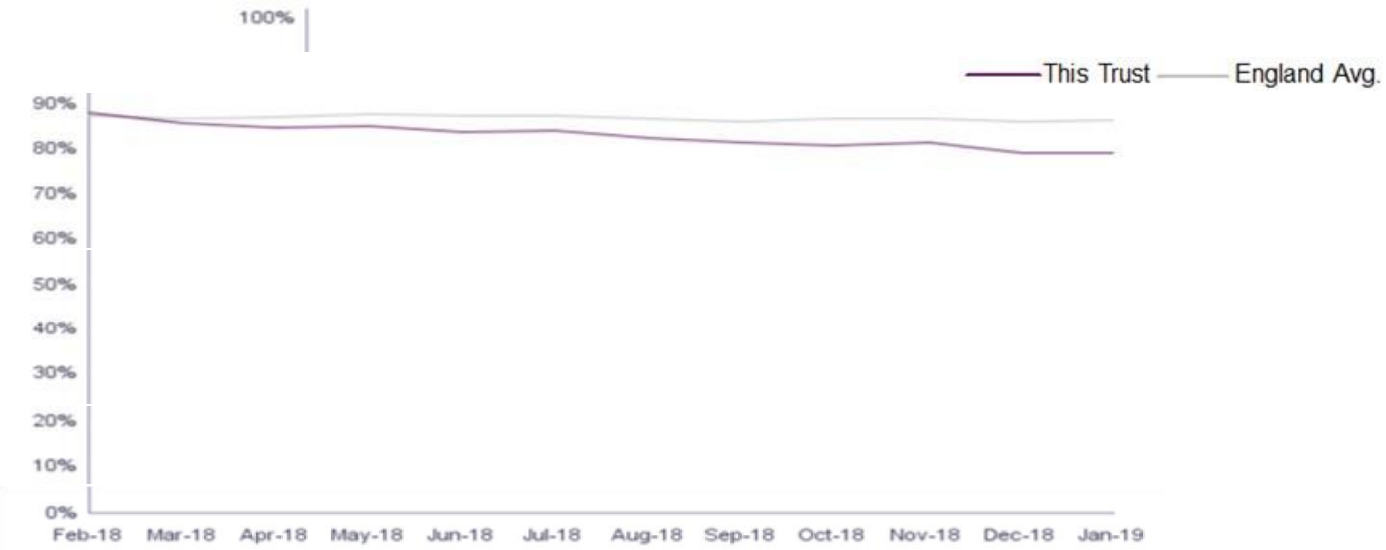
Specialty grouping	Result	England average
General surgery	84.2%	88.4%
Trauma & orthopaedics	81.7%	85.7%
Ear, nose & throat (ENT)	78.4%	84.1%
Rheumatology	66.7%	87.0%
Oral surgery	58.8%	81.0%
Cardiology	50.8%	85.5%

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) – incomplete pathways

From February 2018 to January 2019 the trust's referral to treatment time (RTT) for incomplete pathways has been worse than the England overall performance. The latest figures for January 2019, showed 79.2% of this group of patients were treated within 18 weeks versus the England average of 86.3%.

Referral to treatment rates (percentage within 18 weeks) for incomplete pathways, East Cheshire NHS Trust.



(Source: NHS England)

Referral to treatment (percentage within 18 weeks) incomplete pathways – by specialty

Nine specialties were above the England average for incomplete pathways RTT (percentage within 18 weeks).

Specialty grouping	Result	England average
General medicine	100.0%	92.0%
Thoracic medicine	99.3%	88.4%
Geriatric medicine	99.3%	95.9%
Gastroenterology	95.1%	88.7%
Other	93.9%	89.4%
Gynaecology	92.9%	88.2%
Urology	91.3%	85.6%
Plastic surgery	89.6%	82.4%
Ophthalmology	88.7%	87.2%

Six specialties were below the England average for incomplete pathways RTT (percentage within 18 weeks).

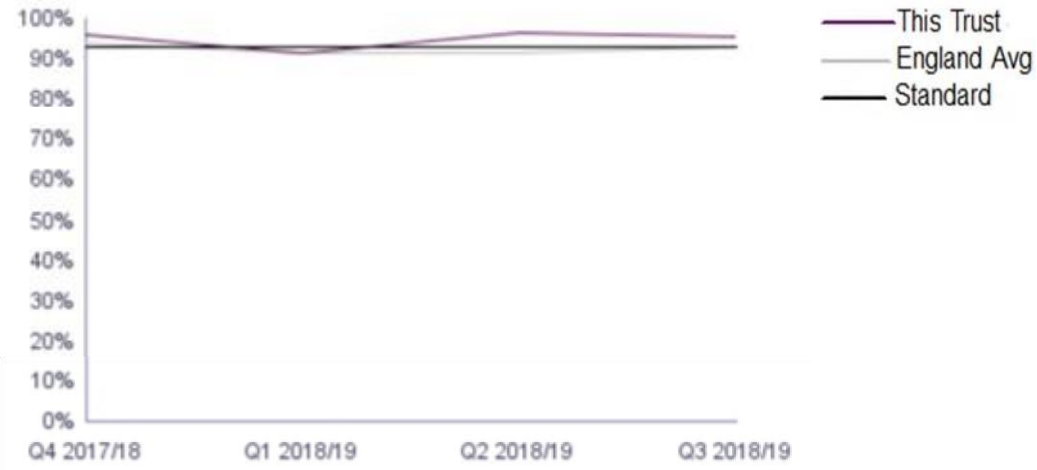
Specialty grouping	Result	England average
Ear, nose & throat (ENT)	83.1%	84.3%
General surgery	82.1%	83.6%
Rheumatology	75.7%	91.8%
Trauma & orthopaedics	71.8%	81.2%
Oral surgery	66.7%	82.7%
Cardiology	59.0%	89.4%

(Source: NHS England)

Cancer waiting times – Percentage of people seen by a specialist within 2 weeks of an urgent GP referral (All cancers)

The trust is performing generally better than the 93% operational standard for people being seen within two weeks of an urgent GP referral. The performance over time is shown in the graph below.

Percentage of people seen by a specialist within 2 weeks of an urgent GP referral (All cancers), East Cheshire NHS Trust



(Source: NHS England – Cancer Waits)

Cancer waiting times – Percentage of people waiting less than 31 days from diagnosis to first definitive treatment (All cancers)

Percentage of people waiting less than 31 days from diagnosis to first definitive treatment (All cancers), East Cheshire NHS Trust

The trust is performing better than the 96% operational standard for patients waiting less than 31 days before receiving their first treatment following a diagnosis (decision to treat). The performance over time is shown in the graph below.

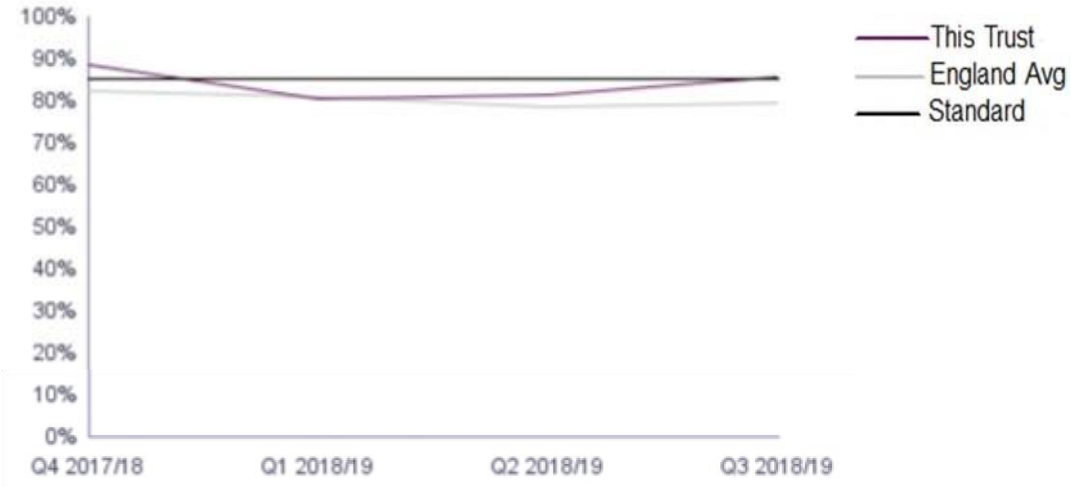
(Source: NHS England – Cancer Waits)

Cancer waiting times – Percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment

The trust is performing better than the 85% operational standard for patients receiving their first

treatment within 62 days of an urgent GP referral. The performance over time is shown in the graph below.

Percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment, East Cheshire NHS Trust



(Source: NHS England – Cancer Waits)

Learning from complaints and concerns

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 outpatient service had very few complaints. Those they did receive were dealt with quickly.

Patients who complained were given information about the Parliamentary and Health Service Ombudsman.

One patient told us that they had always been contacted by the service following their appointment to find out whether they were satisfied, and what they would like to see changed if they were not.

The trust had a Patient Advice and Liaison outreach team that visited various departments throughout the trust on a daily basis to try address any patient concerns.

Summary of complaints

Trust level

From April 2018 to March 2019 the trust received five complaints in relation to outpatients at the trust (5% of total complaints received by the trust). The trust took an average of 22 days to investigate and close complaints, this is in line with their complaints policy, which states complaints should be closed within 25-45 days. A breakdown of complaints by type is shown below:

Type of complaint	Number of complaints	Percentage of total
Values & behaviours (staff)	2	7%
Other (specify in comments)	1	3%
Appointments	1	3%
Communications	1	3%

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

Number of compliments made to the trust

From April 2018 to March 2019 there were 655 compliments about outpatients at the trust. A breakdown of compliments by ward/area is below

Site	Number of compliments	Percentage of total
Musculoskeletal Physiotherapy (MSK) Outpatients	353	54%
Neuro Physio (gym) - Outpatient	18	3%
Nutrition and Dietetics Macclesfield	16	2%
Occupational Therapists - Aston Unit	17	3%
Podiatry	133	20%
Speech and Language in patients	118	18%

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

Is the service well-led?

Leadership

The leaders of the department had the skills and abilities to run the service. Leaders were visible, and staff told us that they were approachable and often in the department.

The executive team had planned walk arounds the various departments. However, there were mixed views amongst frontline staff about how visible the executives were, with some staff saying that had not seen members of the team. That said, some of the staff acknowledged that they were part-time and therefore might not be on site during planned visits

Managers used appraisals well and staff told us that they had their competencies reviewed and planned for the forthcoming year. We saw examples of up to date staff competency files.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action.

The outpatient department had a vision to “treat everyone with dignity and respect. Patients are to be given the appropriate information, treatment and support”. The department’s “philosophies of care” were posted in the outpatient areas. These philosophies included a named nurse responsible for running each clinic; that each patient would be entitled to a full explanation of what would happen at a clinic; and patients would be treated with compassion and respect.

The department had a strategy to improve patient flow as well as monitoring performance in this area. The strategy involved the redesign of the outpatient department and better use of technology. Most of the staff we spoke with had been involved in contributing to the redesign of the department.

Some staff told us that they were not always clear and service's vision and strategy but acknowledged that there was information on the intranet (they did not always have time to read this, especially part-time staff).

Culture

Staff felt respected, supported and valued. All staff we spoke with told us they enjoyed working at the hospital and in their teams. They told us that colleagues were supportive, with good team work between doctors, nurses, support staff and healthcare assistants. Most staff told us there was a good culture at the trust.

There were low sickness, vacancy and turnover rates in the department.

Staff were aware that the trust had a Freedom to Speak Up Guardian and what the role entailed. Not all staff knew who the Guardian was, albeit that we saw this information displayed on computer screensavers. This information was also contained in the trust's *Learning Into Practice* newsletter (June 2019), details of which were in the ward sisters' room. All staff we spoke with told us that they were comfortable approaching their managers if they had concerns.

There appeared to be some disconnect between the general outpatient department and the orthopaedic outpatients. Both departments where in different parts of the hospital with their own entrance and car park. Staff in the orthopaedic department told us that they felt isolated from their colleagues within general outpatients. The orthopaedic team told us that they were not always able to attend the departmental team meeting. They explained that they held their own meetings. During the inspection period, the trust advised us that the teams had been spoken to about their concerns and it had been agreed that the ward sisters would be based within the orthopaedic outpatient department one day a week as part of addressing these concerns. We raised this issue at the inspection. In response to this issue, the trust provided evidence of a "team charter" that was to be launched in August 2019 and which set out how managers and team members would support each other to. The trust also told us that a senior nurse would attend the orthopaedic ward daily and would work on that unit one day a week.

Governance

Leaders operated effective governance processes throughout the service. There was a clear governance structure within the department.

There was a heads of department team meeting every month and the minutes we reviewed from the last three meetings showed that they were well attended. Discussions took place about service updates, including recruitment of a plaster technician and vacancies within the health records department. The departmental performance dashboard was discussed including a review of 'did not attend' rates and clinical correspondence transcription targets. Updates from the service quality standards committee were discussed to ensure that learning from incidents was shared. Positives, such as the recent accreditation from the National Autistic Society, were also

discussed. There was positive feedback regarding the speed of recruitment, and updates on the departmental redesign project and Friends and Family Test scores.

Information from the heads of department meeting was cascade via a monthly team brief with frontline staff, the transcription, and booking and scheduling teams. Minutes from the team brief in early March 2019 included discussions about staffing and performance. There were discussions about incidents and complaints, best practice, finance and an update on the outpatient redesign project.

The booking and scheduling team sent a weekly waiting list report to the operational teams and executive teams. The report highlighted capacity issues in certain clinics and those services with the longest waits. The data could be split to show routine and urgent appointments.

The health records management sub-group met bi-monthly to discuss any issues or concerns, with any actions recorded. Minutes from the last three meetings showed discussions around case note availability and key themes from reported incidents (there were none from the two incidents that had occurred in the previous quarter). A list of actions and owners were produced at the end of each meeting, albeit there were no completion dates for these actions.

Management of risk, issues and performance

Leaders and managers used systems to manage performance. They identified and escalated relevant risks and issues and identified actions to reduce their impact.

The service had its own risk register. Risks were added or removed from this during directorate service quality standard meetings. Risks scores were also discussed at the meeting. The risk register was up to date with clearly assigned action owners, target completion dates and updates. Managers and ward sisters could articulate the key risks to the department.

Leaders had a clear understanding of the risks for the outpatient department including: staffing levels, a lack of capacity in the clinics, training of plaster technicians, and the moving and handling of medical records.

Risks and incidents were discussed at the heads of department meeting and could be raised to corporate level if required. There was a clear process for doing this.

The service carried out weekly validations of the cardiology waiting list to continually review those patients that needed to remain on the list and those that could be discharged back to their GP. This project allowed the service to remove a number of patients from the list and free up clinic capacity.

The service had its own directorate dashboard that provided an overview of performance against a number of key measures. These included cancer performance data, waiting times, clinical correspondence transcription times, cancelled clinics, infection data, and staffing and training levels. The dashboard could easily show whether a performance measure was improving or declining. The service had recently changed its cancelled clinic audit to include the reasons for the cancellation and not just the numbers. The service told us that this would help to identify trends and better predict any capacity issues.

The outpatient redesign had been scheduled in stages so as to not adversely affect the running of clinics during the building phase.

The transcription service had acted to reduce the backlog in transcribing clinical correspondence, agreeing a service level agreement with a third party to provide support. This had reduced the backlog from 4,000 to 1,600 items for transcription.

Information management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. Data or notifications were consistently submitted to external organisations as required.

Patient records were primarily paper based. Some consultant led clinics dictated notes and these were transcribed by staff within the transcription suite. All records were stored securely.

The service had set up a contract with a third party company to transcribe clinic notes and letters when required. The trust's Caldicott guardian was involved in contracting this service to ensure that records could be shared safely and securely with the third party company.

Health record management data was reviewed during a bi-monthly health records management sub-group meeting, which was chaired by the trust's Caldicott guardian.

The service had recently introduced single sign-on allowing staff to log in to a terminal once and then access multiple systems.

Some staff told us that the IT systems were slow. However, staff told us that there was no indication that this had affected patient care.

Engagement

There was some engagement between leaders with patients, staff, the public and local organisations to plan and manage services. There was collaboration with partner organisations to help improve services for patients.

The trust spoke with patients and staff about the outpatient redesign to obtain they're views about how the department should look. They had also developed a "showroom" area (a consultation room set up in the style of the new redesign) that staff could view and comment on in advance of the changes. The service had also given demonstrations of the planned electronic check-in kiosks to doctors, volunteers and nurses.

The booking and scheduling team met quarterly with the local GP forum. The service was able to provide feedback on any best practice or improvements that could be made with referrals to the service.

The booking and scheduling team told us that they had regular contact with the local clinical commissioning group to discuss performance and issues.

However, some departments did not always feel included in decisions that affected their work. For example, staff within the booking and scheduling team told us that there had been changes made to the templates they used to complete their work. These changes had impacted the level of work of the team, but they were not involved in the decision.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had an understanding of quality improvement methods and the skills to use them.

The service was in the processing of redesigning the general outpatient department. Plans included an electronic kiosk allowing patients to check-in more quickly; this service also offered a greater degree of privacy.

As part of the redesign, consultants would have to update a new system to indicate when a patient entered and left the consultation (they will not be able to call the next patient without doing this). The service hoped that this technology would allow better tracking of patient flow for each speciality to see where improvements could be made.

The service had worked with other organisations to see how they could improve their own services. For example, it visited a local hospital to see how they had implemented the use of electronic kiosks. They had also worked with another trust to review digital dictation technology which was now in use at the service.

The service had begun to use a new recruitment system which allowed managers to advertise jobs, shortlist and send offer letter to candidates within the same programme. Told us that this was much more efficient than the previous process which had involved numerous systems.

Community health services

Community Dental Services

Facts and data about this service

The community dental service provides adult and paediatric special care dental services and paediatric exodontia dental services across the South, Vale and East Footprint. General community dentistry requiring local anaesthetic is carried out within the dental clinics at Church View Health Centre in Nantwich and Weston Clinic in Macclesfield.

The dentists also manage a cohort of patients within the David Lewis Centre and do also attend home visits. For patients requiring a general anaesthetic for treatment this is carried out within the theatre environment at Macclesfield Hospital or Leighton Hospital. *(Source: CHS Routine Provider Information Request (RPIR) CHS Context)*

We received feedback from 20 patients and spoke with 11 members of staff. We looked at dental care records for 12 people.

Our inspection between 25 to 27 June 2019 was announced (staff knew we were coming) to ensure that everyone we needed to talk to was available. During the inspection we visited all locations where dental services are provided from. The locations were Church View Health Centre, Weston Clinic and the David Lewis Centre.

Is the service safe?

Mandatory training

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

Staff told us they had good access to mandatory training. Mandatory training included infection prevention and control, fire safety and manual handling. This was a mix of face to face and online training. In some cases, the online training complimented the face to face training such as manual handling. They aimed to complete face to face training such as immediate life support as a team.

Managers monitored staff compliance with mandatory training. The dental service manager was responsible for ensuring the dental nurses and administrative staff completed training. The clinical director was responsible for ensuring the dentists completed it. Staff confirmed that they received e-mail reminders when training was due to be reviewed.

As of June 2019, the service showed a completion rate of 100% for mandatory and statutory training.

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.

The trust had a safeguarding policy and procedures in place. We saw evidence that relevant contact details were displayed throughout the service. The clinical director was the dental safeguarding lead within the service. The trust had a dedicated safeguarding team and staff told us that they had a good working relationship with them.

Staff had a good awareness of the signs and symptoms of abuse and neglect. They told us that they had the confidence and knowledge to raise concerns about a child or a vulnerable adult of necessary. Staff described an incident where they had concerns about a patient. They contacted the trusts safeguarding team for advice and told us that they were satisfied with the response that they were given. We were told that at the David Lewis Centre if they had concerns about a patient then they would follow the David Lewis's safeguarding process. At our visit to the David Lewis Centre we saw evidence of the safeguarding process which was displayed in the office area.

All staff were required to complete level three safeguarding children training and level two safeguarding adult training. As of February 2019, 100% of staff had completed level three safeguarding children training and 83.3% had completed level two safeguarding adult training.

The service had a system to highlight vulnerable patients on the electronic dental care record system such as children with child protection plans, adults where there were safeguarding concerns or people with a learning disability or a mental health condition.

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.

The trust had an infection prevention and control policy. In addition, the service had developed standard operating procedures relating to more specific dental decontamination and sterilisation procedures.

The service used a system of local decontamination at all sites for the re-processing of used dental instruments. At the Church View Health Centre and Weston Clinic there were dedicated dirty and clean rooms. At the David Lewis Centre due to space restraints it was not possible to have separate rooms, however, there was a clear dirty to clean flow. Staff described the end to end process of how used dental instruments were re-processed. Staff wore appropriate personal protective equipment including a disposable apron, gloves, a mask and a visor. The decontamination process followed the guidance as laid out in the Department of Health - Health Technical Memorandum 01-05: Decontamination in primary care dental practices.

There were adequate handwashing facilities in both clinical and decontamination areas. In addition, there was liquid soap and paper towels with each handwashing sink.

Infection prevention and control audits were carried out every six months. This related to the environment and the decontamination and sterilisation processes. The most recent audits showed a high level of compliance with the guidance. We saw that where improvements could be made these had been documented and an action plan formulated. When the actions identified were out of the remit of the service (such as building issues) then they were passed to the trust's estate team. The service also carried out regular hand hygiene and uniform audits. We saw the latest results of these were all positive.

Staff carried out procedures which reduced the risks associated with Legionella developing in the dental unit water lines. They used purified water and disinfectant tablets in the dental units to

reduce the likelihood of a biofilm developing. Dental unit water lines were also flushed regularly following guidance as laid out in the Department of Health - Health Technical Memorandum 01-05: Decontamination in primary care dental practices.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff managed clinical waste well.

Premise and equipment were clean and well maintained. We saw evidence that the equipment used to decontaminate and sterilise used dental instruments was serviced and validated by a competent person on a regular basis as laid out in guidance issued by the Department of Health - Health Technical Memorandum 01-05: Decontamination in primary care dental practices.

Other equipment such as machines used in the provision of inhalation sedation and the hoist at Weston Clinic had been serviced according to manufacturer's guidance.

Radiation protection folders were maintained at each location which we visited. The trust had notified the Health and Safety executive that ionising radiation was used within the service. This is a requirement of the Ionising Radiation Regulations 2017. We saw evidence of local rules relating to each X-ray machine. We also saw evidence that the machines had been serviced and maintained appropriately as required by the Ionising Radiation Regulations 2017. A radiation protection advisor and radiation protection supervisor had been appointed.

The trust had a sharps policy. We asked staff about how they managed sharps. We were told and saw evidence that they used a safer sharps system. Staff confirmed that only the clinicians were permitted to handle and dismantle sharps. However, the service did not have a dedicated sharps risk assessment for other sharp instruments used within dentistry such as irrigation needles and root canal instruments.

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.

The service managed patient risk well. Patients, their parents or carers were required to complete a full medical history prior to their first appointment. This was checked and confirmed if there had been any changes at any subsequent appointments. If a patient had anything significant on their medical history then this could be highlighted within their dental care record so that any other clinicians would be aware. This included if the patient was on any blood thinners or had any medical or physical conditions which may affect treatment.

There were systems in place for an acutely unwell patient. Any patient suffering a medical emergency would be attended to by trained members of staff. If the patient did not make a full recovery then an ambulance would be called. At the David Lewis Centre there were doctors on site and there was an emergency process to call them. Staff were familiar with these processes.

A medical emergency kit including equipment and medicines were held at each location which we visited. During the inspection we noted that buccal midazolam and oro-pharyngeal airways were not held within these kits. We raised this issue during the inspection. Buccal midazolam is used for

patients experiencing an epileptic seizure. Immediate action was taken to address the lack of buccal midazolam and we were told that new emergency medicine kits were delivered to each site during the inspection. We were also told that the lack of oro-pharyngeal airways would be addressed and that these would be ordered. All other emergency medicines and equipment reflected guidance laid out by the Resuscitation Council (UK) and the British National Formulary. We were told that when domiciliary visits were carried out that a full medical emergency kit was taken.

The dentists provided patient and/or their carers with information about what to do after having an extraction. This included advice about how to keep the area clean and avoid getting an infection. Patients undergoing a general anaesthetic or inhalation sedation were also provided with information about the procedure especially with regards to fasting. All information was given verbally and was also supported by an information leaflet.

We asked staff about sepsis. They had a good awareness of the signs, symptoms and serious consequences of sepsis if it was not addressed immediately. Sepsis had been discussed at a recent staff meeting. We saw evidence of sepsis awareness posters throughout the service. Staff told us that any patient presenting with the signs and symptoms of sepsis would be admitted to hospital urgently.

The dentists used latex free rubber dams in line with guidance from the British Endodontic Society when providing root canal treatment.

Mercury and blood spillage kits were readily available at all locations which we visited.

Staffing

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

Staffing levels were good within the service. At each location we visited there were sufficient numbers of suitably qualified staff to support safe and good quality treatment. There was a small close-knit team who worked together well and supported each other. The current vacancy rate was 8.4% but this only related to a full time equivalent of 1.2 staff members.

Between March 2018 and February 2019, the average sickness rate was 1.96%.

During the reporting period from March 2018 to February 2019, community dental services reported that there were no cases where staff have been either suspended or placed under supervision.

(Source: Universal Routine Provider Information Request (RPIR) – P23 Suspensions or Supervised)

Quality of records

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

The service used a mixture of paper and electronic record keeping system. The electronic record keeping system could be adapted to the individual needs of the service. During the inspection we looked at a selection of dental care records. These were well maintained and contained all the relevant details. These included a full up to date medical history, an intra and extra-oral assessment, an assessment of the health of the patients gums and a charting of the patient's teeth. If any X-rays had been taken then these were justified, reported on and graded. This ensured the clinicians were complying with the Ionising Radiation (Medical Exposure) Regulations.

At the David Lewis Centre, dental staff also had access to the medical records of the patients who were under treatment there. This helped them with obtaining a full, detailed and up to date medical history and any other medical treatments which they were currently undergoing. In addition, the dental team were required to add to these records as staff at the David Lewis Centre did not have access to the dental record keeping system.

Record keeping audits were carried out every year. The clinicians confirmed that these were carried out and they received feedback on the results of them. The most recent record keeping audit was focused on improvements identified as a result of a never event which occurred in February 2018. An action plan was formulated as a result of this audit and there was a plan to reaudit again in July 2019.

Medicines

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

The service stored and managed medicines and medical gasses well. Gasses used in the provision of inhalation sedation were either stored on a trolley or secured to the wall in a vertical position. This ensured they were stored safely and securely. Staff described the checks they carried out prior to providing inhalation sedation to patients. This involved ensuring there was sufficient amounts of gas for the treatment session and a back-up cylinder available.

Antibiotics and other medicines (such as high fluoride toothpaste) were prescribed for patients as required. Staff were aware of the current guidelines from the Royal College of Surgeons. We were shown examples of when antibiotics had been prescribed and the justification for the prescription. We asked if any audits had been carried out with regards to antibiotics prescribing. Staff confirmed that these had not been done, but agreed that it would be a worthwhile exercise.

There were systems and processes in place to ensure the safe storage and monitoring of NHS prescription pads. The service maintained an active log of all prescriptions. This enabled then to identify it a prescription were to go missing.

Incident reporting, learning and improvement

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. There were systems in place for receiving and acting on safety alerts.

Staff were familiar with the process of reporting significant events, incidents and accidents. These were reported on the trusts electronic system. Staff showed us the use of this system. Staff had a god understanding of what would constitute a reportable incident.

Incidents were brought to the attention of the dental service manager and any other relevant persons. We reviewed a selection of incidents which had been reported and found that these had been investigated and managed appropriately. Learning from incidents or accidents would be discussed at team meetings. We saw evidence in meeting minutes that these were discussed.

A never event had occurred in February 2018. This related to a wrong site surgery. There had been a detailed root cause analysis carried out on the event. This identified the contributory factors which had led to the event. As a result of the root cause analysis, the standard operating procedure had been reviewed for extractions under general anaesthetic, further training had been carried out and managers ensured that staff were all fully aware of the trust policy and national guidance. The patient's parents had been fully informed of the event, an apology given and were offered a copy of the trust complaints procedure.

There were systems and processes in place for receiving and responding to patient safety alerts from the Medicines and Healthcare products Regulatory Agency and the Central Alerting System.

Never events

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

From March 2018 to February 2019, the trust reported no never events within community dental services.

(Source: Strategic Executive Information System (STEIS))

Serious Incidents

Trusts are required to report serious incidents to Strategic Executive Information System (STEIS). These include 'never events' (serious patient safety incidents that are wholly preventable).

In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents (SIs) in community dental services, which met the reporting criteria, set by NHS England between March 2018 to February 2019,

(Source: Strategic Executive Information System (STEIS))

Is the service effective?

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.

The dentists followed current best practice guidance with regards to providing care, treatment and advice to their patients. They had a good awareness of the principals which underpinned these guidelines. They followed guidance as laid out by the National Institute for Health and Care Excellence, Faculty of General Dental Practice and the British Society for Disability and Oral Health. During the inspection, we reviewed a selection of dental care records which confirmed that the relevant guidelines were followed.

The service provided inhalation sedation for patients who were nervous. Staff followed the guidance as laid out by the Royal Colleges of Surgeons and the Royal College of Anaesthetists 'Standards for Conscious Sedation in the Provision of Dental Care' 2015. We reviewed dental care records of patients where inhalation sedation had been used. We saw that the patient was fully assessed at a pre-operative appointment. This included taking a full medical history and a discussion about the procedure. We were told that the concentration of gas was titrated to effect to ensure the correct depth of sedation was achieved.

The dentists used rubber dam when carrying out root canal treatment in line with guidance from the British Endodontic Society.

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.

The dentists assessed each patient on an individual basis for the need of different levels of anaesthesia. For example, for young children who had no dental experience requiring numerous extractions then a general anaesthetic would be the modality of choice. For older patients requiring less extensive treatment then inhalation sedation would be offered as a first line option. The dentists discussed the risks and benefits linked to each type of anaesthesia. The dentists routinely used topical aesthetic prior to injections.

We were told that for special care patients who did not have the ability to communicate the service had developed a “Dental symptom diary”. This was for when the clinicians were unable to identity a specific cause for the patient’s pain. The carers were asked to complete the diary with regards to when the pain was worse or what activities brought the pain on, such as cold drinks or eating. This helped the dentists come to a diagnosis of the pain.

Patient outcomes

Staff monitored the effectiveness of care and treatment. **They used the findings to make improvements and achieved good outcomes for patients.**

The service used audit to help improve the quality and safety of the service. Audits of infection prevention and control, record keeping and radiography were carried out regularly. Where areas for improvement had been identified then these were disseminated to staff during team meetings. We saw evidence of these in the meeting minutes. We were told that they aimed to do audits which were most relevant to the service. For example, as a result of the never event in February 2018, a dental care record audit focussing on children undergoing a general anaesthetic was carried out. This helped reduce the likelihood of the event from occurring again.

A log was maintained of all sedation cases which the dentists carried out. There were details of the outcome and success of the case. This information was then audited to see if any improvements could be made. **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 had the skills, experience and qualifications to provide safe and effective care to their patients. Many of the dental nurses had completed extended duty training relevant to their roles. These included radiography, conscious sedation, special care dentistry and oral health education. Staff told us that they were able to use some of the additional skills during the working day. In addition, two of the dentists were on the specialist register for special care dentistry.

Staff involved in the provision of conscious sedation had received the appropriate training to do so. Many of the dental nurses had completed extended duty training in the provision of conscious sedation. The dental service manager ensured that the dental nurses completed a certain amount of cases to ensure they remained competent to support the dentists in the provision of inhalation

sedation. The service maintained a sedation log for all staff to monitor the number of cases which they had completed. The service also arranged continuing professional development about sedation for all staff. This is in line with guidance laid out by the Royal Colleges of Surgeons and the Royal College of Anaesthetists 'Standards for Conscious Sedation in the Provision of Dental Care' 2015.

Staff received a detailed induction into the service. We spoke to a new member of staff who described the induction process. This involved an overarching trust induction and a specific induction for the community dental service for each location which they worked at.

Staff received an annual appraisal and monthly one to one meetings with their line manager. The appraisal process enabled managers to identify any additional training needs and for staff to request additional training. As of February 2019, 100% of staff had received an appraisal.

Multidisciplinary working and coordinated care pathways

All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies.

A multidisciplinary approach was taken to patient care when it was in their best interest. This was mainly adopted for patients with additional needs. Staff gave us examples of when they worked with other healthcare professionals. This included asking the patients GP if any blood tests were required prior to a general anaesthetic. In addition, they would consult with the patient's carer and / or family to see if the patient was under the care of any other clinicians. They would then contact the relevant clinicians to see if ay other treatments such as podiatry or Ear, Nose and Throat procedures were required. They could then plan a multidisciplinary approach during a general anaesthetic procedure. This would avoid the need for repeat general anaesthetics. They also worked closely with the oral surgery department at the local hospital. For cases involving complex surgery then they would take a joined-up approach with the oral surgery team.

At Leighton hospital they had access to "Dignity nurses". The role of the dignity nurses was to have oversight of the patient journey. This included making reasonable adjustments to make the patient journey during the general anaesthetic procedure less traumatic for patients. We were told that they had a good working relationship with the dignity nurses.

Dentists and other healthcare professionals could refer into the service. Staff described the process which was followed when receiving referrals. Referrals were received via letter. These were initially triaged by administrative staff and then were subject to a clinical triage. The patient would be contacted to arrange an appointment at the most appropriate clinic. A log was maintained of all referrals which came into the service.

Health promotion

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

Staff provided patients with preventative care and advice in line with the Department of Health's 'Delivering Better Oral Health' toolkit 2017. This is an evidence-based tool kit used for the

prevention of the common dental diseases such as dental caries and periodontal disease. Staff told us that they provided oral health advice, tooth brushing instruction and dietary advice. We saw evidence of this in the dental care records. In addition, there were numerous oral health advice leaflets at each location which we visited. The dentists also applied fluoride varnish to the teeth of patients who were at high risk of developing dental decay. This was documented in the dental care records which we reviewed.

Patients were provided with information about the importance of a healthy diet. At the David Lewis Centre, we were told that the dental team would often liaise with the speech and language therapists about the patient's diet. They told us that many of the patients had specific diets which had been adapted to their individual needs, some of these diets had foods which contained sugar. They would speak to the speech and language therapists to see if any alterations could be made to the diet plan to reduce the likelihood of the patient developing dental decay as a result of the high sugar intake.

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.

Staff were fully aware of the importance of obtaining and documenting evidence of consent. The dentists told us that they discussed options, risks and benefits of different treatments and methods of anaesthesia. These were documented in the dental care records. The service used NHS consent forms for all patients undergoing treatment. They had a good understanding of which form was used in which situation. We saw examples of the different consent forms when we reviewed dental care records.

Staff had a good understanding of the legal requirements of the Mental Capacity Act 2005. They told us about the process for carrying out best interest meetings. We were shown examples of mental capacity assessment forms which were used. At the David Lewis Centre, the staff who worked there carried out the capacity assessments on the patients. Best interest meetings would involve the patient's carer, family member and, if required, an independent mental capacity advocate. At the David Lewis Centre, staff there would arrange and be involved with the best interest decision meetings. This would involve the head of house, next of kin, the carer and the staff from the Psychology and Behaviour Support Services Team. We were shown examples of documents relating to best interest decision meetings. These were well documented and it was clear that a consistent approach was taken towards these decisions taking into account the principals of the Mental Capacity Act 2005.

Staff were aware of the concept of Gillick competence in respect of the care and treatment of children under 16. Gillick competence is used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

Is the service caring?

Compassionate care

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

During the inspection we observed staff communicating with patients. We found them to be caring, compassionate and polite during interactions at the reception and over the telephone. We received feedback from 20 patients during the inspection. Patients commented that staff were very supportive, understanding and caring. Many commented about how good the staff were at treating children and special care patients. This included making reasonable adjustments.

The service carried out the NHS Friends and Family test. As of May 2019, 96.1% of patients who completed the test stated that the were extremely likely to recommend the service to friends or family. Comments from the test included, “Friendly staff”, “Professional staff & reception/ support dental plus kind & caring and visit well organised” and “Quick and simple service and friendly staff”.

Staff were aware of the importance of maintaining patient confidentiality. During the inspection we did not see any breaches of confidentiality. Reception computer screens were not visible to the public, computers were locked and password protected and paper dental care records were locked in fire proof cabinets. Surgery doors were kept closed when patients were receiving treatment so to maintain confidentiality.

Emotional support

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

Staff were fully aware of the importance of providing emotional support to their patients to enable them to receive dental treatment. Feedback from patients stated that staff were extremely accommodating and understood the complexities of dealing with vulnerable adults.

Staff described to us the methods they used to help their patients accept dental treatment. This involved providing as much time as was required to provide the care and / or treatment. They would also take treatments at a slow and steady pace and make sure that the patient was fully aware that they would stop the treatment at any time if they felt pain or just wanted a break.

At the David Lewis Centre they worked with the Psychology and Behaviour Support Services Team. This team helped dental staff develop reasonable adjustments when treating patients there. This helped the dental team carry out treatment on the patients there.

Staff took into account patients' personal, cultural and religious needs when booking appointments. This included arranging appointments at times that do not clash with religious festivals and times when patients may be fasting. They also booked appointments at the time of day which would suit the patient. For example, an early morning appointment may be better for some patients.

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 fully involved their patients and / or family members in decision about treatment. They described to us the different methods which they employed to help with this. For example, they told us that they avoided the use of overly technical language when describing treatment or conditions. This would help the patients and / or family members to better understand the proposed treatment and condition.

Staff provided patients and / or family members with treatment information leaflets to help them better understand their condition and make decisions about their care and treatment. We saw that these were readily available throughout the service. They would also use models, diagrams and Xray images to help describe treatments and conditions to patients and / or family members.

They had also used patient exchange communication cards. These cards help patients with little or no communication abilities (such as autism) to communicate using pictures.

Is the service responsive?

Planning and delivering services which meet people's needs

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 dental services were commissioned by NHS England. They were a specialist referral service for patients with medical, physical or social issues and patients with dental phobia.

Services were available Monday to Friday at Church View Health Centre and Weston Dental Clinic. The service at the David Lewis Centre was carried out every Wednesday. Patients requiring emergency dental treatment would be seen the same day and if not within 24 hours. Patients requiring emergency dental treatment outside normal working hours (such as the weekend or bank holidays) were signposted to the NHS 111 out of hours service. There were details about what to do in the event of an emergency displayed in the waiting areas.

The service carried out domiciliary visits for patients who could not attend the clinics. This would be for medical, physical or social reasons. Patients were initially triaged for this service to ensure there were not other means by which they could access a clinic.

Meeting the needs of people in vulnerable circumstances

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.

Reasonable adjustments had been made to each location which we visited. These included step free access, accessible toilet facilities, automatic doors and lowered reception desks. In addition, they had hoist facilities at Weston Dental Clinic. Staff were familiar with the use of the hoist and confirmed they received regular training during their manual handling training. They also had a dental chair which could support patients who weigh up to 26 stone. If a patient exceeded this weight then they could be seen in a hospital setting where a trolley could be used.

Staff told us about how they made reasonable adjustments for their patients to make the process of receiving dental treatment more pleasant. For example, when planning an general anaesthetic, they would consider the patients place on the list taking into account the best time of day for a patient. This was often the first slot on the list to avoid having to wait. They would also bring patients in a side entrance to avoid having to be in a busy environment. They would also liaise with the patient's carer and / or family members to determine the best approach to make fasting prior to a general anaesthetic least intrusive to the patient's normal day. Staff told us that they were able to have as much time as they required to provide care, treatment and support for their patients.

They used patient passports. These are completed by the patient's carer and / or family members prior to their appointment. Patient passports provide immediate and important information for staff in an easy to read form, promoting a positive experience for people with learning disabilities receiving treatment.

The service had developed photo journey books for "Children having dental treatment with happy air", "Going to hospital to have teeth out" and "Going to see the dentist". These provided a step by step pictorial guide to the different stages of each procedure. These guides were available on the trust's website.

At the David Lewis Centre, they would often visit the patient's home if they did not respond well to being seen within the clinical setting. We were told that this often helped patients feel more relaxed as they were in a familiar setting.

Translation services were available for patients whose first language is not English. There were details in the waiting rooms about this service. In addition, staff had access to hearing loops for patients who required them.

Access to the right care at the right time

People could access the service when they needed it and received the right care in a timely way.

Dentists and other health care professionals could refer into the service for a one-off course of treatment or long-term continuing care. If the patient had been referred for a one-off course of treatment then they would be referred back to their own dentist for continuing treatment.

The service manager monitored the waiting times. Waiting times from referral to assessment were between two and four weeks dependant on the site. Assessment to treatment (non - general anaesthetic) waiting times for special care and paediatric patients were eight and four weeks respectively. Assessment to general anaesthetic waiting times for special care patients were two to four weeks and for paediatric patients were two weeks. The waiting times from assessment to general anaesthetic for special care paediatric patients was up to 16 weeks unless urgent. We were told that any urgent patients would be fitted in at the soonest appointment.

Accessibility

The largest ethnic minority group within the trust catchment area is Polish with 1% of the population.

	Ethnic minority group	Percentage of catchment population
First largest	Polish	1.0%
Second largest	Irish	0.6%
Third largest	Asian / Asian British	0.6%
Fourth largest	Other Western Europe	0.4%

(Source: Universal Routine Provider Information Request – P48 Accessibility)

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 trust had a complaints policy and procedure. There were details of how a patient could make a complaint displayed in each waiting area. There were also details on the trust's website. If a patient made a verbal complaint directly to the service then staff would aim to resolve this in house. If the patient was not satisfied with the response then they would be provided with the details of the Patient Advice and Liaison Service.

The service received a low volume of complaints. The service manager was responsible for dealing with complaints when they arise. If there was any clinical aspect to the complaint then a senior dentist would be involved with the resolution. We were shown details of the one complaint which had been received in the last 12 months. This complaint had been responded to appropriately.

Complaints

From April 2018 to March 2019 there were no complaints about community dental services.

(Source: Universal Routine Provider Information Request (RPIR) – P52 Complaints)

Compliments

From April 2018 to March 2019 there were no compliments about community dental services.

(Source: Universal Routine Provider Information Request (RPIR) – P53 Compliments)

Is the service well-led?

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.

There was a clearly defined management structure in place and staff were aware of their individual roles and responsibilities. Clinical leadership was provided by the clinical director. They had only recently started in this role after the previous clinical director had retired. The previous clinical director was now working part time to help support the transition.

The service manager was responsible for the oversight and day to day running of the service. There were lines of accountability and staff were aware of who their individual line manager was. There were dental nurse team leads at the main locations (Church View Health Centre and Weston Dental Clinic).

Staff told us that leaders were visible and approachable and that they felt appreciated and appropriately supported.

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 service did not have dedicated vision and strategy. We were told that the services vision mirrored that of the overall trust. The trust's vision was "To ensure our patients receive the best care in the right place". It was clear during the inspection that the staff represented this vision during their day to day work.

Managers were focussed on the long-term sustainability of the service. They had systems in place to develop the workforce to ensure the longevity of the service. For example, the newly appointed clinical director had already worked within the service.

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 morale was good within the service. They were a small closely-knit team and many had worked together for many years. It was clear they worked well together as a team and in the best interest of the patient.

Staff were aware of the need to raise concerns. They were aware of the freedom to speak up guardian. Staff showed us where the contact details of the freedom to speak up guardian were held on the trust's intranet page.

Staff were aware of the importance of being open and honest with patients in line with the Duty of Candour. We reviewed records relating to the never event which occurred in February 2018. It was clear from these that the persons affected by the event were fully informed about the event and an apology was given.

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.

The trust held overarching policies and procedures on their internet page. Staff were familiar with how to access these. These included health and safety, equality and diversity and safeguarding. The dental service had also developed their own standard operating procedure for topics such as inhalation sedation and the decontamination of re-usable dental instruments. These were regularly updated and checked to ensure they reflected current nationally recognised guidance.

There were systems in place to disseminate information to staff working within the clinics. As they were a small team and only worked over two main sites they communicated with each other on a

daily basis. Formal team meetings were held every three months involving all staff. As part of the meeting there were separate clinical and administrative meetings. We reviewed the minutes relating to team meetings and saw that these were well attended.

The service manager was in regular communication with the operations manager and also attended the divisional governance meetings. We were told that there was very much an opendoor policy with regards to communication between the two of them.

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 maintained an up to date risk register to help them manage foreseeable challenges to the service. Staff were able to highlight risks. Any risks were escalated to the operations manager and could then be escalated further to a corporate risk if deemed necessary. The trust had a dedicated “risk team”. The risk team assessed and provided support to the service to help manage the risk.

The only risk (which was on the corporate risk register) related to the waiting times for general anaesthetic at Leighton hospital. There were actions in place to help reduce the risks associated with this. We also reviewed a selection of historical risks which had been on the risk register and these had been acted upon and closed when the risks were no longer deemed to be of concern.

Information management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Managers monitored performance by the use of audit and data received from NHS England. These were discussed with staff during meetings and where improvements could be made an action plan was developed. Performance data was regularly submitted to NHS England to ensure the service was complaint with their contractual obligations.

The service used a combination of electronic and paper dental care records. Staff told us that they had good access to patient information when they required it. They could access any patient records across the different sites. This enabled them to see patients at either of the two main sites. When a domiciliary visit was carried out, records would be recorded on paper and then transferred to the electronic system upon return to the clinic.

The electronic dental care record system was password protected and backed up to secure storage. We observed staff locking the computers when they left their workstations. Any paper records were stored in locked and fire proof cabinets to ensure they were secure.

Staff were required to complete information governance training. As of February 2019, 94.7% of staff had completed this training.

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 new clinical director was due to start attending the local managed clinical network meetings for special care dentistry and paediatrics. The now retired clinical director had previously attended these meetings. Managed clinical networks are groups of professionals from primary, secondary and tertiary care who work together to ensure the equitable provision of high-quality effective services. Managed clinical networks involve those who are responsible for providing the service, those referring into the service and organisations who commission the service.

The service manager attended annual meetings with the NHS England local area team. There were also interim six-monthly meetings. At these meetings they discussed access and performance. We were told that they had a good working relationship with the NHS England local area team.

The service carried out the NHS Friends and Family test throughout the year. In addition to this they carried out a patient satisfaction survey every two years. Feedback from patients was always very positive about how staff treated them and the overall experience.

The trusts carried out an annual staff satisfaction survey. The results of this were feedback to staff during team meetings.

Staff told us that they had a good line of sight to the trust board and felt appreciated and supported. For example, we were told that one of the clinical directors had called up the service manager to wish them well prior to the inspection.

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 working within the service were continually encouraged to develop their skills. Many of the dental nurses had additional qualifications such as sedation, special care dentistry and radiography. The service arranged for staff to attended refresher training to keep them up to date with current best practice guidance. For example, the staff had recently attended sedation refresher training.

The service offered school children who were interested in following a career in dentistry with the opportunity for work experience. This was thoroughly risk assessed to ensure the individual was kept safe. In addition, they were subject to a induction process which included highlighting the importance of patient confidentiality. They were due to have another work experience student in July 2019.

Community inpatients services

Facts and data about this service

East Cheshire NHS Trust has access to 58 intermediate care nursing beds which are provided over two of the hospital sites including Aston Ward at Congleton War Memorial Community Hospital. Provision in Macclesfield is delivered from the acute hospital site but commissioned as an intermediate care unit. The service provides integrated health and social care assessment and therapy for adults who are suffering an acute illness resulting in a change in their ability to care for themselves but not requiring admission to hospital (step up) or people who have been hospitalised and are medically optimised but are unable to return home due to change in their ability to self-care (step down). The service also provides health transitional care for people who are temporarily unable to self - care due to a health reason such as a fracture.

(Source: CHS Routine Provider Information Request (RPIR) – CHS1 Context CHS)

Ward 11 at Macclesfield General hospital has 30 beds and Aston ward, 28 beds.

From April 2018 to March 2019 there were 439 admissions to Aston ward and 343 admissions to ward 11.

We inspected the service from 2 July 2019 to 4 July 2019. As part of the inspection we visited ward 11 at Macclesfield General hospital and Aston ward at Congleton War Memorial hospital.

During the inspection, we spoke with 28 staff of various grades, including ward managers, nurses, occupational therapists, physiotherapists, consultants, middle grade and junior doctors, a consultant, healthcare assistants, and a housekeeper. We spoke with 11 patients, observed care and treatment and looked at 16 patient's care records including some medicines charts. We received comments from people who contacted us to tell us about their experiences, and reviewed performance information about the service.

The service was last inspected in 2014. At that inspection, it was rated good overall.

Is the service safe?

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

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

Mandatory training

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

All staff received and kept up to date with mandatory training.

Mandatory training completion rates

The trust target for completion of mandatory training was 90%.

Staff completed statutory and mandatory training online and face to face. In addition, they completed annual clinical updates. Training completion data we reviewed during the inspection for nursing staff, showed 87% of staff on ward 11 were up to date with statutory and mandatory training in May 2019, although the completion rate in March 2019 was 93%. On Aston ward, the statutory and mandatory training completion was 98% in May 2019 for nursing staff. The ward managers said there was a time lag between completion of mandatory training and it being recorded on the electronic staff record, resulting in some temporary dips in rates of completion as in the most recent data for ward 11.

In respect of annual clinical updates, 98% of nursing staff on ward 11 and 92% of nursing staff on Aston ward had completed their annual clinical update training in May 2019. Topics covered in the training were relevant to the needs of staff working in community inpatient areas. For example, training included basic life support, infection prevention and control, sepsis, pressure ulcer prevention, and falls prevention.

Although we did not see mandatory training completion rates for therapies staff, all the staff we spoke with, said they were up to date with mandatory training and referred to a traffic light system on the intranet that showed when a member of staff's training was due.

Ward and department managers monitored staff completion of mandatory training and we observed a grid on each ward, showing the dates each member of staff was due to renew each training topic. Staff told us ward managers received emails when staff were due for mandatory training and staff themselves received an email reminder. We were told administrative staff took a forward look at mandatory training due dates, to enable staff to be booked for training in advance.

The trust covered basic dementia awareness within mandatory training. In addition, staff on Aston ward told us they had received training from an external provider on dementia on the ward, approximately 18 months prior to the inspection.

Medical staff completion of mandatory training was included in their annual appraisal.

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.

Nursing staff and allied health professionals received training specific for their role on how to recognise and report abuse.

Safeguarding Training completion

	Safeguarding Adults Level 2	Safeguarding Children Level 2	Prevent / Wrap
Aston ward	100.00%	97.37%	100.00%
Ward 11	100.00%	95.35%	97.78%

The trust's target for completion of safeguarding training was 90%. Data provided showed both wards exceeded the trust target.

Safeguarding training included awareness of female genital mutilation and child sex exploitation.

The trust provided Workshops to Raise Awareness of PREVENT (WRAP) Home Office accredited training across the Trust. The PREVENT initiative was introduced to safeguard vulnerable people from being radicalised to supporting terrorism or becoming terrorists themselves. Completion of this training was over 95% for both wards.

Staff had access to safeguarding policies and procedures for children and adults, including pathways for female genital mutilation and child sex exploitation, to provide guidance for staff on the reporting process.

Staff knew how to identify people at risk of, or suffering from, abuse and worked with other agencies to protect them. Staff were aware of the signs of abuse and action they should take if they identified concerns. They told us they would report any concerns to the ward manager and said they would make a safeguarding referral if necessary. Safeguarding referrals were made through the trust computer system to the local authority safeguarding team and a copy was sent to the trust safeguarding team. Staff were familiar with how to make a referral.

The admission and ongoing assessment process to intermediate care included a prompt to identify any safeguarding concerns and identified those who might need additional help and support on discharge to provide early consideration of safeguarding and welfare issues.

Staff said the trust safeguarding team were available by telephone when they needed advice and they had access to social workers on a daily basis on the wards with whom they could discuss safeguarding issues. Staff on ward 11 said a member of the safeguarding team sometimes attended morning board rounds on the ward, particularly if there was a patient with a safeguarding concern.

Safeguarding referrals

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children's Services, Adult Services or the police should take place.

Safeguarding referrals - adults

Between April 2018 and February 2019, the trust made 261 safeguarding adult referrals. The trust did not break down the information down by core service therefore we were unable to determine if any related to community inpatient services.

(Source: Universal Routine Provider Information Request (RPIR) – P11 Safeguarding)

Data provided by the trust as a result of a information request, showed that from April 2018 to March 2019, ward 11 made two safeguarding referrals and Aston ward made one safeguarding referral.

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.

There were no recorded MRSA bacteraemia, or Clostridium difficile infections on ward 11 or Aston ward from April 2018 to March 2019.

Prior to admitting patients to the wards, the patient's MRSA status was checked as part of the verbal handover checklist and was also recorded on the admission proforma. This enabled patients to be allocated a single room if necessary.

The National Institute for Health and Care Excellence (NICE) quality standard (QS) 61, statement three states people should receive healthcare from healthcare workers who decontaminate their hands immediately before and after every episode of direct contact or care. There were sufficient hand washing facilities within the clinical areas and we observed staff adhering to good hand hygiene practices. Hand sanitising gel was available and clearly visible, at the entrance to every clinical area, in the ward corridors between bays and at each bedside. Hand wash basins were also readily available. Personal preventative clothing and equipment (PPE) was readily available within the wards.

During the inspection visit, we observed staff showing good compliance with hand hygiene procedures and they used PPE appropriately. Staff followed the trust's bare below the elbows policy and we observed them washing their hands or using the hand gel between patient contacts. Patients we spoke with, told us staff cleaned their hands before attending to them

Staff said hand hygiene audits were completed. The trust did not provide results of hand hygiene audits on ward 11 however, results for monthly audits on Aston ward showed 100% compliance from January 2019 to June 2019

Wards and clinical areas were visibly clean at the time of the inspection. We checked the cleanliness of a range of bathroom and toilet facilities, bed areas and equipment. Curtains surrounding each bed space were disposable and were dated to indicate when they had been changed. Patients told us housekeeping staff were efficient and thorough. A patient said, "It is definitely clean. The staff are very thorough." Housekeeping staff were knowledgeable about the procedures required when a patient had an infection. They were present on the wards during the inspection and we observed them completing cleaning duties thoroughly and systematically. We observed them pulling empty beds away from the wall in order to clean the bed frame and behind the bed.

The trust participated in the Patient Led Assessment of the Clinical Environment (PLACE) audit during 2018. Data provided showed that Aston ward scored 100% for cleanliness and Ward 11 scored 99.67%.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We observed that labels had been placed on equipment and these showed they had been cleaned recently.

Clinical waste was appropriately stored and disposed of. In all clinical areas, there was correct segregation of clinical and non-clinical waste into different coloured bags. This was in line with the

Health Technical Memorandum 07-01, ‘Control of Substance Hazardous to Health, and the Health and Safety at Work Regulations’. Sharps bins were labelled, and the bins were not overfilled.

There were a number of side rooms available on both wards to enable the segregation of patients with an infection or those suspected as having an infection. We observed staff used signs at the entrance to these rooms, when visitors and staff needed to take specific precautions to prevent infection. We observed staff using PPE appropriately when entering these rooms.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment mostly kept people safe. Staff were trained to use them. Staff managed clinical waste well.

Ward 11 was divided into bay areas and single side rooms. There was free access to the ward during the day, although those entering and leaving the ward were immediately visible to staff at the reception desk. The entrance doors had the facility to be locked with swipe card access and doors were locked at night. Staff told us it was unusual to need to restrict those leaving the ward; however, when a deprivation of liberty safeguards authorisation was in place, the system could be activated during the day if necessary.

We identified a concern during the inspection in relation to open full length windows similar to doors on ward 11. These allowed patients to potentially leave the ward without being observed and were also a trip hazard, due to the base of the frame sitting approximately two inches above floor level. The ward manager told us an incident had occurred during the previous weekend when a patient had left the ward through the window, although staff had observed them and followed them, thus preventing any adverse consequences. Staff had completed an incident form and the ward manager told us they were in the process of completing a risk assessment as a result. They told us the windows originally had window restrictors in place preventing them from being opened enough to allow a person to exit via this route, but some of the restrictors were not in place. The maintenance department were immediately contacted to ensure all windows on the ward were checked, restrictors were put into place and functioning correctly. When we returned to the ward two days later, a risk assessment had been completed and following the inspection the trust confirmed window restrictors had been installed.

All bed spaces on ward 11 had access to ceiling tracking hoists apart from a low acuity bay. There was a range of other equipment for transferring patients such as stand aids, transfer turners and walking frames. All patients who required mobility equipment had it in easy reach of their chair or bed. Of the twenty bed spaces we checked, 17 had transfer information available at the bedside, so that staff were informed as to how a patient could be moved safely.

Other equipment was available as required. Pressure relieving equipment such as mattresses and cushions were supplied via a contract with an external supplier. Staff explained the service was good and equipment was available promptly during the day direct from the supplier. In addition, pressure relieving equipment was stored away from the ward on the hospital site for access out of hours. Bariatric hoists and commodes were available within the hospital and other equipment such as beds and seating were available on hire.

Emergency resuscitation equipment was available on a resuscitation trolley on the ward. Records showed it was checked daily and we noted it was secure and clean.

There was free access to Aston ward, although as with ward 11, there was the facility to restrict access through the main entrance, which was secured at night. There was a mix of bay areas and

single rooms, used mainly for patients with infections or end of life care. Bathroom and toilet facilities were accessible for those with limited mobility. Piped oxygen and suction were only available for half of the beds on the ward. Therefore bottles of oxygen were kept on the ward and these were stored securely and safely.

There was a small gym on Aston ward although space was limited and there was not sufficient room for a plinth. When necessary, the main gym in the physiotherapy outpatient department could be used. Therapists identified that some of the chairs on the ward were too low for patients, especially those who had had hip surgery. In addition, the ward lacked a riser, recliner, chair to allow staff to appropriately assess those patients who relied on one at home.

Staff had access to medical equipment they required. Pressure relieving equipment was provided through the trust contract with an external supplier, as was bariatric equipment. Staff told us equipment was available in a timely manner. A resuscitation trolley was available on Aston ward and records showed it was checked daily. It was secure and clean. It had an automated external defibrillator as there was no resuscitation team on site.

The trust had arrangements for the maintenance of medical devices in accordance with the MHRA Managing Medical Devices (April 2015), and other national guidance. Device alerts were cascaded through the maintenance team. Equipment we checked on both wards showed evidence of electrical safety checks and required maintenance. Medical gases were stored appropriately. Sterile supplies and consumables we checked were within their use by date.

Staff completed medical devices training and this was recorded centrally. We were told the training department had a trolley they brought to the wards with pumps and other medical devices to enable them to provide on the spot training. Both wards had over 85% compliance with medical devices training.

Assessing and responding to patient risk

Staff mostly completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration. Protocols were in place for the emergency transfer of patients from Aston ward to an acute hospital, although staff on Aston ward did not use an early warning score to ensure prompt identification of patients at risk of deterioration or sepsis.

Ward 11

A systematic approach was used to gathering information about patients and risks to their health and safety when patients were moved to ward 11 and this was documented in the patient's records.

Although the ward was primarily focused on providing intermediate care, we found some patients were transferred to the ward when they required ongoing medical input and were not assessed as being medically fit for discharge. However, the risks were mitigated by the daily medical presence on the ward and access to medical staff throughout the 24 hour period. Managers maintained an oversight of patients admitted to ward 11 at the capacity meetings held three times a day and an escalation process was in place. Junior medical staff completed an initial admission assessment

for patients, that included their presenting problem, past medical history and physical assessment. They reviewed patients on a daily basis and could escalate concerns when needed.

Nurses completed risk assessments to assess each patient's risk of developing pressure ulcers, risk of falls, nutritional risk and risks associated with moving and handling. These risks were reviewed and updated regularly. Where patients were identified as being at risk, plans to reduce the risks were in place. For example, when patients were at risk of developing a pressure ulcer, pressure relieving equipment was used and the patient was assisted to change their position on a regular basis. The trust used an intentional rounding document to record individual checks of the patient and interventions such as re-positioning. Records we reviewed of patients at high risk of developing pressure ulcers, showed staff documented they had re-positioned the patients two hourly.

Risk of developing a venous thrombo-embolism was assessed on admission to the trust and reassessed after 24 hours. Records we checked contained evidence that the risk assessments had been completed.

Staff checked patient's vital signs observations daily, or more frequently if they were unwell. This was recorded electronically. They calculated the national early warning score (NEWS) when they completed vital signs observations. This was done to identify deteriorating patients and is in line with national guidance. Staff were clear about the action they should take if the NEWS score increased, indicating the patient's condition was deteriorating. They rang the critical care outreach team and contacted their junior doctor. The electronic system was also monitored by the critical care outreach team, who rang the ward if the patient's NEWS score increased and they had not been contacted by the ward team. We checked the observations for six patients and found the NEWS score was recorded with every set of observations. We did not find any instances when the score had increased to the level where escalation was needed. Nursing staff said the critical care outreach team responded promptly when they were called. The trust monitored the timely recording of observations and results demonstrated that at least 90% of observations were timely from June 2018 to June 2019. They did not audit the appropriate escalation of NEWS scores when the score rose.

Sepsis is a life-threatening condition that arises when the body's response to infection causes injury to its own tissues and organs. The trust had a sepsis protocol and used the national pathway to identify and treat sepsis. Sepsis awareness was provided in nursing staff clinical update sessions and staff told us they would complete the sepsis pathway if they had concerns about possible sepsis.

Aston ward

The same approach to gathering information and assessing patient risk on admission to Aston ward was taken as with ward 11 and stored in the patient's care records. A registrar was available on the ward Monday to Friday; they assessed all new patients and reviewed patients as required.

Nurses completed risk assessments to assess each patient's risk of developing pressure ulcers, risk of falls, nutritional risk and risks associated with moving and handling. Records showed the risks were reviewed and updated regularly. Care plans were in place and actions taken to reduce risks to patients. Staff told us the ward had previously had a large number of patient falls. As a result, staff used one bay to cohort patients at risk of falls and a member of staff stayed in the bay wherever possible, to monitor patients and provide prompt assistance when it was required.

Intentional rounding documents we reviewed of patients at high risk of developing pressure ulcers, showed staff documented they had re-positioned the patients two hourly.

Risk of developing a venous thrombo-embolism was assessed on admission to the trust and reassessed after 24 hours. Records we checked contained evidence that the risk assessments had been completed.

Staff checked patient's vital signs observations daily, or more frequently if they were unwell. However, staff on Aston ward did not record a NEWS score. Patients cared for on the ward were not acutely unwell and senior staff told us the nurses were alert to signs of deterioration and would call for assistance if needed. They used the nationally recognised ABCDE assessment to record the patient's vital signs if they showed any signs of deterioration. A registrar was based on the ward four and a half days a week. Outside these hours the GP service could be contacted or emergency assistance sought through the 999 service. Staff were clear about the protocol for transfer of patients to Macclesfield in the event of their deterioration.

Staff had completed sepsis training. However, they were not aware of a particular focus on sepsis and their familiarity with the initiative and requirements was not always good.

Staffing

Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction. The service mostly had enough 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, optimal levels of staffing were not always achieved, as when additional staff were required to provide enhanced care, they were sometimes moved to other areas.

Nursing staff from both wards told us that when they required additional staff to provide enhanced care, this could not always be provided. Data provided by the trust shown below, indicated additional care staff above the rostered levels were provided during April 2019, however, data relating to use of temporary staff from March 2018 to February 2019 also provided below, shows that not all available hours were filled by bank or agency staff. Staff on ward 11 also said the skill mix for the ward was based on the provision of intermediate care and did not account for patients cared for on the ward with increased acuity and dependency. This was being reviewed by senior nurses.

Ward	Day		Night	
	Average fill rate % Registered nurses/midwives	Average fill rate % care staff	Average fill rate Registered nurses/midwives	Average fill rate % care staff
Aston ward	104%	90%	98%	108%
Ward 11	98%	138%	101%	125%

Safer staffing levels

Staff fill rates compare the proportion of **planned** hours worked by staff (Nursing, Midwifery and Care Staff) to **actual** hours worked by staff (day and night). Community health trusts are required to submit a monthly safer staffing report and undertake a six-monthly safe staffing review by the director of nursing. This is to monitor and in turn ensure staffing levels for patient safety. Hence, an average 70% fill rate in January 2016 for nursing staff during the day means; In January, 70% of the planned working hours for daytime nursing staff were actually 'filled'.

Details of staff fill rates within community inpatient services for registered nurses and care staff for April 2019 published on their website by the trust are below:

The fill rate of over 100% for registered nurses/midwives during the day and care staff during the night indicate an over establishment of staff. This may be due to the requirement for enhanced support for patients who had additional needs.

Planned v Actual Establishment

Data provided by the trust showed the following information for community inpatient wards from April 2018 to March 2019:

Aston Ward

Staff group	Planned staff WTE	Actual Staff WTE	Staffing rate (%)
NHS infrastructure support	0.95	0.55	58.0%
Qualified nursing & health visiting staff (Qualified nurses)	13.26	12.52	94.0%
Support to doctors and nursing staff	20.02	19.79	99.0%
Total	34.23	32.85	84.0%

Ward 11

Staff group	Planned staff WTE	Actual Staff WTE	Staffing rate (%)
NHS infrastructure support	0.8	0.8	100.0%
Qualified nursing & health visiting staff (Qualified nurses)	15.4	12.9	84.3%
Support to doctors and nursing staff	25.6	21.1	82.5%
Total	41.8	34.9	83.5%

(Source: Universal Routine Provider Information Request (RPIR) – P16 Total Staffing)

Vacancies

Ward 11 did not have any vacancies for nursing staff at the time of the inspection.

The ward manager on Aston ward reported 0.4 whole time equivalent (WTE) vacancies for registered nurses and three WTE health care assistant vacancies. However, they told us they had just appointed 1.5WTE healthcare assistants and were awaiting their start date.

Vacancy rates were therefore below the trust target of 5%

Turnover

From April 2018 to March 2019 the trust reported a turnover rate of 6% for qualified nursing staff on ward 11 and 0% for other staff groups. This was lower than the trust target of 10.5%. In the same period, the trust reported a turnover rate of 11% for qualified nursing staff and 10% for support staff on Aston ward.

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

Sickness

The trust's electronic staff record system was not able to map individual staff to core clinical services as defined by the CQC. It therefore could not provide a breakdown of sickness rates by ward or site for this service.

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

Nursing – Bank and Agency Qualified and non qualified nurses

The service requested and utilised the trust's bank staff when required. There were some bank staff who were local to Congleton, who worked on Aston ward only. As both wards had limited vacancies, bank staff were mainly used when enhanced care was required on a one to one or cohort basis.

The table below shows the numbers and percentages of nursing hours in community outpatient wards at the trust from March 2018 to February 2019 that were covered by bank and agency staff or left unfilled.

Qualified staff

Ward	Total hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
Aston	25928	1692	7%	1918	7%	-117	0%
Ward 11	28900	1784	6%	3348.5	12%	3116	11%
Intermediate Care Team	23425	2467	11%	0	0%	6739	29%

Of the 78,253 total working hours available, 8% were filled by bank staff and 7% were covered by agency staff to cover sickness, absence or vacancy for non-qualified nurses.

In the same period, 13% of the available hours were unable to be filled by either bank or agency staff.

Non- qualified staff

Ward	Total hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
Aston	37543	7352	19.6%	0	0	1877	5.0%
Ward 11	47066	9673	20.6%	0	0	3865	8.2%
Intermediate Care Team	2307	10535	456.6%	0	0	743	32.2%

Of the 86,916 total working hours available, 32% were filled by bank staff and no hours were filled by agency staff.
In the same period, 5% of hours on Aston ward and 8% of hours on Ward 11 were not filled by bank or agency staff.
(Source: Routine Provider Information Request (RPIR) - Nursing – Bank and Agency tab)

Medical locums

The trust was unable to provide the appropriate data on use of medical locums for community inpatients.

(Source: Universal Routine Provider Information Request (RPIR) – P21 Medical Locum Agency)

When medical staff covering community inpatient services were absent through annual leave, cover was provided from within medical services at the trust. A registrar from medical services provided on site cover for Aston ward when the regular registrar was on leave.

The trust used a nationally recognised tool twice a year to review and set nurse staffing levels for community inpatient wards. In addition, a safe care tool was used on a daily basis to assess staffing requirements. The senior management team told us the “matron of the day” reviewed risks across the trust and staffing requirements, allocating staff accordingly to ensure safety. However, ward staff told us temporary staff were not always available to provide additional staff when they were required.

Staff on ward 11 explained their staffing template was based on the ward providing intermediate care and due to capacity issues in the rest of the hospital, they frequently cared for patients who had ongoing medical problems and higher dependency and acuity than for intermediate care. They cared for patients with confusion and mental health needs and significantly more physical needs. Senior staff told us they had considered alternative ways to manage staffing, to support the care patients required and had introduced a band three role to support and coordinate discharges. However, they had been unable to secure additional resources needed to improve overall permanent staffing levels. When they requested an additional member of staff to provide support to patients with complex care needs and who required enhanced care, the trust was unable to provide this at times. However, they did not report these as incidents unless they resulted in a negative impact for a patient. We reviewed incident reporting information from April 2018 to March 2019 and a total of 12 staffing incidents were reported. A consultant expressed some concerns about the level of monitoring of patients with dementia and those who required a lot of encouragement to eat and drink, due to staffing levels. The number of nursing staff on duty in the afternoon and evening was lower than in the morning and some staff told us this impacted on the timely care of patients. The senior management team said staffing reviews were being undertaken, however, they were required to work within the current financial envelope. During the inspection, we found staff had been successful in reducing patient falls and pressure ulcers, and reducing the number of late observations; therefore we could not identify an impact of sub-optimal staffing levels on the safety of care

Three of the four patients asked about staffing levels said they felt there were not enough staff on duty at times. One patient said, “There’s not enough staff; it is up and down, but it is mostly a problem in the evening when they are rushing, as most people want to be in bed before evening visitors arrive and other patients need one to one attention.”

Physiotherapists, occupational therapists and therapy assistants were allocated to ward 11. They were available weekdays and provided plans for the weekend for rehabilitation assistants. They told us they tried to provide patients with input three or four times a week. Some nursing assistant posts had been used to develop rehabilitation assistant posts and staff told us this had been very beneficial in relation to the provision of rehabilitation for patients across the seven day week.

Therapists provided exercise plans for patient to follow with the rehabilitation assistants and the patient's family if appropriate.

Medical staff were allocated to ward 11 as part of the medical rotation. There were a minimum of two trainee or non-trainee junior doctors on the ward, Monday to Friday from 9am to 5pm. There was also a staff grade doctor available on the ward two days a week. Two consultants covered the ward and all patients were under the care of one of the two consultants. Each carried out a ward round once a week. Consultant cover out of hours was available from the medical consultant on call rota.

Aston ward did not care for patients who were acutely unwell medically, as there was no medical cover on site out of hours and cover was provided by the GP out of hours service. A registrar grade doctor was based on the ward four and a half days a week and all patients were under one named consultant. During annual leave, a registrar normally covered from medical services at Macclesfield General hospital.

Nurse staffing levels mirrored those on ward 11. The ward manager told us they had completed an audit of nursing needs and were making the case for additional staff. They had introduced a twilight shift as they had identified that more patient falls occurred in the late afternoon and early evening. As with ward 11, they told us their requests for additional staff to provide cover for the cohort bay was often not fulfilled. They submitted their daily staffing data to the matron of the day at Macclesfield and said they sent an email listing the reasons they needed cover.

Physiotherapy and occupational therapy staff were based on Aston ward, although, there were no band 5 rotational posts on Aston ward and therapy staffing levels were similar. Therapists created lists of patients undergoing rehabilitation for the rehabilitation assistants to work with at weekends.

Quality of 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 on ward 11.

Information needed to deliver safe care and treatment was available to staff in a timely way. The majority of patient records were paper based, although there was electronic recording of vital signs observations on ward 11. Records of nursing assessments and daily nursing care were stored separately in folders by each patient's bed. Therapists and other staff documented daily care in the medical records. This meant staff were able to access the information they required to provide safe care and treatment.

We reviewed parts of 16 patient records. Entries were legible, dated, timed, signed and the designation of the person making the record was usually recorded, in line with required practice. Each page had patient identifiable information present.

An initial assessment proforma was completed on admission to intermediate care, with a list of the patient's medical problems, past medical history, background and social history, and a mental health test score. Allergies and other risk factors such as smoking, alcohol intake and physical exercise were also documented. Physiotherapists and occupational therapists recorded their assessments on a standard proforma to ensure a consistent and systematic approach. Medical and therapies staff completed records to document their ongoing treatment and care plans.

Printed copies of access or home visit reports were included when they had been completed. We found entries were clear, there was a plan for the patient and daily updates were recorded.

Nursing assessments and care plans were completed. When risks to patient's health and safety were identified, a care plan was in place to reduce this risk. For example, a falls care plan was used to identify additional measures to reduce patients' risk of falling, such as reviewing foot wear and observing them more closely. Nursing staff completed intentional rounding charts to record care interventions such as hydration, toileting and continence care and re-positioning. Intentional rounding is a structured process, where nurses carry out regular checks with individual patients at set intervals. We saw staff completed intentional rounding at two hourly intervals. Patients had paper medicines administration record charts and records seen were legible.

Discharge summaries were completed in preparation for patient's discharge and were sent to the patient's GP.

Medical records were stored in trolleys in the doctor's office on Aston ward and the door was closed when there was no one in the room. However, on ward 11, medical records were stored in closed lidded trolleys near the reception desk and the nurses' station. This meant they were not secure and could be accessible to unauthorised people. The risk was mitigated by the fact they were near to areas where there was usually a staff presence.

Medicines

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

Medicines were stored safely in locked cupboards and refrigerators behind locked doors, or in locked medicines cupboards by the patient's bedside. Staff recorded the temperature of the rooms and refrigerators used to store medicines daily. Records showed the temperatures were recorded consistently on both wards, although the temperature occasionally exceeded the recommended limits. On Aston ward, the temperature was recorded as being 27ºC on two occasions in the month and we were shown evidence that the issue had been reported to the maintenance department. On ward 11, June temperatures were between 25ºC and 30ºC regularly. The issue had been escalated to the maintenance department and air conditioning for the room had been approved. In the meantime, staff were clear about when to report to pharmacy and the escalation process was displayed within the medicines room. Staff told us that on one occasion, the shelf life of the medicines had been reduced by pharmacy to compensate for the increased temperatures. Nursing staff completed daily checks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and recorded their use in line with requirements. A pharmacy technician or trainee completed medicines stock checks weekly.

Staff reviewed all patient's medicines regularly and provided advice to them about their medicines. A pharmacist visited ward 11 daily. They reviewed all new patients, planned discharges and monitored all drug charts. Pharmacists and other staff provided advice to patients about their medicines. A pharmacist was based on Aston ward three half days a week. This was covered by rotation of pharmacists from the Macclesfield site and they provided a full service for patients on Aston ward.

We reviewed six medicines administration records and found medicines were mostly prescribed in line with best practice and records of administration were consistently completed. We saw

evidence of pharmacy input where required. Staff recorded patients' allergies and all records were legible, clearly dated and signed. However, the designation or bleep number of the prescriber was not recorded, making it difficult to identify the prescriber at times.

Staff followed current national practice to check patients had the correct medicines. Patients told us staff checked their identity and date of birth before administering medicines and we observed this during the inspection. When patients had drug allergies a red identity bracelet was used in line with national best practice guidance. We observed that when a person was prescribed timespecific medicines for Parkinson's disease, nurses used an alarm to remind them when the medicine was due, to ensure they were prescribed in a timely manner. When a person refused their medicine this was recorded and the doctor was informed.

Incident reporting, learning and improvement

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and took action to prevent recurrence. 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.

However, there was not a systematic process in place to share lessons learned with the whole team and the wider service.

Never events

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

From April 2018 to March 2019, the trust reported zero never events relating to community inpatient services.

(Source: Strategic Executive Information System (STEIS))

Serious Incidents

Trusts are required to report serious incidents to Strategic Executive Information System (STEIS). These include 'never events' (serious patient safety incidents that are wholly preventable).

Serious Incidents (SIRI) – Trust data

In accordance with the Serious Incident Framework 2015, the trust reported one serious incident (SIs) in community services for inpatients, which met the reporting criteria, set by NHS England between April 2018 and March 2019. This was a pressure ulcer meeting SI criteria.

(Source: Strategic Executive Information System (STEIS))

We reviewed a root cause analysis into the serious incident and found there was a full

investigation of the incident, with a timeline and discussion of all relevant factors contributing to the incident. Learning was identified and results fed back to staff on the ward. Duty of candour best practice was followed.

From April 2018 to March 2019 there were 229 incidents reported for Aston ward and 217 incidents reported for ward 11. The five most frequent types of incident are listed below.

Incident Category	Aston ward	Ward 11
Slip, Trips and Falls	121	77
Tissue Viability Incidents	61	63
Medication Incidents	6	17
Delay or Failure in Treatment or Care	5	9
Staffing Incident	3	9

All staff knew what incidents to report and how to report them. Nursing and medical staff we spoke with, were aware of what an incident was, and the importance of reporting incidents. The trust used an electronic incident reporting system and staff were confident in using it. However, a member of medical staff said the process of completing an incident record took between 20 and 30 minutes and was an issue in relation to reporting incidents. They said that if reporting was more accessible, it would encourage reporting.

A member of nursing staff told us of the arrangements in place to investigate serious incidents and identify learning from them. They provided information about the root cause analysis which was undertaken to investigate the occurrence of a pressure ulcer that developed under a plaster cast while patient was on Ward 11. The investigation involved theatres, the emergency department, and plaster room. As a result of the incident, plaster care plans were developed, awareness of the importance of plaster checks was raised, documentation of plaster checks introduced and windows in plasters were used to enable skin checks to be completed.

Nursing staff told us they received feedback from incidents and learning from incidents at handover and in staff meetings. They told us of changes introduced to reduce falls for example. However, some of the medical staff including senior medical staff said they did not receive any communication on learning from incidents and they did not have any involvement in any governance meetings in which themes from incidents were discussed. One doctor said that when patients were discussed on the grand round, learning points were identified, however, other medical staff said most of the learning from incidents was informal learning from colleagues.

From November 2014, trusts were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 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 the person. Staff understood the duty of candour. They were open and transparent and gave patients and their families a full explanation if and when things went wrong. Staff we spoke with, were aware of the duty of candour legislation and the importance of being open and transparent with patients and families when mistakes were made. The trust provided a copy of letters sent following an incident, which provided an

explanation of the investigation process, a full apology and a commitment to provide the parents with a copy of the final investigation report.

Prevention of Future Death Reports (Remove before publication)

The Chief Coroner's Office publishes the local coroners Reports to Prevent Future Deaths which all contain a summary of Schedule 5 recommendations, which had been made, by the local coroners with the intention of learning lessons from the cause of death and preventing deaths.

In the last two years, there have been no prevention of future death reports relating to community inpatient services.

(Source: Universal Routine Provider Information Request (RPIR) – P76 Prevention of future death reports)

The acute and integrated community care directorate held mortality and morbidity meetings although not all medical staff engaged in them. One doctor said, "We do have meetings, but we don't have many deaths and I don't go to them." Another told us they were not invited to the meetings. A third doctor said they were asked to do investigations into deaths for the morbidity and mortality meetings and presented the cases at the meetings. They told us there was a healthy discussion at the meetings and learning was identified.

Safety performance

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and the public.

The trust monitored harm free care. Staff told us there had been a focus on reducing pressure ulcers and falls within the trust on both community inpatient wards.

The trust monitored all pressure ulcers and this was reported on the ward quality dashboard. Staff explained they had experienced a high number of grade two pressure ulcers, although they felt this was a result of better reporting by staff. Action they had taken to improve included ensuring there was regular review of pressure ulcer risk assessments. There was an emphasis on ensuring pressure relieving equipment was obtained in a timely manner and staff awareness of the importance of re-positioning patients two hourly. Records showed that pressure ulcer risk assessments were undertaken and reviewed and patients were assisted to move their position two hourly. We saw evidence of the involvement of a tissue viability nurse and referrals were made promptly. The ward manager on Aston ward said they had sat down every member of staff individually to discuss pressure ulcers and pressure ulcer prevention.

In relation to falls, the falls coordinator for the trust provided an education session within the annual clinical update. On ward 11 they told us they had identified that most falls were occurring around a meal time, so the ward had changed their meal time routine and when meals were distributed, a member of staff stayed in the bay to assist and monitor patients. Aston ward staff told us they had reduced falls over the last two years. They had introduced a cohort bay for patients at risk of falls and a member of staff was allocated to stay in the bay to monitor and assist patients. A member of staff had identified an initiative from other areas called, "Pimp my zimmer" which they had introduced. They identified that patients who needed to use a walking frame, frequently forgot to use it. Patients were encouraged to decorate their walking frame with glitzy

decorations and put their name on the frame. This attracted their attention to it and encouraged them to use it.

Is the service effective?

Evidence-based care and treatment

Staff provided care and treatment based on national guidance and evidence-based practice. Staff protected the rights of patients in their care.

However, compliance with NICE guidance was not checked.

Staff had access to trust clinical guidelines on the trust intranet system. We reviewed eight clinical guidelines relevant to the specialty and found these referenced national best practice guidance on the topic and were within their review date. Staff were able to access clinical guidelines from the National Institute of Health and Care Excellence (NICE) and trust policies from the trust intranet.

Medical staff told us they followed guidelines and pathways for the management of specific conditions such as urinary tract infections, pneumonia and diabetes. They were aware of NICE guidance and said they followed it. However, the trust did not complete any clinical audits to assess compliance with NICE guidance during 2018/ 2019. We noted that the clinical governance report for the directorate for April 2019, identified that a baseline assessment of the trust's compliance with the NICE quality standard (QS173) in relation to intermediate care including reablement was required and had not been provided.

Nursing staff used validated tools to assess risks to patients, such as the development of pressure ulcers, falls risk and risks associated with the use of bed rails. They used some standardised care plans such as a diabetes care plan and urinary catheter care plan, to ensure care was provided consistently and in line with good practice. Ward managers completed weekly audits of documentation to monitor care and identify areas for improvement. The documentation of fluid intake was a focus for improvement from audits. Records we checked during the inspection showed fluid charts were completed consistently.

We observed best practice guidance for medicines, a sepsis action tool and care bundle and other best practice guidance was displayed in the medicines room on both wards.

There was evidence of validated cognitive screening tools being used by the occupational therapists and a nationally recognised elderly mobility scale to record objective markers of physical mobility by physiotherapists. Physiotherapists were looking at the patient discharge and transfer process in intermediate care, so that patients were assessed and a plan put in place prior to the weekend to ensure there was no delay to their therapy.

Patients undergoing rehabilitation had personalised care plans which were up to date. Outcome goals were identified and were clear and personalised. All patients had access to physiotherapy and occupational therapy regardless of whether they were transferred for rehabilitation or for other reasons. Therapists considered all patients admitted to the ward to have been referred for review. We saw timely referrals were also made to other professionals such as speech and language therapy, dietetics and psychiatric liaison when required.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They monitored the amount they ate and drank when necessary. The service made adjustments for patients' religious, cultural and other preferences.

Staff measured each patient's nutritional status on admission to hospital, using a national screening tool (MUST) and a nutritional care plan was put into place based on the results of this. The screening score was reviewed and recalculated on a weekly basis. Patient's care records showed they were referred to a dietitian when staff were concerned about their food intake. A patient with swallowing difficulties was also referred to a speech and language therapist. Staff used food charts to monitor patients' food intake when staff had concerns about their eating and drinking. We noted a person's requirement for a soft "fork mashable" diet was clearly identified and a food chart was used to record the amount they ate.

Patients had hydration care plans to ensure their individual support needs were addressed. Fluid balance charts were completed to record patients' fluid intake. A doctor told us of concerns they had had in relation to patients' fluid intake on ward 11 and they were in the process of completing an audit in relation to this. The ward manager said there had been some issues with accurate recording of fluid intake and staff were focusing on this. The ward took a proactive approach to hydration needs and when a person's intake fell below 750mls during the day, they provided subcutaneous or intravenous fluids at night.

Fluid balance charts we checked on both wards showed patients were receiving sufficient fluids to maintain their health.

We also spoke with two people who had individual dietary needs, for example one person required Kosher diet and another was not able to drink cow's milk. They told us they were offered a choice

of food which met their needs. Patients provided varied feedback about the quality and quantity of food they received. One patient told us the portion sizes were small on Aston ward and others on ward 11 told us the menu was repetitive for those staying more that a few weeks. Both wards had a two week rotating menu. Patient records showed they were weighed weekly and the records we reviewed indicated patients were maintaining their weight and were not losing weight.

Pain relief

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

Nursing staff assessed patients' pain regularly, as part of their routine observations. They used a zero to 10 scoring system. They said they would use picture scales if necessary, or observe patients' facial expressions, body language and a change in behaviour, if they were unable to communicate with them. We saw evidence of pain assessment and prescriptions of pain relief medicines in patient's care records.

Patients who were experiencing pain had a care plan for the management of their pain. This identified when medicines were prescribed and when they were to be taken. A patient on ward 11 said, "I can ask for pain relief, but sometimes staff see I am in pain and they will offer me fast acting pain relief in between my regular pain relief." They went on to say they had experienced severe ongoing pain when they were at home and since coming to the ward the management of their pain was much better.

Patient outcomes

Staff assessed individual patient outcomes and achieved good outcomes for patients. They monitored length of stay, delayed transfers of care and re-admissions; however, patient outcome results were not collated to demonstrate the overall effectiveness of the service.

The trust had not participated in any clinical audits in relation to this core service as part of their clinical audit programme.

(Source: Universal Routine Provider Information Request (RPIR) – P35 Audits)

However, a doctor told us they had participated in a dementia and delirium audit and an action plan was put into place as a result. A study day for nurses on delirium had been delivered and additional pages inserted in documentation to check for delirium. The trust did not provide information in relation to the audit.

We were also made aware of two local audits related to the service which had not been registered with the clinical audit department. For example, we were told an audit of inpatient falls had been undertaken by another clinician, but we were not provided with any data to confirm this. A consultant and junior doctor told us they were completing audits of hydration on the community inpatient wards and record keeping in relation to this. Another doctor said they were starting an audit of venous thromboembolism as there had been a small number of patients presenting with pulmonary embolism.

Medical staff attended clinical audit meetings for the directorate in which findings from audits were presented and discussed. As a result, there was learning from audits in other specialties.

The service monitored length of stay, delayed transfers of care, number of discharges, readmissions and whether expected dates of discharge were set and achieved. These were reviewed and discussed to bring about improvements. Therapies staff used a range of measures of outcomes for individual patients to look at their mobility and ability to self care. For example, the Barthel score was used on admission and discharge to assess patient's independence in the activities of daily living. The trust provided evidence the average score on admission and discharge were assessed collectively to assess clinical outcomes of the service, although we did not see any evidence of comparisons with other trusts or assessments as to whether these were in line with expected levels.

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 said they received a comprehensive induction when they commenced work at the trust. This included a trust wide induction programme and local induction. A band five nurse on ward 11 said they had spent a week working alongside a Band 6 nurse on a supernumerary basis, as part of their induction. A nurse who had trained overseas said they had been provided with a very good induction and training programme when they came to the trust. Both nurses said they had felt able to ask questions if they were unsure and felt they had been well supported. A therapist also said that they had been given a full induction and they had sat down with their manager and their initial objectives had been agreed.

Nurses told us of additional courses they had attended in areas relevant to their practice. For example, a nurse said they had completed training on an aspect of wound management the day before the inspection, and another mentioned dementia training. The diabetes specialist nurse had provided training for staff on ward 11 and an external organisation had provided some dementia and delirium training for staff on Aston ward.

Junior medical staff said they were able to access their weekly teaching sessions and were allocated an educational supervisor and clinical supervisor where relevant. The trust employed some non trainee medical staff in junior and middle grade doctor roles. These staff said they did not have protected time for training and it was more difficult to attend training due to work commitments, however, they did access some of the training provided.

Therapy staff said they had access to training when they identified a training course that was relevant to their needs. They said they received good support and had access to clinical supervision.

Medical and nursing staff told us that they had sufficient support to undertake revalidation. Revalidation is a process by which doctors and nurses can demonstrate they have undertaken continuing professional development and maintained their competence to practice safely.

Volunteers were utilised to help with housekeeping duties, serve meals and sit and keep patients company. Volunteers were checked for their suitability to work with vulnerable adults and underwent trust induction and training. A small number of volunteers provided assistance to

patients with eating and these had undergone specific training to ensure they were competent to undertake this task safely.

Clinical Supervision
The trust provided the following information about their clinical supervision process:

The Trust has a clinical supervision policy applies to registered healthcare professionals who work within a clinical setting. Clinical supervision is not mandated across all professional areas. This policy excludes midwifery and medical cohorts of staff due to profession specific clinical supervision arrangements.

Every member of staff has access to clinical supervision from a clinical supervisor and may be accessed as an individual 1:1 or in group supervision. There is a template for recording clinical supervision (available via policy). A clinical supervision update is presented annually to the professional forum which is chaired by the Director of Nursing and Quality. A database of clinical supervisors is held corporately for those accessing supervision from the central access point. Individual services also offer managerial supervision in the form of group and individual supervision.

(Source: CHS Routine Provider Information Request (RPIR) – CHS4 Clin Supervision)

Therapists told us they had supervision formally every six to eight weeks with the band 7 for intermediate care and additional informal supervision every two to three weeks. Support staff in therapies had supervision with band five therapists. Band five rotational staff had supervision every month.
Nurses said supervision was available and they could request it at any time. They told us they ward managers were supportive of this.

Appraisal rates

Data provided by the trust indicated that 89.5% of nursing staff on Aston ward and 95% of nursing staff on ward 11 had had an annual appraisal as of May 2019. Therapy staff we spoke with had all had an annual appraisal. Staff said their appraisals were constructive and they discussed their personal development and training needs. A health care assistant said they were being supported to become a trainee nurse associate after this was identified in their appraisal and they were completing their key skills training in preparation for this.

Multidisciplinary working and coordinated care pathways

All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies.

Information provided by the trust stated in relation to multi-disciplinary team working:

The multidisciplinary team in intermediate care includes general nursing and advanced nurse practitioner support, social work, physiotherapy and occupational therapy. The teams aim to

provide integrated, goal focused, person centred care for patients in both bed bases and their own homes with the aim of avoiding admission to hospital or supporting early discharge. In support of the integrated intermediate care teams, an integrated discharge service (made up of nursing, social care and therapy) identifies individuals in the acute setting, develops the initial plan based on their assessment in order to support individuals to return home (or intermediate care) in a timely manner and based on Home First principles. (CHS PIR MDT tab)

We observed excellent multi-disciplinary team working in both community inpatient areas throughout the inspection. The different professionals worked closely together to provide care and treatment and maximise patient outcomes. All staff reported good working relationships and this was apparent from our observations.

Morning board rounds were held in both wards and were well attended. On ward 11 the integrated discharge team attended board rounds. We attended a board round on Aston ward and found it was well structured and key members of the team were present, including a physiotherapist, two occupational therapists, a social worker and two registered nurses. Each patient was discussed in relation to the next steps in the pathway towards their discharge. Each member of the team provided a specific update on their input. The board was updated with the information, and dates were changed to match the information being discussed. There was challenge and support by the different members, to ensure the best outcome for the patients and each member of the team was given new actions for the day. It functioned efficiently and was completed in a timely way.

Formal multi-disciplinary meetings were held weekly when all admissions in the previous week were discussed and there were regular multi-disciplinary discharge planning meetings. We reviewed the notes of one discharge planning meeting that was attended by a full range of professionals, the patient and their family member. Actions were agreed and a management plan was developed.

The integrated discharge team worked closely with staff to assist with complex discharge planning and when patients required fast track discharge at the end of their life. Staff made sure the required care packages were in place prior to discharge and there was good communication with the relevant professionals who would be providing services after discharge.

Specialist nurses regularly visited ward 11 and could be requested to visit Aston ward. This included the tissue viability nurse, diabetes nurse, respiratory nurse, chronic and acute pain team and an admiral nurse for dementia. We were made aware of delays in responses to referrals for psychiatric input. The trust reported they no longer had a community psychiatric nurse attached to the service. Staff on ward 11 said there were waits of a few days if a psychiatrist was needed although access to a community psychiatric nurse was more timely. Aston ward said they were experiencing longer waits for psychiatric input and said recently it had taken approximately two weeks to obtain a review of a patient by a psychiatrist. The trust were unable to provide any data on wait times from referral to review.

Health promotion

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

The initial assessment process when patients were admitted to ward 11 and Aston ward, included information about the patient in relation to smoking, alcohol, physical exercise and a mental health score. Patient records did not contain any information about advice given to patients in relation

these issues, however, staff told us they used it as an opportunity to discuss these issues and promote a healthier lifestyle.

Patients who were smokers were offered nicotine patches to reduce their reliance on smoking and they were offered a referral to the smoking cessation service. Patients with diabetes were seen by the diabetes nurse specialist whilst in hospital.

A breakfast club was held by therapy assistants to promote patient's independence and assess their independent living skills. Staff used this as an opportunity to promote healthy eating. The rehabilitation programme was focussed on patients regaining their ability to live independently, promote healthy lifestyles and prevent admission to hospital.

We saw there were a variety of information leaflets available on both wards. These included information on eating well, dementia and delirium and personal alarms at home.

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 agreed personalised measures that limit patients' liberty.

Patients said they were asked for their permission before staff provided care and treatment and we saw examples in patients care records where they had signed to give their consent to receiving intermediate care. Therapists said they gained verbal consent in their initial interviews with patients and checked with them each time they provided care. Therapists documented that patients had consented to their input in their daily records of care.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and be as least restrictive as possible.

Staff we spoke with were aware of the requirement to complete a mental capacity assessment and to act in the patient's best interests when patients were unable to make a specific decision for themselves. Some staff described how sometimes people had fluctuating capacity and a member of staff identified a patient who had lacked capacity to make most decisions when they had been admitted and who was now improving and could make some decisions at some times of the day. They explained how they assessed the person's capacity on a day to day basis to identify when they were able to make a decision with support and when they lacked capacity. They described how they involved their relatives and other professionals in the best interest decision making process. We saw evidence of best interest decision making meetings and a multi-disciplinary approach throughout. Staff involved independent mental capacity advocates when the patient did not have any family or informal carers to be involved in determining the person's best interests.

However, documentation of mental capacity assessments did not always evidence a decision specific approach to assessing capacity and although the trust provided a form for staff to complete in relation to the capacity assessment, there was no documentation in some cases of the outcome in terms of the best interest decision, other options that had been considered and why it was the least restrictive option for the patient. Despite this, our discussions with a wide range of staff, gave us confidence that the requirements of the Mental Capacity Act were being followed.

Deprivation of Liberty Safeguards (DoLS) protect patients who are subject to restrictions that deprive them of their liberty and are unable to make decisions when they are in hospital and care homes. Some patients had DoLS authorisations in place and the trust had followed the correct process for assessing the patient's mental capacity and gaining authorisation to restrict their liberty in certain ways to maintain their safety. Copies of the DoLS authorisations could not be initially located for two patients on ward 11 when we asked to review them. However, the trust quickly located them and ensured a copy was available in each patient's care records.

Is the service caring?

Compassionate care

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

Patients we spoke with on Aston ward and ward 11 told us staff were friendly and helpful. They said staff were kind and caring in their approach. Patients said staff were attentive to their needs and offered to help them when they needed it. One patient said, "Staff are absolutely lovely; I haven't found anyone who isn't willing to do anything for you."

We spoke with four patients on Aston ward and three of these praised the kindness of staff towards them. However, we spoke with one patient on Aston ward who said they had experienced a poor response from one member of staff at night on one occasion, when they had asked for assistance to the toilet. They said they were first told to wait and the staff would come back. When they pressed their call bell again as the staff had not returned, the staff member told them they didn't need to go and left them without assistance. We asked the ward manager if they were aware of any issues with night staff and they told us they were very surprised and would investigate immediately. They provided us with assurance that this type of issue had not been reported previously and they would address the concerns raised.

Patients told us their privacy was respected and they were able to have a confidential conversation when necessary. Staff were able to explain the steps they took to protect people's dignity during care. For example, a member of staff spoke about patients who needed assistance to the toilet, saying they would ensure the call bell was within reach and knock and check if the patient had been there a while. They told us they tried to have private conversations away from the bed if the patient was in a bay area.

We observed a range of staff as they interacted with patients, reassuring them and explaining what they needed to do. For example, we observed therapists working with patients on their mobility. They greeted each person by name, and each step was explained during the procedure. We heard staff gently reminding a patient of a decision made in a discussion the previous day, when they had fluctuating capacity and difficulty with short term memory loss.

Emotional support

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

Staff spoke about the difficult decisions patients and families had to make during their stay in intermediate care, in relation to whether they would be able to return home, their changing support needs or a possible move to residential care. Staff showed empathy and understanding towards the patients they cared for and provided reassurance and support to them.

A member of staff said that due to the length of time some patients were on the ward, the staff often supported family members with difficult issues. They also signposted patients and families to the patient advice and liaison service where appropriate.

The chaplaincy team provided religious care, spiritual and pastoral support to patients, visitors and staff of all religions, beliefs and world views, including those with no religious belief.

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.

Patients told us they felt they were involved in the decisions about their care. Patients were aware of plans for their care and treatment and said they had been provided with the information they needed to help them make decisions. One patient we spoke with said, "We are having a meeting today to talk about what happens next, as I am unable to walk." They told us they felt they could ask questions and when they asked, staff responded and explained things to them well. Other patients were aware of the plans for their care and said staff kept them up to date as their treatment progressed.

Patients said they saw the doctors regularly and the consultant each week. They said medical staff gave good explanations and listened to their views. One patient said, "They treat you like a person, not like a number and they listen."

Staff told us and we observed in care records, that patients and their families were involved in care planning and discharge planning meetings. We observed there was information available for patients and families about voluntary organisations and support networks that could provide support and advice. We noted that on Aston ward there was a poster headlined: "To patients,

carers and relatives," asking them to speak with staff and be involved in decisions about their care and with the strap line: "No decision about me, without me."

Is the service responsive?

Planning and delivering services which meet people's needs

The service planned and mostly 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.

However, the adaptations of the environment and facilities for people living with dementia were limited.

The trust had worked as partners in the East Cheshire, "Caring together" programme with stakeholders including the other providers and the commissioners of health and care services. This was transformation programme aimed at joining up health and social care, helping people to stay well and providing integrated care. It engaged with patients and the local population to ask for their views about what could be done to improve the quality of care and service provision.

The senior management team said that as part of this programme they had completed a number of reviews looking at the local population demographics and care communities. They identified there was a high percentage of people over 80 years of age in Macclesfield and high levels of frailty. Intermediate care provided an opportunity for older and frail patients to regain their independence following illness or injury and provided a stepping stone towards returning home.

The local commissioners were also investing resources in identifying frailty in older people and providing a comprehensive assessment of their needs. The integrated discharge team were all frailty champions and training was provided for staff.

The primary focus of ward 11 and Aston ward was on intermediate care and therefore rehabilitation. They catered mainly for patients over 65 years of age and we did not find any evidence of admission of patients who were very young. However, patients admitted to the wards, particularly ward 11, were not always patients who were able to undertake a rehabilitation programme and some on ward 11 had continuing medical needs. Staff identified there were some issues with meeting the expectations of patients admitted to the community inpatient wards in relation to the level of therapy provided, as they were frequently told by staff in other areas that they were being transferred to the wards for a period of intensive therapy. They explained that the input from all staff was aimed at being therapeutic and contributed to patients achieving greater levels of independence, as opposed to being time spent with them by the physiotherapist. The service had responded to this feedback from patients by developing rehabilitation assistants to support the physiotherapists and occupational therapists and implement rehabilitation and exercise programmes set by them, to provide additional input for patients.

Ward 11 provided an environment which generally met the needs of patients with reduced mobility and provided a number of areas for patients to relax and spend their time and regain their independence, such as a dining area with tea and coffee making facilities, a conservatory and small walled garden area. An artistic mural in the garden was also planned. The ward had areas for therapists to work with patients on mobility and activities of daily living. There was access to rehabilitation facilities such as a small physiotherapy gym, and a kitchen for making hot drinks and basic meals. There were some adaptations to make the environment more accessible and safe for people living with dementia, such as contrasting colour schemes and a range of activities were available for people to engage with. However, the adaptations to the environment were minimal and we did not see visual aids used to orientate people to time and date or identify facilities. There was a mix of bays and single rooms enabling the ward to adhere to same sex accommodation requirements.

Aston ward had similar facilities to ward 11; it was pleasantly decorated and had some wall art which made the environment less clinical. Staff told us the wall art had been introduced following engagement with patients and staff had raised funds to purchase it. Fund raising was continuing to create further wall displays. There was a day room where patients could spend their time if they wished and a library area within the dayroom stocked with a range of books. Feedback from patients and relatives has also led to improved lighting being installed outside the unit and additional footstools being purchased. However, adaptations for people living with dementia were limited.

Ward moves

The trust was asked to list ward moves for a non-clinical reason during the last 12 months. For example if a patient has to move wards several times because there is no room in the speciality ward they should be on.

Between March 2018 and February 2019 there were no ward moves for any non-clinical reason for patients within community inpatient services.

(Source: Universal Routine Provider Information Request (RPIR) Universal P43 – Ward moves)

Moves at night

The trust was asked to list ward moves between 22:00 and 08:00am for each core service for the most recent 12 months

From March 2018 to February 2019 the trust reported that there were no moves at night for community health inpatient services.

(Source: Universal Routine Provider Information Request (RPIR) Universal P44 – Moves at night)

Mixed sex breaches

Mixed Sex Breaches are defined by CQC as a breach of same sex accommodation, as defined by the NHS Confederation definitions. Whilst these are specifically for mental health providers the same definitions apply to community health service and acute providers from a CQC perspective. Also included is the need to provide gender sensitive care, which promotes privacy and dignity, applicable to all ages, and therefore includes children's and adolescent units. This means that boys and girls should not share bedrooms or bed bays and that toilets and washing facilities should be same-sex. An exception to this might be in the event of a family admission on a children's unit, in which case brothers and sisters may, if appropriate, share bedrooms, bathrooms or shower and toilets.

The trust reported that between April 2018 and February 2019 there were no mixed sex breaches within community inpatients services.

(Source: Universal Routine Provider Information Request (RPIR) P47 –Mixed sex)

Meeting the needs of people in vulnerable circumstances

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.

Patient's individual needs were assessed on admission to the wards and their care and treatment was planned individually. Patients who were ready for rehabilitation had an individual programme developed with them.

Staff were not aware of the accessible information standard that makes sure people that have a disability, impairment or sensory loss, are provided with information that they can easily read or understand and are supported to communicate effectively. However, patients were provided with accessible information. Patients with communication difficulties were referred to speech and language therapy where appropriate and a plan was put into place to cater for their individual needs. Picture charts were used and other communication aids. Information was available in large print and easy read format. On Aston ward, they kept a box in the office with a range of aids for communication. One of the occupational therapists had a basic knowledge of Makaton. They had audio books and a talking newspaper for the blind.

The trust used an alert sticker on the front of care records to indicate that a person had an information and/or communication support need. The trust told us that information could be provided in large print, braille or audio format. They also had an alert and flagging system for

patients with learning disabilities and/or autism and patient's information and communication needs could be recorded on this system.

Staff had received training in relation to dementia and delirium and they were able to explain how they assisted patients who were anxious and confused to calm them and gain their cooperation. An admiral nurse had been appointed to provide specialist advice and support for patients living with dementia.

Both wards encouraged people to get dressed each day and to bring in items to allow them to go outside. Neither of the wards employed activities coordinators or had a programme of planned activities for patients.

On Aston ward the ward manager said the rehabilitation assistants did activities with patients, although there was no activities schedule. They said they had a stock of reminiscence aids which one of the staff used to hold reminiscence sessions for groups of four or five patients at a time. Other staff did exercise classes with patients and a variety of aids including sponge balls and movement to music. Other activities provided included bingo, visits from a local choir who held singing sessions to help improve patients well being and assist with memory stimulation. "Twiddlemuffs were provided for patients with dementia to provide sensory stimulation and keep their hands occupied.

There were regular visits from a PAT (Pets as Therapy) dog to ward 11, introduced in response to feedback from patients who were dog owners and missed their companions while on the ward. A local community choir also visited and performed for patients. Ward 11 provided patients with additional comforts such as their own hand-knitted blankets, toiletries and Christmas presents during the festive period funded from the local community.

Patient passports or "This is me" documents were utilised to identify patient's individual needs and adjustments that were needed to improve their experience of care and maximise their involvement. The service had access to the local mental health trust's community learning disability team health facilitators who could be contacted for advice.

Staff told us it was unusual for a patient with learning disabilities to be admitted to the community inpatient wards. However, they told us that when they were, staff liaised with family and carers to find out the adaptations they could make to meet the patient's needs. Family and carers were encouraged to participate in the patient's care if they wished.

Interpretation and translation services were available either by telephone, face to face or British sign language. Staff were aware of how to access the service but told us it was unusual to need the service.

Access to the right care at the right time

People could not always access the service when they needed it and receive the right care in a timely way. Criteria for admitting patients were not clear and patients were admitted to intermediate care who extended stays and there was no clear plan for their discharge.

The trust provided information about the number of patients per month, who were waiting for intermediate care and the number of days patients waited. From June 2018 to May 2019 there were on average 64 patients per month waiting for intermediate care and 409 bed days per month spent waiting for an intermediate care beds.

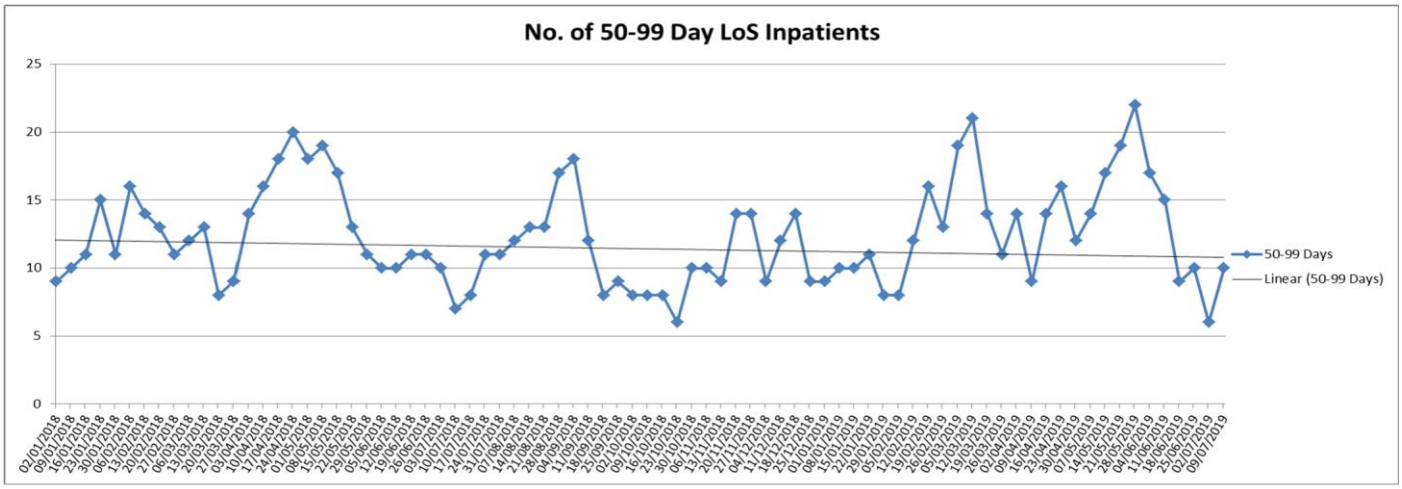
The service did not have any current formally agreed criteria for admission to the community inpatient wards. The original criteria were based on providing intermediate care and the senior management team told us they had tried to expand the original limited criteria to meet the needs of patients within the wider trust. Ward 11 was used to accommodate patients with additional needs, due to demands on bed capacity in the rest of the trust. Patients were admitted to both wards who were not able to undergo rehabilitation and therefore did not receive full benefit from the expertise and resources provided on these wards. This could have an impact on access for patients requiring rehabilitation who did not have access to the specific expertise on the intermediate care wards. In mitigation, managers said patient on other wards received input from occupational therapists and physiotherapists.

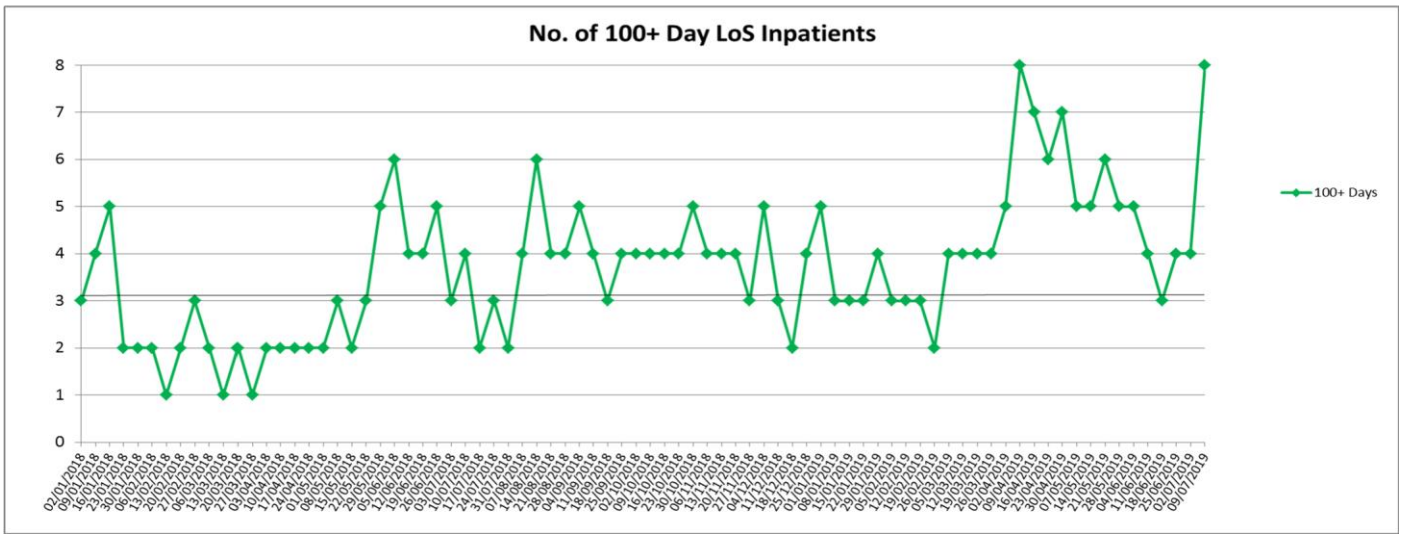
Aston ward was situated away from the acute hospital site at Congleton War Memorial hospital and as a consequence, there were no acute care facilities on site and no medical presence overnight and at weekends. Therefore, patients admitted to Aston ward were medically fit and if they became clinically unwell, they were mostly transferred to Macclesfield General hospital. Staff told us they did not admit patients requiring intravenous antibiotics. Most of the patients who were admitted to Aston ward, were admitted for rehabilitation, or who were awaiting assessments for continuing health care, awaiting residential placement, or packages of care. However, there were patients on the ward that could not follow a rehabilitation programme. The trust did not provide neurology services. If patients required this level of support they would be transferred to another trust.

Ward 11 was on the Macclesfield General hospital site and had access to medical staff 24 hours a day, seven days a week. This enabled patients who continued to require medical treatment to be cared for on the ward safely. Patients were admitted to the ward with confusion, mental health needs and significant physical health needs and some patients were cared for on the ward for an extended period. At the time of the inspection, two patients on ward 11 had been on the ward for several months and there were no immediate plans for their discharge. The nurse staffing for the ward was based on providing intermediate care and therefore did not account for patients who had higher acuity and dependency needs. Staff told us patients were transferred to the ward despite them not having the ability to undergo rehabilitation and this also caused confusion for families who had unrealistic expectations of what could be achieved. Access of patients and flow through the unit was therefore affected.

Bed occupancy in year to March 2019 was above 98% on ward 11 and above 95% on Aston ward in same time period. *(Source: PIR)* This is well above the recommended limits and was evidence of the potential impact on access and flow.

The average length of stay (LoS) by month in the year to March 2019 ranged from 16.9 days to 28.8 days on Aston ward and 25.1 to 42 days on ward 11. These figures do not fully reflect the extended length of stay of individual patients. Weekly data provided by the trust showed that from January 2018 to July 2019, between two and eight patients had stays of over 100 days and between six and 22 patients had stays of between 50 and 99 days. As can be seen from the graphs below, the number of patients staying over 50 days showed a small decrease over the previous 18 months.





(*Source: DR145)*

We were told of some delays to rehabilitation of patients on Aston ward due to a lack of prompt access to outpatient orthopaedic review of post operative orthopaedic patients in relation to their weight bearing status. Orthopaedic outpatient clinics were held at Congleton Ward Memorial hospital each week. However, patients had to be seen by their own orthopaedic consultant; consultants would not review another consultant's patients. Therefore, patients had to be taken (with a member of staff) to Macclesfield General hospital if the consultant did not have a clinic at

Congleton or wait until the consultant was at Congleton. This could impact on the patient's overall length of stay.

The trust provided the following data on the largest Black and Minority Ethnic (BME) groups within the trust catchment area of Tameside.

The largest ethnic minority group within the trust catchment area is Polish with 1% of the population.

	Ethnic minority group	**Percentage of catchment population (if known)**
First largest	Polish	1%
Second largest	Irish	0.60%
Third largest	Asian / Asian British	0.60%
Fourth largest	Other Western Europe	0.40%

(Source: Universal Routine Provider Information Request – P48 Accessibility)

The teams on both wards took a proactive approach to discharge planning. An expected date of discharge was agreed and reviewed at multi-disciplinary team meetings and at board rounds. The integrated discharge team at Macclesfield General hospital were active on ward 11, supporting staff to ensure discharges were planned and delays to discharge reduced. All patients staying over 21 days were reviewed regularly to identify reasons for their extended stay and remove any blockages to their discharge where possible. Staff worked well together on both wards to plan discharges and ensure there was good communication between the hospital and community providers.

However, there were a minority patients with an extended stay in the service. When we spoke with staff they identified reasons hindering the patient's discharge in relation to their ongoing health or social care needs, but there continued to be no clear plan for their discharge.

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.

Complaints

From April 2018 to March 2019, there were no complaints about community inpatient services.

(Source: Universal Routine Provider Information Request (RPIR) – P52 Complaints)

Patients on both wards said they would speak to one of the nurses or the ward manager if they had a complaint. Patients were aware of who the ward manager was and had confidence that their complaint would be dealt with appropriately.

We saw information about how to make a complaint and the patient advice and liaison service (PALS) was available in the leaflet racks on the wards. The patient information leaflet for ward 11 had contact details for the customer care department within the trust.

Staff told us they tried to deal with any concerns as they occurred and found that good communication reduced the number of complaints received. Senior staff said that concerns raised tended to occur when relatives thought their family member was being moved to the ward for rehabilitation, but the patient was not ready or able to undertake a rehabilitation programme.

Ward managers said complaints and learning from complaints would be discussed at ward meetings and were monitored within the ward dashboards.

Compliments

From April 2018 to March 2019, there were no compliments about community inpatient services.

(Source: Universal Routine Provider Information Request (RPIR) – P53 Compliments)

We saw thank you and compliments cards on both wards, however, these were sent directly to the ward and not registered with the trust.

Is the service well-led?

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.

Community inpatient services were classified as intermediate care and were managed within the directorate of acute and integrated community care. There was an associate director for the directorate and under this were two general managers, one for urgent care and frailty and the other for acute care. The acute care general manager post was vacant at the time of the inspection and intermediate care sat within acute care. There was a matron for intermediate care. In addition there was a clinical director for the directorate.

We met with the associate director for the directorate and senior nurses. The matron and clinical director were not available during the inspection. The team had a good understanding of the performance within the service and key challenges. Staff within the directorate worked well together and the matron team provided cover for the medical wards and the intermediate care wards, including a matron of the day role. The intermediate care wards benefited from inclusion in the wider directorate meetings to share practice, gain peer support and discuss performance issues.

There was a separate structure for medical leadership with a clinical director for the directorate. Junior medical staff working in intermediate care were within the medical rotation and the rota and on call arrangements fell within medical services.

Staff on ward 11 said the matron normally attended the ward approximately twice a week and the matron of the day visited the wards in relation to staffing issues. The matron visited Aston ward once a week and the ward manager said other matrons kept in touch. Ward managers and other ward staff told us the matron was approachable and supportive. They felt they would be able to raise issues with them when needed. Staff on both wards said it was unusual to see any more senior staff on either ward.

Nursing, therapy and medical staff were extremely positive about the leadership shown by the two ward managers and their knowledge and understanding of patient care and operational issues. The ward managers were both enthusiastic, organised and acted immediately to address any issues we identified during the inspection. They had a good grasp of the ward's performance and quality issues.

There were regular staff meetings on both wards that were open to all professions. Staff had the opportunity to add items to the agenda and notes of the meeting were circulated and available on the wards afterwards. Ward managers said they did a daily walk around of the ward, speaking to patients and checking on care. Patients we spoke with were familiar with who the ward manager was and said they saw them on a regular basis.

Therapy staff met with the rest of the community therapy team on a regular basis and there was also a wider meeting for all therapy staff in the trust. They were also included in ward meetings.

Vision and strategy

The service had a vision for what it wanted to achieve but did not have a strategy to turn it into action, developed with all relevant stakeholders. There was a trust vision and clinical strategy which 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 a vision to 'deliver the best care in the right place.' Staff we spoke with, although not using these specific words, gave us the essence of the vision, speaking about providing the highest quality of care, evidence based care, providing patient choice and being in the right environment for the patient or getting the patients back home to their families.

The trust provided an update of their clinical strategy, which focused on:

- Improving health outcomes
- Responding to the changing needs of the population
- Meeting rising quality and safety standards
- Shifting care from treatment to prevention
- Shifting care from hospital to community
- Increasing market share for some services
- Recognising when others are better placed to provide services.

The strategy identified key challenges for the trust and an update of the strategy for 2019 identified progress to date. The sustainability of services was a key factor in the strategy. However, there

was no specific mention of community inpatient services or intermediate care. The trust did not provide us with further detail of plans for the service. However, we were made aware there were high level discussions to determine the future direction of services.

Senior managers spoke about the work being done in developing care communities and frailty initiatives within community and acute services. They recognised the importance of building relationships and integrated working with other care providers, and with better engagement between GPs and consultants in order to provide services in the best place for the patients. Their involvement in cross organisational initiatives such as the frailty project, demonstrated their commitment to working with all stakeholders and ensuring services were sustainable.

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.

The focus of all staff of all professions we met during the inspection, was on the well being of patients and the provision of patient centred care. There was excellent team working and good communication between all professions. This was observed during the inspection, where we saw each member of the team were able to contribute their knowledge and experience to achieve the best outcomes for patients. We observed staff were not afraid to challenge each other in a constructive way in discussions about treatment plans for patients and were supportive of each at other times, to achieve the best outcome for patients.

Staff we met during the inspection were welcoming, professional, friendly and helpful. They were open with us and staff said they were always encouraged to be open and honest. The understanding of the duty of candour was variable amongst staff, however, they were able to explain the basic principles of openness and apologising to patients when things went wrong. The trust provided us with evidence that they were adhering to the requirement of the duty of candour.

Managers were proud of the levels of pastoral care provided to staff and they recognised the importance of helping staff to maintain their health and well-being. They sourced counselling for staff when necessary and provided open access for staff to discuss any concerns or issues.

The trust had a Freedom to Speak Up policy (whistleblowing policy), which contained details of the processes staff could follow if they wished to raise a concern. Staff were aware of the policy and said they would be able to use it if necessary, although they were confident issues would be dealt with at local level and they would not need to use it.

Governance

Leaders operated effective governance processes, however, there was limited engagement of medical staff in some governance processes. 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 was a directorate clinical governance framework and monthly clinical governance meetings in the form of SQS (Safety, Quality, Standards) meetings. We reviewed the minutes of two meetings and found there was attendance from the trust governance department, operational management team and matrons. One of the two meetings was attended by the clinical director,

however, there was no other medical involvement in the meetings. Reports presented to the meetings showed there was a systematic approach to ensure key elements of governance were covered. There was a discussion of incidents, complaints, risks, clinical audits and NICE guidance and other issues affecting the quality and safety of care. Specific incidents and learning from these were discussed and disseminated. We were told at each meeting a different branch within the directorate was focused on and minutes of an SQS meeting provided a schedule for this.

Medical staff we spoke with, from consultants to junior doctors, were not aware of clinical governance meetings and told us they had not been invited or requested to attend. There was no formalised process for receiving feedback and learning from incidents or complaints and no knowledge of the risk register. Not all medical staff attended mortality and morbidity meetings.

Medical staff told us of clinical audit meetings that were held every two to three months for the directorate. There were presentations at the meetings of the findings from audits and learning from these. Medical staff were not aware of a clinical audit plan for the year. However, junior doctors told us they were expected to undertake audits and they were able to tell us of audits they were undertaking. The trust provided an audit plan for community inpatient services for the current year; however, it listed only the national dementia audit which stated there was an action plan in the process of implementation from the previous year, an audit of the use of the national early warning score, a re-audit of falls and a matron's audit. There was no indication of an audit of any other clinical outcomes or compliance with NICE guidance. We concluded that there was no structured plan to ensure a systematic approach was taken to clinical audit to ensure key aspects of the service were assessed against national and local best practice guidance, although some audits were occurring that were not registered with the governance department.

All the staff we spoke with were clear about their responsibilities and their accountabilities. Therapy staff said they were managed both by community and acute services, however, they did not have any concerns about this and they did not identify any conflicts. Ward managers within the directorate met regularly for KIT (keeping in touch meetings). They told us they found the meetings extremely helpful in terms of discussing and sharing practice, taking forward improvements to practice and they were a source of peer support.

Ward managers participated in a pressure ulcer prevention focus group alongside other senior nurses within the trust. Regular monthly meetings were planned as part of the quality strategy 2019-2022. The aim was to achieve a reduction in the development of grade two and three pressure ulcers by 10% for 2019-2020, and to eliminate grade four pressure ulcers completely.

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.

A directorate risk register identified the key risks within the directorate for acute and community integrated care. Two risks were identified for Aston ward in relation to generator supply and medical cover if the staffing arrangements changed. Two risks were also identified for ward 11 in relation to additional bed capacity and flooring. Actions to mitigate the risks were identified.

However, we noted that the risk in relation to the flooring on ward 11 had been in place since 2017 and remained on the current risk register.

Ward quality performance indicators were measured and these were discussed at SQS meetings and on a one to one basis between the matron and ward managers. A “Safer Metrics Report” provided information at a glance in relation to:

- Number of patients with a stay of over 14 days (with reasons for delays)
- Number of patients with an expected date of discharge recorded
- Venous thrombo-embolism risk assessment completed
- Discharges before 12 midday
- Average length of stay
- Number of discharges and transfers by day of the week

Another dashboard was provided with detailed data for the year 2018/2019 on admission and discharges, length of stay, monthly bed occupancy, discharge destination, patients on self-medications, re-admissions, and average Barthel scores on admission and discharge.

There were multi-disciplinary weekly meetings to discuss and review patients with a length of stay of over 21 days to look at reasons for delays and any action that could be taken to overcome blocks to discharge.

There was also a ward quality dashboard that covered quality indicators including, pressure ulcers, falls, number of patients with C. difficile infection, MRSA bacteraemia, friends and family test, complaints, late observations and workforce indicators such as vacancies and appraisals. Ward managers told us these indicators were also discussed with their matrons on a monthly basis. We asked for copies of the dashboard, however, the trust did not provide it.

The trust had a major incident policy and a business continuity policy. Staff on Aston ward said they had undertaken an evacuation exercise a few weeks prior to the inspection. Staff were aware of their responsibilities in the event of a major incident.

Information management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

A range of information was available to enable managers to assess and understand performance in relation to quality, safety, patient experience, workforce, operational performance, and finances. The trust had identified targets for some of their performance indicators and rated performance using the traffic light, RAG (red, amber, or green) rating system. This allowed managers to assess their performance at a glance and identify those areas which required further improvement or investigation. However, we noted the displays at the main entrance to Aston ward, provided different figures for numbers of discharges per month, as compared to the safer metrics report. Staff at ward level were not able to explain the reason for this and told us the displays at the main entrance were supplied by a central trust team.

Most patient information was paper based and stored on the wards for immediate access. Staff did not identify any issues with availability of records or information about the patient. Staff had access to investigation results such as blood results, X rays and scans via the trust computer system for both ward 11 and Aston ward.

Discharge letters were sent to patients' GP and a copy was given to the patient. Medicines to take home were prescribed electronically. However, the patients' medicines charts had to go to pharmacy prior to the take home medicines being dispensed. This meant there were some delays when the pharmacist was not on Aston ward, as patient's medicines charts had to be sent to pharmacy at Macclesfield General hospital and the medicines returned.

Wards had white boards identifying patients in each bed, however, these were away from public view in offices.

Trust policies and clinical guidelines were available on the trust intranet. Staff told us they found it relatively easy to access policies and guidelines as they were searchable.

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.

A patient's reference group was established for the trust and managers told us they consulted with the group on a number of initiatives that were introduced within the service. This included seeking feedback from them in relation to the trust's "HelpingFlo" discharge campaign to free up hospital beds, which had a strong focus on intermediate care. Senior managers told us the session helped ensure they were communicating the campaign effectively to the public. As part of the campaign, staff and patient and public surveys were undertaken to look at people's understanding of issues around patient discharge and the best ways of communicating with people which provided suggestions for action to be taken. The introduction of an initiative to encourage patients to get dressed during the day was also discussed with the patient's reference group.

The service completed quarterly feedback from relatives and carers as well as obtaining feedback from patients. Staff on Aston ward told us they had received feedback about the food provided and as a result had made changes to the sandwiches provided at tea time. Engagement with relatives of patients with dementia, led to the implementation of a scheme where appropriate patients were encouraged to bring their own blankets or bedding in order to make their bed on the ward feel more like home, increasing their wellbeing levels and reducing confusion. Collaboration with local knitting groups led to the group supplying sensory items for patients with dementia.

The re-launch of the rehabilitation assistant role on ward 11 was influenced by feedback from relatives. We also noted ward 11 had an information leaflet for patients and relatives which described the rehabilitation process and explained what patients could expect. Feedback from patients had also led to the refurbishment and layout of the day room on ward 11 to make it more welcoming and comfortable. Liaising with patients' relatives also identified that the plastic bags used to return deceased patient's belongings to their next of kin could be perceived as impersonal, so ward staff liaised with the knitting group to create individual hand-made hessian bags to replace them.

Staff we spoke with were proud to work at the trust and proud of their clinical area. They had opportunities to give their views and contribute to collective decision making. They felt a part of the local teams and the wider trust. Although Aston ward was some distance from the acute hospital site, staff felt well connected and fully involved with the rest of the directorate. Regular staff meetings were held on both wards which were inclusive for all staff to attend and staff had the opportunity to contribute.

There was a quarterly trust newsletter for staff that covered a range of topics including stress risk assessments and a stress e-learning package, staff awards, information about a resilience programme and other staff wellbeing issues.

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.

The service was committed to improving services by learning from when things went well and when they went wrong and looking at how practice could be improved. There were regular forums where learning was discussed. Performance indicators were monitored to identify where improvements could be made.

Both wards were working to reduce length of stay and streamline discharge processes. Multidisciplinary team meetings and board rounds were organised in such a way as to maximise their effectiveness and reduce any delays to the patient journey. Good relationships between the trust and external providers were established and this had a positive impact on reducing delayed transfers of care.

A trusted assessor scheme had been agreed whereby patient assessments undertaken by the integrated discharge team were accepted by six of the surrounding long term care providers, avoiding waits for the providers to complete their own assessments of the patients prior to discharge. The senior management team told us the next step was to increase the engagement between consultants and the local GPs to agree pathways and establish more seamless services.

Staff told us of the reductions in falls and pressure ulcers they had achieved. On Aston ward they said falls had reduced by over a half in the last three years. We identified from trust data that following discharge from ward 11 and Aston ward, only one patient was re-admitted to the trust following a fall during 208/2019. This was a testament to the effectiveness of the rehabilitation programme provided on both wards.

Accreditations

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

The trust did not report any accreditations awarded relevant to community inpatient services.

(Source: Universal Routine Provider Information Request (RPIR) – P66 Accreditations)

Community health services for children, young people and families

Facts and data about this service

The children's and young person's community health service consists of a nursing team, an Allied Healthcare Professionals and Medical Team for paediatrician clinics.

The children's nursing team is made up of three different services.

- Children's Community Nursing Team provides support such as intravenous antibiotics, chemotherapy, oxygen and dressing changes in the patient's own home. This service operates from the children's ward in Macclesfield District General Hospital. The service operates for patients from birth till 16. Support can be provided for young people up till aged 19. The service provides support for 304 patients and their parents.
- Complex Care Team operates from Congleton War Memorial Hospital. They supply care and support packages to assist parents in meeting the needs of six children and young people. The service operates for patients from birth until 16. Support can be provided and is in place for young people up till aged 25.

- Children's Specialist Nursing Team is available based within the hospital. They support a programme based on the Children's ward undertaking home and school visits, including individualised care plans, school/nursery training and monitoring of the child's condition for children under the care of the children's ward. The service supports various numbers of patients at any one time, this can be up to 400 patients and their parents. Support can be provided and is in place for young people up till aged 19.

The nursing team also supplies school nursing support for Park Lane School. The school has pupils with both physical and learning additional needs. The nursing team is responsible for the physical health of the pupils whilst at school.

The Allied Healthcare Professional's teams comprised of Speech and Language Therapists, Occupational Therapists and Physiotherapists. They operate from six different locations.

- Handforth Clinic
- Poynton Clinic
- Park Lane School
- Knutsford District Community Hospital
- Pavilion House
- Congleton War Memorial Hospital
- Ashgrove Clinic

Times and days of the service provisions vary. Overall, they supply support to approximately1,500 patients. The service operates for patients from birth until16. Support can be provided and is in place for young people up age 19.

Paediatrician Community Clinics operate from Pavilion House. Referrals are received for children who are not meeting their developmental targets. Children have a development assessment and are then signposted to other services for additional support.

Is the service safe?

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

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

Mandatory training

The service provided mandatory training in key skills to all staff.

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

Core Statutory and mandatory training included health and safety, safeguarding adults and children, infection control, fire safety, equality diversity and human rights.

Core clinical e-learning included: consent, Mental Capacity Act 2005 (MCA), deprivation of liberty (DoLS), learning disabilities awareness and record keeping.

Annual clinical update sessions are bespoke (depending on role) and topics reviewed annually, this is classed as statutory due to the inclusion of basic life support (BLS).

For the community care nursing team and the complex care team, data sent following the inspection stated that core and statutory training were 100% met and core clinical eLearning was 94%.

For speech and language team, data sent following the inspection stated that core and statutory training and core clinical e-learning were 100% met.

The trust reported Preventing radicalisation/workshop to raise awareness of prevent (WRAP) training as a statutory or mandatory training module. Data supplied showed that 87% of the speech and language team, and 100% of the community care nursing team and the complex care team had completed the training. The trust target was 90%. There was no information made available regarding Physiotherapists teams, Occupational Therapist teams or Medical staff.

Staff told us that received and kept up to date with their mandatory training. However, in discussions with managers there was no consistently clear system as to how mandatory training was assessed as being completed and discussed with staff as part of their personal development.

Staff completed training on recognising and responding to children and young people with mental health needs, learning, disabilities and autism.

There were several staff members with speciality training including areas such as Autism Spectrum disorders (ASD).

Training was a mixture of on-line and classroom learning. Staff told us they were given time and encouraged to complete all mandatory training and thought that this was of benefit to them.

Across the services there where varying rates of compliance with mandatory training. Managers reported there was a priority for staff transferring from a previous provider in order that the training could be determined and supported appropriately.

Sepsis training was not included in all staff mandatory training programme. Most staff within Allied Healthcare Professionals we spoke with were unaware of any pathway to identify or escalate sepsis concerns and did not believe it impacted on the service they provided.

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.

Due to the trust's electronic staff record system not being aligned to how the CQC defined a core service, it could not separate out the safeguarding training rates for all staff. However, the data we received highlighted that paediatric physiotherapy staff and occupational therapy staff had met the target for safeguarding training. A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

For the community care nursing team and the complex care team, data sent following the inspection stated that training for children safeguarding level 3 and adults safeguarding level 2 was 100%.

For the speech and language therapy team, data sent following the inspection stated training for children safeguarding level 3 was 100%. Training for adults safeguarding level 2 was 94%. Training in safeguarding was above the trust target of 85%.

Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted

to determine whether an external referral to Children's Services, Adult Services or the police should take place.

The trust did not capture internal referrals made directly to adult social care. These referrals could not be extracted from the adult social care system. The trust was working on a system to capture internal referrals made in relation to the trust. The trust was unable to provide data per core service; data was only provided at trust level.

Safeguarding referrals at trust level were only provided for children. However, it was not clear if these referrals were within acute, mental health or community children's services.

Overall a total of 1,267 referrals for children were made over the period at trust level between April 2018 to February 2019. This was an average of 115 referrals per month. The trust did not provide a core service breakdown therefore we could not establish how many or if any related specifically to community children and young people's services.

(Source: Universal Routine Provider Information Request (RPIR) – Safeguarding tab)

Staff spoken with gave examples of how to protect children, young people and families from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff were aware of how to obtain safeguarding advice from the trust's safeguarding lead. Staff spoken with were able to explain their understanding between a general concern and a reportable incident.

Staff knew how to identify children and adults at risk of suffering or 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.

Community nursing staff were actively attending looked after children, and children in need meetings, including the local safeguarding children's board meetings, when required.

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.

All clinic and office areas were clean and had suitable furnishings which were clean and wellmaintained. Cleaning records were up to date and demonstrated that all areas were cleaned in accordance with the schedule.

Staff followed infection control principles including the use of personal protective equipment (PPE). We observed staff adhering to cleanliness, infection control and hygiene practices. Staff adhered to the 'arms bare below the elbow' protocol and washing their hands before and after contact with patients in clinics.

The most recent audit of hand hygiene undertaken by the community nursing team showed 100% compliance with hand hygiene. There were no audits made available for the speech and language team, physiotherapist, complex care, occupational therapist and medical staff.

There were enough antibacterial gel dispensers and hand washing facilities in the premises we visited.

There were no incidents recorded where a child, young person or parent had acquired an infection following treatment by the community team. Staff were made aware of any hospital acquired infections for patients supported in the community and these were risk assessed appropriately.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff managed clinical waste well. However, risk assessments for the appropriate use of equipment were not in place.

The design of the facilities followed national guidance.

Staff carried out safety checks of specialist equipment, in clinics and in the community in accordance with risk assessments.

The service had suitable facilities to meet the needs of children and young peoples' families.

The service had enough suitable equipment to help them to safely care for children and young people.

Equipment was provided after an assessment for patients to use in their own homes. The service had recently developed contracts with external services to make sure that any equipment was maintained and replaced as needed. Following an incident where the area had a power cut, the services ensured that patients in their own homes had back up equipment that was suitably charged to make sure that patients always had the equipment they needed.

Staff disposed of clinical waste safely in clinics and had arrangements in the community to make sure clinical waste was safely disposed of.

Premises used in the provision of care and treatment were visibly clean and tidy. Community services staff were responsible for cleaning any equipment used; for example, toys used by the community physiotherapy and Speech and Language Therapy staff. Childrens games and equipment for assessment and development was stored correctly and cleaned before and after each usage.

Records showed that all equipment used for patients either in clinics or in their own homes was not always consistently risk assessed for the patient's individual usage. Moving and handling equipment, including lap straps, was assessed for usage. However, risk assessments that included that the items were suitable for the intended use and those who used them had received adequate information, instruction and training were not available. **Assessing and responding to patient risk**

Staff completed and updated risk assessments for each patient and removed or minimised risks. The service had systems in place to identify and quickly act upon patients at risk of deterioration. However, some groups of staff were unaware of the systems in place to respond to the potential risks of patients who were deteriorating.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. However, the arrangements for sepsis awareness, recognition and escalation were not in place for Allied Healthcare Professionals and the healthcare assistants in the complex care team.

Staff completed risk assessments for each child and young person and updated them when necessary. Risk assessments for children and young persons' homes where staff delivered care and support were in place. Where support was provided in a school, staff followed the risk assessments in place for the environment.

The service had the ability to access mental health liaison and specialist mental health support if they were concerned about a child or young person's mental health.

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

Staff shared key information to keep children, young people and their families safe when handing over their care to others such as parents.

Shift changes and handovers included all necessary key information to keep children and young people safe.

Staffing

The service had enough staff with the right qualifications, skills 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 bank, agency and locum staff a full induction.

In data requested and provided by the trust following the inspection, the complex care team reported they provided seven full time packages of care to support families with 2.7% whole time equivalent staff. In the month of May 2019, there were 26 shifts that were covered by agency staff, with six shifts not covered. The service is supplied as support to parents in their own homes. If a shift was not covered, the parents provided the care and support.

Parents received training in meeting the individual needs of the child. Agency support was overseen by substantive staff and the service monitored their performance.

In data requested and provided by the trust following the inspection, the community nursing team reported a whole-time equivalent vacancy of 0.6. Managers informed us that they were recruiting to this vacancy. The community nursing care staff team worked part of their time on the assessment unit on the children's ward. When the children's ward was busy the staff were required to remain on the ward. This meant that the community children's nursing service was suspended during these times. In April, the service was suspended for 42.5 hours and in May 32.5 hours.

We were informed by staff and managers that there were vacancies within the physiotherapy team, the occupational therapy team and the speech and language team. There were plans in place to recruit new staff to fill the vacancies and recruit permanent staff.

The service managers could adjust staffing levels daily according to the needs of children and young people.

Quality of records

Records were stored securely. Not all records were up to date and easily available to all staff providing care.

Of the records viewed, we saw that there was a variety of different systems in place. This included electronic and paper records. The services had different systems, this meant records sharing between the different aspects of community children and young people was not always easily undertaken.

We saw some parts of the service that were entirely paper based records, although they had plans to move towards an electronic system and were planning to scan paper records onto an electronic system. As children and young people could receive care and support from the services for several years, paper records could be extensive and occupy a large central space limiting their access by all staff.

There were some aspects of the service that were predominately electronic using tablet computers in the community and allowing access in real time to records relating to the child or young persons. However, where electronic records were largely in use, paper-based records were also used meaning that ready access was not always consistently available for some key information such as advanced decisions which were a paper record not logged within the electronic system.

Paper records reviewed were inconsistently maintained. We saw that of the 17 records we viewed 12 had been not been reviewed within the last 12 months and updated in accordance with the services policy. None of the records viewed was appropriately signed by the relevant member of staff, patient or their representative as needed. Most records viewed did outline the care and treatment provided to the individual and included support arrangements to parents as necessary.

When children and young people transferred to a new team, there were no delays in staff accessing their paper records.

The service has undertaken audits on various records and was moving towards a planned structure of electronic records to facilitate staff access to records across the services of community children and young people. However, the audits viewed had not consistently identified where records had become out of date or where appropriate signatures were not available.

Records were stored securely.

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. Records varied for each team and appropriately included medication administration records for the complex care team where responsibility for the management of medicines was shared with the patient's parents.

Staff made sure that children and young people's medicines were reviewed regularly. Suitable advice to children, young people and their families about their medicines was made available.

Training and support for parents to build confidence in managing medicines such as the administration of insulin was made available to parents and children and young people.

Staff followed current national practice to check children and young people had the correct medicines.

The service had systems to ensure staff knew about safety alerts and incidents, so children and young people received their medicines safely.

Where cytotoxic medicines were administered in the patient's own home, staff carried the appropriate spill kits.

Staff were protected by ensuring that they did not carry medicines as all medicines used in the community were delivered directly to the patients home where appropriate.

Medicines were not used or available in any of the clinics.

Incident reporting, learning and improvement

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 reported all incidents that they should report. All staff spoken with knew what incidents to report and how to report them. There could be a delay in reporting incidents for community staff who did not have access to the reporting system whilst in the community. Where staff, particularly the Allied Healthcare Professionals staff and complex care team, did not have access to an electronic tablet, staff needed to return to a main base or clinic to have the incident appropriately recorded or logged. Staff and managers confirmed that staff would report the incident by telephone to their manager and make the electronic record as soon as they could. They did agree that this could potentially be up to 72 hours or possibly longer if the member of staff went on leave before they could attend a base or clinic.

The service had no never events in community children's and young person's services.

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

From April 2018 to March 2019, the trust reported no never events for community services for children, young people and families.

(Source: Strategic Executive Information System (STEIS))

Managers shared learning with their staff about never events that happened elsewhere. These were discussed at team meetings as a point of learning.

Staff confirmed that they were not aware of any serious incidents in the last year and would be made aware of any learning from these if they had occurred.

In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents (SIs) in community services for children, young people and families, which met the reporting criteria set by NHS England from April 2018 to March 2019.

(Source: Strategic Executive Information System (STEIS))

The Chief Coroner's Office publishes the local coroners reports to prevent future deaths which all contain a summary of Schedule 5 recommendations, which had been made, by the local coroners with the intention of learning lessons from the cause of death and preventing deaths.

In the last two years, no prevention of future death reports sent to the trust.

(Source: Universal Routine Provider Information Request (RPIR) –Prevention of future death reports tab)

Staff spoken with understood the duty of candour and what their responsibilities were. They were open and transparent, gave children, young people and their families a full explanation of care and support including if things went wrong.

Staff met to discuss the feedback and look at improvements to children and young people's care.

Managers and staff told us that although they had not had any serious incidents they were confident that staff would be debriefed and supported.

There was evidence that changes had been made because of feedback, this included areas such as changing equipment arrangements and the development of specific pathways.

Managers and staff gave examples of investigated incidents. Children, young people and their families were involved in these investigations as needed.

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidenced-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of children and young people.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance.

Staff protected the rights of children and young people 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 children, young people and their families.

Several care pathways were developed and used such as the autism pathway recently trialled and awaiting further funding before being recommenced. **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 adjusted for patients' religious, cultural and other needs.

Staff monitored children's nutritional and hydration needs were met for those patients they supported in their own homes.

Fluid balance records were used to monitor patients' hydration levels. These were checked monthly when records were returned to the base

Drinks were available for patients receiving occupational therapy or physiotherapy in clinic.

Pain relief

Staff assessed and monitored patients to see if they were in pain. They supported those unable to communicate using suitable assessment tools. However, the use of formal pain assessment was inconsistent across the services.

Although staff provided pain relief if needed and adjusted care and treatment plans accordingly, there was inconsistent use of formal pain assessment or guidance for the administration of pain relief across the services.

Of the care plans we reviewed for patients supported in their own homes none contained any formal pain assessment tools. We also saw that included an appropriate pain management plan, or guidance on provision of pain relief on a per required need basis.

The occupational therapy and physiotherapy services used a paediatric pain profile tool. This supported staff in awareness of both verbal and non-verbal expressions of pain in children, which included checking with parents on what was normal for their individual children. Staff adjusted care and treatment plans accordingly if a child was expressing pain.

Patient outcomes

Staff monitored the effectiveness of care and treatment on an individual basis. The staff used the findings to make improvements and achieved positive outcomes for patients on an individual basis. However, patient outcome results were not collated to demonstrate the overall effectiveness of the service.

The trust did not participate in any clinical audits in relation to this core service as part of their Clinical Audit Programme.

(Source: Universal Routine Provider Information Request (RPIR) – P35 Audits tab)

The service did not participate in all national clinical audits. Managers spoken with confirmed that there were no benchmarking arrangements in place that allowed the service to compare its performance with similar services.

Managers carried out an audit programme. The results of these were shared with the teams and actions taken to build on strengths and improve quality as needed. Managers used information from the audits to improve care and treatment.

The speech and language team utilised the therapy outcome measures (TOM). This is an outcome measure to describe the relative abilities and difficulties of a patient/client in the four domains of 'impairment', 'activity', 'participation' and 'wellbeing' to monitor changes over time. The physiotherapy team had also utilised these measures to review patient outcomes and reported that, whilst they were of use, they did not meet all their outcome needs. There were no similar arrangements in the nursing support provided. Although the therapy outcome measures were undertaken, these were used on an individual basis only, and the overall outcomes and improvement was not utilised across the service to assist in patient and service outcomes.

Competent staff

Managers held meetings with staff to provide support and development. However, the service did not meet trust targets for staff appraisal rates. In some areas rates were significantly below the trust target. Information requested from the services was not all made available

There were enough clinical educators to support staff learning and development. There was a joint training approach for relatives and carers supporting patients in their own homes. This was done to ensure that the families and staff were aware of the patients' needs. We saw evidence within the community nursing team of training competencies for both staff regarding tracheostomy and care. The complex care team were supported by a practice educator.

Managers gave all new staff a full induction tailored to their role before they started work. An induction programme was in place for new staff. New staff undertook competency assessments in line with the requirements of registration with their professional body. We saw staff competency information which was fully completed and had been appropriately signed-off by a team-leader.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of children, young people and their families. Staff undertook training specific to their job role.

The service had a clinical supervision policy which applied to registered healthcare professionals who worked within a clinical setting. Clinical supervision was not mandatory across all professional areas. This policy excluded Midwifery and Medical staff due to profession specific professional clinical supervision arrangements.

Every member of staff had access to clinical supervision from a clinical supervisor and this could be as an individual one to one or in group supervision. There was a template for recording clinical supervision. The service updated the trust as clinical supervision was presented annually to a professional forum chaired by the director of nursing.

A database of clinical supervisors was held by the trust for those accessing supervision. Individual services also offered managerial supervision in the form of group and individual supervision.

(Source: CHS Routine Provider Information Request (RPIR) – Clinical Supervision tab)

The Allied Healthcare Professionals had developed peer to peer supervision. This was designed to provide each professional with a safe space to discuss any areas of concern, practice development or clinical development. Everyone had received training on how to provide appropriate peer supervision. Staff spoken with told us that they found this particularly useful.

Due to the trust's electronic staff record system not being aligned to how the CQC defined a core service, it could not separate out the appraisal rates for all staff. However, the data we received highlighted that the 90% target rate for appraisals was not consistently achieved. Data sent following the inspection showed that the Complex Care team were above the target, as where paediatric physiotherapists and occupational therapists. The Speech and Language Therapy were just below the target at 86% and community nursing team latest rates were significantly below at 20%.

Managers and staff spoken with reported there was not a supported formal clinical supervision process as outlined by the trust. They however confirmed that regular meetings were held with minutes available for all to assist in sharing clinical best practice.

Managers and staff confirmed that any identified training needs were recognised with support given to attend relevant courses.

Staff stated that they had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge.

Managers were confident that they made sure staff received any specialist training for their role.

Managers identified poor staff performance promptly and supported staff to improve.

Multidisciplinary working and coordinated care pathways

All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies. However, transition arrangements of children and young people were not monitored to ensure that they were in line with national standards or met patient individual needs.

Staff held regular and effective multidisciplinary meetings to discuss children and young people and improve their care.

Staff worked across health care disciplines and with other agencies when required to care for children, young people and their families. This included working with education and private health and social care services as needed.

Staff referred children and young people for mental health assessments when they showed signs of mental ill health, depression.

Transition pathways from children's services to adult services were not always clear. There were no individual plans in place that had been discussed and agreed with the parents and the children and young people. Staff spoken with did say they took some role in transition planning, but this was in the final weeks before the patients services came under the responsibility of adult care. Support from the teams for transition was not in place and staff spoken with had no advanced links with transition services. Records viewed for children and young people over the age of 16 and approaching 18 had no records in relation to any transition discussion or plans.

Between 12 March 2018 to 16 March 2018, Ofsted and the Care Quality Commission (CQC) conducted a joint inspection of the local area of Cheshire East to judge the effectiveness of the area in implementing the special educational needs and disability reforms as set out in the Children and Families Act 2014.

Their findings highlighted several good practice areas in relation to community health support such as professionals working across the area being proactive in identifying where the needs of children and young people could be met. Other strengths included health staff engaged in multi-agency working to help safeguard children, which ensured that children's health was considered as part of ongoing multi-agency assessments. There were also areas for development, such as in health autism spectrum disorder diagnostic pathways across Cheshire East as these were inconsistent and not compliant with NICE guidance. Children under four years of age were not able to access

any diagnostic pathway in parts of the area. As a result, the service implemented an autism spectrum disorder diagnosis pathway that assisted in the diagnosis. The pilot was successful as a suitable diagnosis pathway and made available for those children who needed it. The service is awaiting additional funding to continue the pathway following the pilot.

Health promotion

Staff gave children, young people and their families practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support available. This included information for parents and signposting to additional services as needed.

Staff included an assessment for each child and young person's health when they started the service and provided support for any individual needs to live a healthier lifestyle.

Consent and Mental Capacity Act

Staff did not consistently support children, young people and their families to make informed decisions about their care and treatment. They did not consistently know how to support children, young people and their families who lacked capacity to make their own decisions or were experiencing mental ill health. When patients reached the age of 16 the service had not considered their responsibilities regarding legal and appropriate consent to care and treatment.

The arrangements for patients' rights to be protected under the Mental Capacity Act 2005 were not effective. Mental capacity assessment records were not available as needed and there were no corresponding best interests records.

Of the records viewed for patients over the age of 16, managers and staff spoken with identified that six of the patients did not have capacity to agree to the care and treatment provided. None of the six records contained any capacity assessment or any best interest discussion record.

We reviewed three advance decision making records for patients aged over 16. None of these had evidence that these been discussed with the young person or that there was any previous Gillick competency assessment to assist in the decision making. Gillick competence is where a child under the age of 16 and can consent to their own medical treatment without the need for parental permission or knowledge.

Staff stated that two of the patients who had an advanced decision in place did not have capacity but there was no information within the records that the young person's capacity had been reviewed or that best interests had been explored.

Records reflected and were confirmed by staff that it was mostly parents who provided consent for procedures on behalf of their child. None of the staff spoken with demonstrated an understanding of the Mental Capacity Act 2005 and obtaining decision specific consent. None were aware of when there could be a need for lasting powers of attorney in relation to young people who had legally come of age. Staff were unaware that the Mental Capacity Act 2005 applied to patients from the age of 16.

Parents we spoke with told us staff had discussed the care and treatment plans for their children with them. However, there were inconsistent records with signed confirmation that parents had been involved in the development of, or agreed to, their children's care plans where the decision was still legally the parents or responsible persons.

We were informed that the Mental Capacity Act 2005 training formed part of the mandatory training. However, the trust did not supply data that determined how many staff had received up to date training.

There were no arrangements in place for managers to monitor how well the service followed the Mental Capacity Act and to make changes to practice as needed.

After the inspection, the trust provided information that immediate action was to be taken to ensure staff are aware of documentation requirements for best interest aged over 16. Training was to be provided and a patient leaflet to assist in parental understanding was to be developed.

Is the service caring?

Compassionate care

Staff treated children, young people and their families with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for children young people and families. Staff took time to interact with patients and those close to them in a respectful and considerate way.

Children, young people and their families said staff treated them well and with kindness. There was a strong, visible person-centred culture. We observed interactions between staff and patients who used services that were positive, individual and nurturing in nature. This included support to parents that took the time to ensure that parents were also supported.

Staff followed the services policy to keep care and treatment confidential. Records were kept in patient own homes with copies returned to the base office.

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

Staff understood and respected the personal, cultural, social and religious needs of children, young people and their families and how they may relate to care needs.

Proactive supportive relationships with the patient and their families were in place. We were given an example in Complex Care where the relationship between staff and the parents of the child did not function appropriately. Action was taken to maintain a professional stance.

We reviewed several comments from patients and their families. Comments expressed thanks to the team as well as to individual staff members. Patients relatives spoken with were very positive in their support from staff.

Emotional support

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

Staff gave children, young people and their families help, emotional support and advice when they needed it. There were arrangements for the service to refer patients and their families for talking therapies if needed.

Staff supported children, young people and their families who became distressed in an open environment and helped them maintain their privacy and dignity. We saw staff support a distressed relative in a manner that meet their individual needs.

Staff understood the emotional and social impact that a child or young person's care, treatment or condition had on their, and their families, wellbeing.

Staff were able to describe how they would maintain dignity and privacy for children in different settings and we observed many examples of verbal and non-verbal communication to aid the assessment of needs and the delivery of care.

The complex team supported patients to in a familial environment. This provided additional support to patient's sense of well-being by maintaining a social and family life.

Understanding and involvement of patients and those close to them

Staff supported and involved children, young people and their families to understand their condition and make decisions about their care and treatment. They ensured a family centred approach.

All staff we spoke with talked to patients in a manner that was supportive to their individual needs. When patients enquired or were referred to the service, staff discussed with patients and their relatives the service that could potentially be offered. All patients and their relatives we spoke with said they understood the treatment they were having and were involved in making the decisions about their treatment.

Staff told us that all aspects of the care to be provided to patients was discussed with them at the point of delivery to maintain a structured and supportive involvement. Care plans were shared with the patient, parents and with the child's school where appropriate.

Patients' personal, cultural, social and religious needs were determined, although they were not consistently planned for to meet individual needs. Care records contained limited information regarding individual social, cultural or personal preferences. This was particularly noted where social activities, such a time out with parents or attendance to school, were supported by the service but did not form a clear part of the planning.

Staff talked with children, young people and their families in a way they could understand, using communication aids as needed.

Children, young people and their families could give feedback on the service and their treatment, and staff supported them to do this. The service carried out patient satisfaction surveys. The surveys supported patients to provide comments and to report on issues and themes. The results of these were consistently positive.

Staff supported children, young people and their families to make advanced decisions about their care.

Staff supported families to make informed decisions about the care for children and young people.

Is the service responsive?

Planning and delivering services which meet people's needs

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 physiotherapy team accepted referrals from general practitioners, health and social care teams, school nursing teams, patients and their families. The team had a triage lead practitioner who assessed all referrals and allocated to a member of the team. The staff we spoke with agreed that their caseloads were manageable and the allocations fair. The team scheduled follow-up contact with young people following transition into adult services. Staff told us this had been effective and beneficial for patients and their families as therapists may have been providing treatment to the patient for many years.

The speech and language team accepted referrals from a variety of sources such as health visitors, school nurses and special educational needs coordinators. A triage system was in place to individually triage and allocate referrals in accordance with each individual patient's needs.

Staff could access emergency mental health support as needed for children and young people with mental health problems and learning disabilities. There was a learning disability lead based in Macclesfield hospital. Staff state they had limited communication with this lead and there was no equivalent community lead.

The service had systems to care for children and young people in need of additional support, specialist intervention.

There was no formal system in place for missed appointments. Individual professionals monitored these and contacted families when appointments were missed.

Managers ensured that children, young people and their families who did not attend appointments were contacted.

Allied Healthcare Professionals had access to electronic systems, including mobile electronic tablets.

Meeting the needs of people in vulnerable circumstances

Staff coordinated care with other services and providers. The service was inclusive. However, reasonable adjustments were not consistently made to made to meet individual communication need.

Individual patient care records showed that there was collaborative working with education and social care to meet individual patients' needs.

The largest ethnic minority group within the trust catchment area is Polish with 1% of the population.

	Ethnic minority group	Percentage of catchment population
First largest	Polish	1%
Second largest	Irish	0.60%
Third largest	Asian / Asian British	0.60%
Fourth largest	Other Western Europe	0.40%

(Source: Universal Routine Provider Information Request – P48 Accessibility)

Staff had communication equipment to assist them in communicating directly with children when delivering care and treatment. However, the service had not had not considered how information such as leaflets that for reference was made available to meet patients' and their parents' individual needs. Information leaflets were available in the community sites, and on the trust's website. These were in printed English, although staff told us they could access leaflets in other languages if needed. However, leaflets we viewed were predominantly written for an adult audience of parents and carers, which risked excluding children from receiving information about their care in a format they could easily understand. We were unable to find evidence of any leaflets or information in alternative formats such as large print or pictorial.

Staff were able to access translation services for children and parents whose first language was not English. This included telephone and face to face translation. Similarly, staff could access British sign language translation services if needed. Portable loop systems were available that assist patients and families with hearing impairment.

Staff made sure children and young people living with mental health problems and long-term conditions received the necessary care to meet all their needs. However, children and young people living with a learning disability such as autism spectrum disorders had no clear links with the main hospital. Autism pathways that had been successful were no longer in place with no interim measures whilst funding was agreed.

We saw one patient areas with limited access for disabled people, such as Congleton War Memorial Hospital. Access to the main reception area was via a significant number of steps that wheelchair users or those with walking difficulties would have problems negotiating.

There was vehicle access via a sloping road but there was no footpath for safe access for wheelchair users or pedestrians.

Access to the right care at the right time

People could access the service and received the right care. However, waiting times from assessment to treatment and arrangements to treat and discharge children and young people were not consistently monitored to ensure that they met patient individual needs.

We requested information from the service that would outline how many, if any, patients were waiting beyond an 18-week referral to assessment. We received some information with regards to Allied Health Professionals. At the time of inspection, three patients were waiting over 18 weeks for occupational therapy, four patients were waiting over 18 weeks for speech and language therapy and no patients were waiting longer than eight weeks for paediatric physiotherapy.

Managers monitored the caseloads, number of referrals, visits and telephone calls made by the community care nursing team. However, there was no triage criteria or monitoring arrangements to make sure that patients were seen in a timely manner.

When children and young people had their appointments cancelled at the last minute, individual professionals made sure they were rearranged as soon as possible. However, there were no formal arrangements in place that managers worked to keep the number of cancelled appointments to a minimum.

There were no clear discharge plans for children and young people. Staff spoken with and records reviews did not outline the arrangements and planning for the discharge of the patient from the service. Managers had no plans in place that monitored any discharge planning to make sure it was appropriately targeted and met individual needs.

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.

From April 2018 to March 2019 there were no complaints received by the trust that related to community children, young people and family's services.

(Source: Universal Routine Provider Information Request (RPIR) – Complaints tab) Children,

young people and their families knew how to complain or raise concerns.

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

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

Data from the trust submitted prior to the inspection April 2018 to March 2019 there were no compliments received by the trust that related to community children, young people and family's services.

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

During the inspection we saw that there was several compliments cards and letters available across the services. Staff reported that they had had written compliments and positive feedback. Following the inspection, we received some examples of compliments but were not supplied with the information regarding how many compliments the service received.

Is the service well-led?

Leadership

Leaders had the skills and abilities to run the service. They supported staff to develop their skills and take on more senior roles. There were gaps in the leadership team. Leaders were not consistently visible in the service and not always available to understand and manage the priorities and issues the service faced. Leaders were not consistently visible in the service.

Staff were able to describe the leadership and reporting structure for their direct managers, and they told us they felt supported by their managers. There were gaps in the leadership above the matron and clinical lead level. Staff and managers for Allied Healthcare Professionals reported that there had been a gap in management that had not been filled and there were going to be further gaps in their management structure. Following the inspection, we were informed that there were arrangements in place to recruit appropriate staff. However, these had not been implemented and leaders for the role had not been identified staff and managers we spoke with were unsure how or when the leadership gap would be managed to ensure that the leadership structure was available.

Staff reported that there was a disconnect between the trust board and staff providing community services for children, young people and their families. Staff did not know who the senior managers were and felt that they were not visible.

Leadership development opportunities were available, including opportunities for staff below team manager level.

Vision and strategy

The service did not have a clear vision for all areas for what it wanted to achieve or a strategy to turn it into action that was developed with all relevant stakeholders. Leaders and staff did not consistently understand or knew how to apply the vision of the trust or to monitor progress.

The service did not have vision for what it wanted to achieve and workable plans to turn it into action with involvement from staff, patients, and key groups representing the local community. Whilst there was a vison and strategy within the nursing services, staff were not all aware of this. Allied Healthcare Professionals including managers were unaware of a service vision or strategy and how this supported the trust to achieve appropriate outcomes for patients.

Staff told us that they had not had the opportunity to contribute to discussions about the strategy for their service, especially where the service was changing.

Staff could explain how they were working to deliver high quality care within the budgets available.

Culture

Staff 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 felt respected, supported and valued in their immediate teams. However, not all staff knew who the senior managers were. Allied Healthcare Professionals did not feel that they were connected or visible to the wider trust.

Staff we spoke with throughout the service were positive about the culture within their teams, and in their cross-team interactions with other health professionals. Staff described the culture as being open and honest and the level of support from their managers was, good. Staff told us they felt able and confident to discuss issues of concerns with their leaders.

None of the staff spoken with knew who the freedom to speak up guardian was or what their role was. At the time of the inspection, the trust's intranet did include this information as a screen saver on the computer. However, not all staff regularly accessed base computers.

Staff based in the wider community locations expressed views of an ongoing sense of geographic isolation from the rest of the trust's community services. They had undertaken events to raise their profile but had not felt that this impacted on being more included by the wider trust.

The Allied Healthcare Professionals' teams had a buddy system for safer lone working. Staff were able to monitor other staff working alone. All staff we asked told us they felt safe when attending visits alone.

The complex team service had developed a handbook that outlined the role of staff and the expected behaviours. This guided staff to maintain a professional role in their support of patients.

Staff felt able to raise concerns without fear of retribution.

Staff report their peer supervisions and appraisals included conversations about career development and how it could be supported.

Staff reported that the provider promoted equality and diversity in its day to day work and in providing opportunities for career progression. This included support to staff with protected characteristics.

Staff had access to support for their own physical and emotional health needs through an occupational health service.

The provider recognised staff success within the service, for example, through staff awards.

Governance

Staff within local teams were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. However, governance processes were not consistent throughout the service.

While most staff could describe their immediate management structure, they could not describe the governance structure within the trust or how quality groups fitted into that structure. However, we did find that some learning was cascaded via team leaders to front-line staff.

There was not a clear framework of what must be discussed at a ward, team or directorate level in team meetings. Minutes of meetings were not consistent with differing topics discussed. Team meetings did not discuss governance matters or staff development but did discuss care and treatment of patients and how to progress individual cases as needed.
There had been some implementation of the recommendations from the Special Educational Needs and Disability report of 12 March 2018 to 16 March 2018. However, there was no structure plan that covered all the areas of recommendation or monitoring arrangements in place that showed the progress the service had made in implementing and sustaining the recommendations.

Although local audits were in place these were not always enough to provide assurance on the quality of the service. Examples included a lack of appropriate arrangements for assessing and acting on capacity and gaps within care records that were not recognised within the service.

Management of risk, issues and performance

Consistent systems to manage the service performance were not in place. Managers did not constantly identify and reduce relevant risks to the service. 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 inconsistent systems for identifying risks, planning to eliminate or reduce them. As an example, there was gaps in the management of risks for individual patients and a lack of recognition regarding the rights of patients once they were aged over 16 to include them appropriately in the management of their own care. The records available for patients were in different formats this meant that staff did not have a clear access to all the records in relation to patients and their individual needs, choices or risks, Examples included a paper record for advance decision making that was contained in the main hospital were staff could not access it whilst in the community.

We reviewed the services risk register this included risk, such as the delays in the autistic spectrum disorder and attention deficit and hyperactivity disorder pathways, and difficulties in measuring patient outcomes due to complexity of individual patients. The register included mitigation actions and implementation dates. However, the restarting of the autistic spectrum disorder programme that when a trail had no confirmed date as to when this would recommence and no arrangements as to how the risks to children who may not be identified in the interim. The risk assessment did not include the findings and recommendations from the joint inspection of the

local area of Cheshire East for the special educational needs and disability reforms as set out in the Children and Families Act 2014. Recommendations regarding health had been made and staff were aware of these, but these recommendations had no risk management or plan in place as to how the recommendations or any associated risks would be managed in the interim.

The service had no arrangements in place to make sure that it checked when referrals were made how promptly they addressed this and how they made sure that parents and children did not have significant waiting times before they received appropriate care and support.

Incidents were logged on the trust's management system and were reviewed by senior managers.

Leaders of the community services were aware of, and able to describe, the risks, issues and performance challenges that faced each of their teams. The specialisms and division maintained a risk register for community services. These risks fed into the trust's overall risk register. Staff below team leader were not clear as to what risks were in place and logged on the register.

Information management

Staff could not find data as they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were not integrated. However, data and records were maintained securely. Information or notifications was consistently submitted to external organisations as required.

Staff did not consistently have access to the equipment and information technology needed to do their work.

Electronic and paper records were used throughout the service. The community nursing primarily used the trust's main electronic patient records system. The Speech and Language Therapy, physiotherapy and complex care service used a mainly paper-based records system. Records were not consistent across the service and meant that there were gaps in data that was not easily accessible by staff or managers to review and improve the service available. As not all the systems were linked there was a risk that vital information would not always be shared.

For example, as the community-based system did not link to the hospital's main records system, not all the information was available to the Allied Healthcare Professionals' team if patients were seen in other areas of the trust. In such cases, staff had to contact secretary's or outpatient clinics or rely on patient and family feedback for some information. Staff we spoke with felt this did not impact on patient care and they were able to provide appropriate care and treatment with the information they held.

Team managers did not have consistent access to information to support them with their management role. This included information on the performance of the service, staffing and patient care. Requests made to the trust for data were not consistently accommodated and data requested was not made available or was inaccurate including information contained in the trust's submissions prior to the inspection.

All records, in whichever format, were stored securely.

Engagement

Leaders and staff did not consistently engage with patients, staff, equality groups, the public and local organisations to plan and manage services. Leaders were working collaborative with partner organisations.

We found mixed evidence of staff engagement with the trust board. We were told by community staff that the trust was focused on Macclesfield District General Hospital and they felt separate from the acute trust.

Staff were involved in some aspects of improving service such as findings from reviews.

The trust had recently restructured some areas of the services to meet the needs of the population. However, managers and staff confirmed that there was no consultation with children, young people and families during this process.

Parent support groups were in place across the services, however these discussions and opportunities were not used to determine the effectiveness of the service or to plan any developments.

Individual surveys to patients and their families concerning individual care received were positive and complimentary regarding the direct contact and support patients received from staff.

Individual patient care records showed that there was collaborative working with education and social care to meet individual patients' needs.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services.

Staff told us they were given the time and support to consider opportunities for improvements and this led to changes. They were supported to make suggestions regarding quality improvement. We were informed of one example of innovation where the service worked collaboratively with a school. The service adapted their service provision by removing the barrier that was preventing the children accessing the service. A pilot clinic for half a day a week using a room in the school has commenced.

NHS Trusts can participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed to continue to be accredited.

There were no services within community services for children, young people and families that have been awarded an accreditation

(Source: Universal Routine Provider Information Request (RPIR) – Accreditations tab)