East Cheshire NHS Trust

Evidence appendix

Macclesfield District General Hospital
Victoria Road, Macclesfield
Cheshire, SK10 3BL

Tel: 01625 661449

Date of inspection visit:
9 to 11 January, 16 January to 18 January and 30 January to 1 February 2018

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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

A list of the sites offering acute services at the trust is below.

Name of acute hospital site	Address	Geographical area served
Macclesfield District General Hospital	Victoria Road Macclesfield Cheshire, SK10 3BL	East Cheshire CCG footprint, includes - Congleton, Macclesfield, Handforth, Chelford, Alderley Edge, Wilmslow, Poynton, Bollington, Knutsford, Holmes Chapel
Congleton War Memorial Hospital	Canal Road, Congleton Cheshire, CW12 3AR	East Cheshire CCG footprint, includes - Congleton, Macclesfield, Handforth, Chelford, Alderley Edge, Wilmslow, Poynton, Bollington, Knutsford, Holmes Chapel

(Source: www.eastcheshire.nhs.uk)

Is this organisation well-led?

Leadership

The trust board had the appropriate range of skills, knowledge and experience to perform its role. Our discussions with the Chair, Executive and Non-Executive Directors demonstrated a level of awareness of the priorities and challenges facing the trust.

The challenges to quality and sustainability were understood by the leaders and articulated through the operational plan. Senior leaders spoke with insight about staffing particularly medical staff, the infrastructure and cost pressures, which they noted as their biggest challenge to quality. This was recognised in the corporate risk register and Board Assurance Framework.

The non-executive directors had a variety of skills, knowledge and experience, which was relevant to their roles. Non-executive directors provided appropriate challenge and worked well with the Board. Non – executives were clear that they looked at productivity rather than cost cutting to ensure services were not affected and there was no impact on quality. Any programmes that effected quality would be filtered out before reaching board level. The longest standing risk was finance. Non- executives were aware of service reviews to see if the trust could continue providing services safely or needed to transfer them out, for example, the stroke service and the single handed consultant role.

Performance appraisals for non-executive directors went to the Remuneration Committee. The Committee was chaired by the Chair of the trust and its members were three Non-Executives Directors. Its role was to oversee and agree the remuneration and terms of service of the Chief Executive, the Executive Directors, together with any staff employed by the trust whose terms of service were not covered by national agreements. It provided advice to the Board on a range of employment issues. The Committee outlined an annual programme and provided an annual report to the Board.

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

Most staff reported that the leaders were visible and approachable. Directors and non-executive Directors undertook a programme of walkabouts and reported these back at board meetings. However some staff across community services felt they were ‘out on a limb’ in terms of location and general communication with the trust’s headquarters.

Of the executive and non-executive board members at the trust, none were British minority ethnic (BME) and 50% were female.

Of the non-executive board members none were BME and 50% were female.

Staff group	BME %	Female %

Executive directors	0.0%	50.0%
Non-executive directors	0.0%	50.0%
All board members	0.0%	50.0%

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

Vision and strategy

The trust had no organisational strategy in place; however the trust was an integral part of the system-wide development of 'Caring Together.' The Caring Together programme is a multiagency programme, which aims to transform the way that health and social care is provided in Eastern Cheshire.

In September 2015, the Trust Board stated that the organisation was not sustainable and wider economy reform was needed.

Whilst there had been no organisational strategy in place for the past two to three years, the service provision was underpinned by key internal strategies including the Quality Strategy and Professional Strategy.

The trust had a Quality Strategy which supported the Clinical Service Strategy. The Quality Strategy aimed to ensure the trust delivered the best care in the right place for patients. The key objectives of the Quality Strategy included no avoidable deaths, reduce patient harm, working in partnership with patients, carers and families to meet their needs and deliver integrated care. The strategy was developed with input from patients, public, staff and commissioners. It combined feedback from complaints, incidents, surveys, conversations at 'health matters' events and contract discussions. Quarterly updates were provided against each of the objectives to the Safety, Quality and Standards Committee.

The five year Workforce and Organisational Development Strategy (2015-2020) aimed to ensure future patient needs could be met through the transformation and development of the workforce. Aligned to the strategy were directorate workforce plans. The plans were developed in line with 'delivering the forward view' recognising the need to work in an integrated way across provider and partner organisations. The workforce plans were monitored by the Board and reviewed annually.

There was a Professional Strategy (2017 – 2020) for nurses, midwives, and allied health care and pharmacy professionals. The strategy had four overarching areas to focus on over the next three years. This enabled professionals to work together to deliver person-centred care, patient involvement in decision making, promoting a healthy life and professional development of staff. The strategy had been signed off by the Board and was aligned to the Quality Strategy.

The Medicines Optimisation Strategy was being renewed this year, though key milestones had not been achieved in some areas and priorities remained such as electronic prescribing and seven day services. The pharmacy workforce strategy had been discussed but as yet was not captured on paper.

Culture

There was strong patient focus, which included the wider community. We found the culture centred on the needs and experience of people who used services. Most staff felt positive and proud about working for the trust and their team.

There was a Planned Care Workforce delivery Plan 2017/2018. The plan covered resourcing, development and engagement of staff. Most actions were either completed or on track.

There was a guardian of safe working. This role was introduced nationally to protect patients and doctors by making sure doctors were not working unsafe hours. The guardian was always available to support and attended induction for trainees. A junior doctor's forum was held six times a year. The guardian had attended a Board meeting to describe what they did. The forum invited members of the Board to the forum to listen to concerns. The Director of Nursing had attended and the Chairman was attending the next forum meeting. The guardian said the Board were very supportive and engaged in the process. Junior doctors were encouraged to do quality improvement work. There were three junior doctors currently looking at issues about the trust IT systems, an on line survey had been sent to every doctor asking for their views.

Staff described the culture as being open and honest. Staff said they were supported to be able to deliver safe care and treatment to patients although staff working in medical care did raise concerns regarding the hospital capacity to deliver the right care to patients due to the high demands on the services. Staff told us they felt able and confident to discuss issues of concerns with their leaders. Medical staff reported a good level of clinical input with the ability to improve services. They described the Chief Executive and board members as 'open' and they had no problems raising concerns.

The trust had a trained Freedom to Speak up Guardian who worked part time and sat outside operational services to ensure independence. The role was communicated through walkabouts, meeting with students and associate nurses as part of their development programme and liaison with staff side representatives. Training was being provided for Freedom to Speak Up champions. A quarterly report went to the Safety and Quality Standards Committee. The number of cases reported was small.

The Chief Pharmacist was supported by the trust to complete leadership courses. There were some gaps in staffing but currently bank staff were utilised where needed. Pharmacists were being encouraged and supported to complete their prescribing qualification. Pharmacy technicians had been supported to attend the Diploma Medicines Management. This enabled the roles to support the clinical pharmacy and Neighbourhood Integrated Medicines Optimisation service.

The appraisal system had been recently updated with positive feedback from pharmacy staff. Twice weekly learning at lunch events provided an opportunity for clinical learning. Lessons learned were also shared at the clinical pearls sessions where there was an opportunity to share specific examples of clinical practice. The pharmacy team attended lunchtime presentations to update them about the Hospital Pharmacy Transformation project and discussed the Carter report.

The trust provided the following breakdowns of medical and dental and nursing and midwifery staff by Ethnic group.

Ethnic group	Medical and dental staff	Qualified Nursing and health visiting staff	Qualified Nursing and midwifery staff
	(%)	(%)	(%)
White – British	82%	40%	93%
White – Irish	1%	2%	0%
Any other white background	4%	6%	1%
Mixed White and Black Caribbean	0%	0%	0%
Mixed White and Black African	0%	0%	0%
Asian or Asian British – Indian	3%	20%	0%
Asian or Asian British – Pakistani	0%	12%	0%
Any other Asian background	2%	2%	0%
Black or Black British – African	0%	3%	0%
Chinese	0%	1%	0%
Any other ethnic group	3%	3%	0%
not stated	5%	12%	6%
Total	100%	100%	100%

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

The trust has four key findings that exceeded the average for similar trusts in the 2016 NHS Staff Survey:

Key Finding	Trust Score	National Average
Quality of non-mandatory training, learning or development	4.10	4.06
Percentage of staff agreeing that their role makes a difference to patients	92%	90%
Staff motivation at work	4.02	3.93
Percentage of staff experiencing discrimination at work in the last 12 months	7%	12%

The trust has one key finding worse than the average for similar trusts in the 2016 NHS Staff Survey:

Key Finding	Trust Score	National Average
Percentage of staff/colleagues reporting most recent experience of violence	60%	67%

(Source: NHS Staff Survey 2016)

Workforce race equality standard

The scores presented below are the un-weighted question level score for question Q17b and un-weighted scores for Key Findings 25, 26, and 21, split between White and Black and Minority Ethnic (BME) staff, as required for the Workforce Race Equality Standard.

Note that for question 17b, the percentage featured is that of "Yes" responses to the question. Key Finding and question numbers have changed since 2014.

In order to preserve the anonymity of individual staff, a score is replaced with a dash if the staff group in question contributed fewer than 11 responses to that score.

			Your Trust in 2016	Average (median) for combined acute and community trusts	Your Trust in 2015
KF25	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	White	27%	27%	29%
		BME	25%	27%	40%
KF26	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	White	19%	22%	22%
		BME	17%	26%	37%
KF21	Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	White	90%	88%	91%
		BME	88%	75%	70%
Q17b	In the 12 last months have you personally experienced discrimination at work from manager/team leader or other colleagues?	White	4%	6%	4%
		BME	10%	14%	23%

Of the four questions above, no questions showed a statistically significant difference in score between White and BME staff:

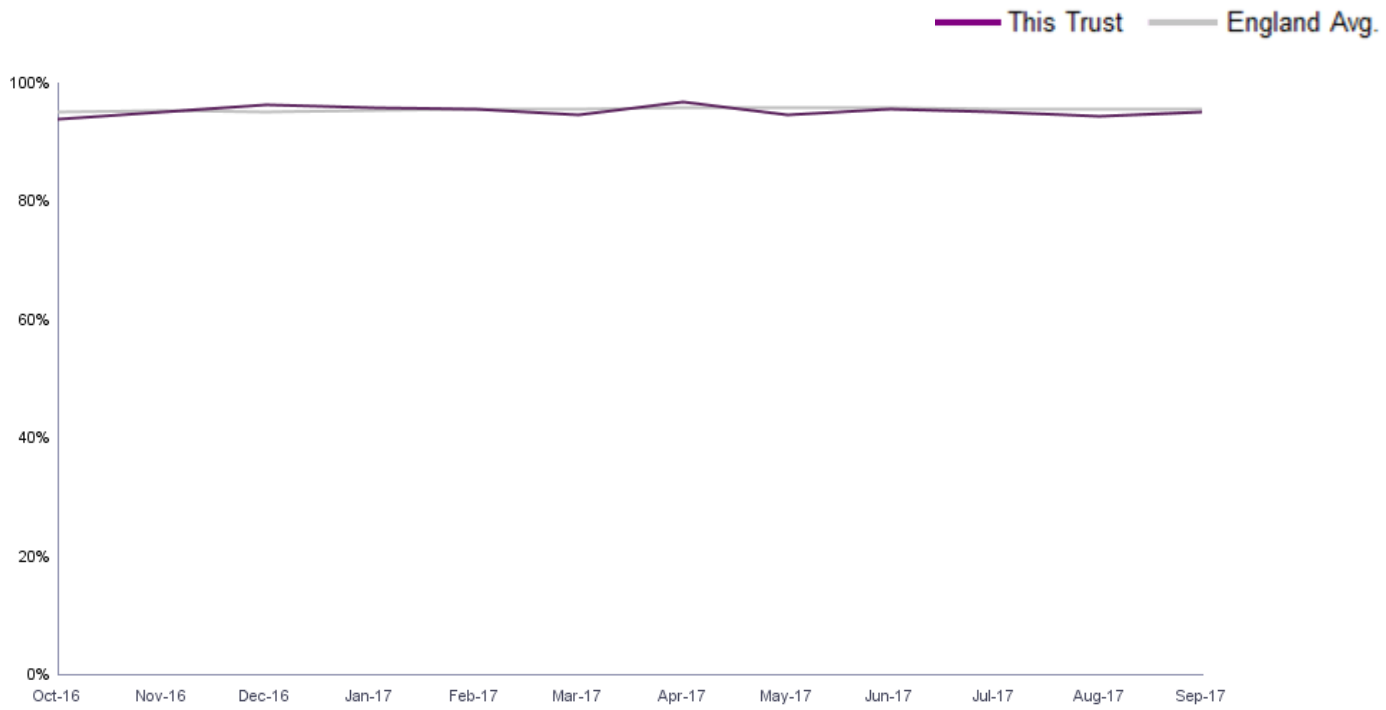
(Source: NHS Staff Survey 2016 - http://www.nhsstaffsurveys.com/Page/1019/Latest-Results/Staff-Survey-2014-Detailed-Spreadsheets/)

The Equality and Human Rights assurance report was provided to the Board. This showed compliance with the requirements of the Equality Act (2010), the Equality Delivery System, the Workforce Race Equality Standard (WRES) and progress on learning disabilities and autism.

There was an equality action plan 2017/2018. This set out the action required against each equality objective. The trust had implemented an inclusion action plan based on the WRES findings to improve outcomes for Black and Minority Ethnic staff as measured by the NHS staff survey. The trust had tried to develop a Black and Minority Ethnic staff network group, but this had not been well attended.

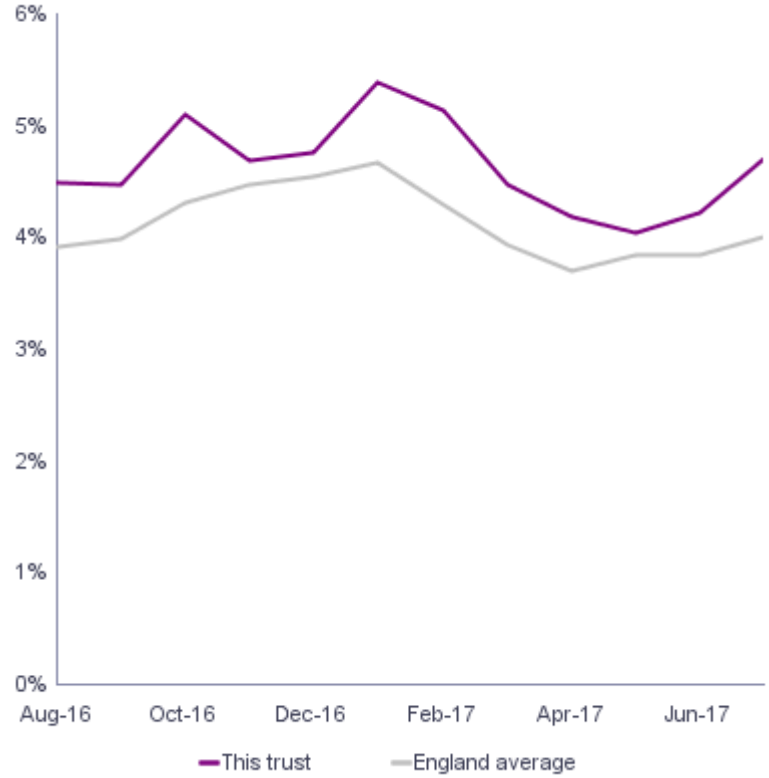
The Friends and Family Test was launched in April 2013. It asks people who use services whether they would recommend the services they have used, giving the opportunity to feedback on their experiences of care and treatment.

The trust scored about the same as the England average for recommending the trust as a place to receive care from October 2016 to September 2017.



(Source: Friends and Family Test - http://www.nhsstaffsurveys.com/Page/1019/Latest-Results/Staff-Survey-2014-Detailed-Spreadsheets/))

The trust's sickness absence levels from August 2016 to June 2017 were higher than the England average.



(Source: NHS Digital)

In the 2016 General Medical Council Survey the trust performed the same as expected for all 14 indicators.

(Source: General Medical Council National Training Scheme Survey)

Governance

The board and other levels of governance in the organisation functioned effectively and interacted with each other appropriately. We found at an executive level governance structures and systems were articulated effectively but this was less so at some corporate levels.

The Non-Executive Directors were engaged in quality governance, and sat on the assurance committees to the Trust Board. We felt they were sighted on most issues and did provide appropriate challenge, for example, an in-depth review of medical staffing.

Structures, processes and systems of accountability were in place to support the delivery of the strategy and good quality services. There were four sub-committees of the board, each chaired by a non-executive director. These were the Safety and Quality, Finance, Performance and Workforce, Audit and Remuneration Committees.

The Board had oversight and assurance of quality through the Safety Quality and Standards Committee. The Committee was chaired by a non-executive director and membership included two non-executive directors and all executive directors, the Chief Pharmacist, and the Associate Medical Director for Clinical Effectiveness who had delegated authority for mortality, and Caldicott Guardianship. The Director of Nursing, Performance and Quality was the executive director with responsibility for quality systems.

The trust was divided into clinical service areas supported by corporate and operational services. 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.

There was a Clinical Management Board. Although this was not a Committee of the Board its purpose was to ensure there was clear accountability for clinical engagement and leadership across the organisation. It provided assurance that key objectives were being achieved and risks managed in relation to the business and recovery of the organisation.

During the year, weekly Executive Team Meetings were held to support additional focus on strategy, recovery and delivery of key business cases at executive level.

The board reviewed its risks and Board Assurance Framework which set out the strategic risks which could impact on the delivery of the organisations' objectives. The board scrutinised the assurance framework and corporate risk register to provide assurance that the strategic risks and the controls in place to mitigate the risk were appropriate and effective.

The Chief Pharmacist was also a clinical director and had a direct line to the Trust Board. An annual report was produced to give the board assurance. Monthly 1:1s allowed feedback from meetings. The Medication Safety Officer received papers and remained situationally aware. Medicines Optimisation fed in to the trust by the Medicines Management Group sub-group and the risk management group fed into the Trust Safety, Quality and Standards meetings, to the Trust board. Directorate pharmacists attended sub Safety, Quality and Standards meetings. There was pharmacy representation on the care group to capture NICE updates. All medicines safety incidents are reviewed by the Medication Safety Officer.

In line with best practice, ward staff were supported to care for patients with presenting mental health conditions through the provision of psychiatric liaison staff employed by the nearby mental health trust. There were good working relationships with the liaison team. Ward staff told us they received a timely response to referrals to the service and would also ring and ask for advice and information. Staff within the psychiatric liaison team and staff on the wards valued each other's input and commented that the service worked well together to meet patients' physical and mental health.

The trust had funded the liaison psychiatrist to provide training for staff. This had involved to date mental health awareness training and sessions which were scenario based within the hospital simulation suite. Staff on medical wards who had attended gave positive feedback for this training and the effect on their own knowledge and skills. There were also set sessions provided for junior medical staff training. Staff attended mandatory training in dementia, learning disability and autism awareness.

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

1. Empower, develop and value staff in providing innovative patient focused care.

2. Provide the best services to our population through improvements to safety, productivity and patient experience.

3. Effectively provide services that are sustainable both now and in the future.

(Source: Trust Board Assurance Framework)

Management of risk, issues and performance

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

We observed a Safety and Quality Standards Committee meeting. It started with a patient story; which included what went well, what could be improved and any actions. There was a review of assurance documents which included policy changes and key performance indicators such as waiting times.

We found that corporate and operational risk management had been strengthened since the last inspection. All directorates received monthly Governance Data Packs, including a range of risk management and patient experience data. Therapy staff received reports and data packs containing quality and workforce metrics.

There was staff engagement in terms of health and safety at the trust's Risk Management Sub-Committee. Risks were identified, reported and reviewed at both service and corporate level. In addition to operational escalation processes, the Director of Nursing Performance and Quality reviewed staffing incidents on weekly basis, taking action where appropriate.

The Director of Nursing, Performance and Quality had established a 'Patient Safety Exchange' mechanism where she provided feedback on incident trends and actions being taken. This also gave an opportunity for staff to discuss concerns they may have relating to safety.

The trust directors had identified risks associated with single-handed services. This was identified on the risk register. The trust had taken action to address or mitigate the concerns. For example, they identified concerns regarding the sustainability of a safe and effective stroke service so worked with local providers to transfer the service to another trust for the benefit of patients.

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 Medical Director provided the quarterly mortality dashboard to the trust board and, in conjunction with the Chair of the trust Mortality sub-committee, a quarterly mortality report to trust Safety, Quality and Standards sub-committee.

The trust had introduced a two-stage review process in line with good practice. Mortality review nurses were responsible for managing the mortality review process and ensuring that stage two reviews were completed and appropriately identified lessons learned and good practice. Avoidable deaths were identified and investigated. The mortality review nurses provided information and data compiled from the mortality reviews for inclusion in reports to the mortality sub-committee and the board.

At an operational level there was a process for staff to share learning from mortality reviews. However, in some areas for example, medicine staff we spoke with reported they did not always receive feedback following a mortality review of a patient from their ward.

There was a process for review of patient's with a learning disability who died as an inpatient. A proforma was completed from the Cheshire learning disability mortality group. This was shared with the Learning Disabilities Mortality Review Programme and discussed as part of a multiagency case review.

Clinical and corporate teams worked with external organisations to assess and manage risks to safety, for example safeguarding teams, GP practices, and mental health teams. The trust had responded to the clinical commissioning group quality concerns regarding community services and had worked together to produce and agree a Quality Risk Profile. This provided further assurance on quality to the commissioners and regulators.

A quarterly report on complaints, incidents, claims and patient experience was produced which identified trends and learning from a range of patient safety and experience sources. Learning from incidents was shared in a variety of ways; through the incident reporting system, through staff newsletters, for example, Learning into Practice, Safety Matters (Medicines Management) and the Maternity Newsletter.

Learning was also discussed on an individual basis with those who may be directly involved with incidents and with a range of staff through team, departmental and directorate meetings. Serious Incident Summary Sheets provided staff with an overview of these incidents, lessons learnt and recommendations.

We looked at ten serious incident investigations completed during 2016/2017. These were of a good standard and contained appropriate information, action plans and evidence of learning and improvement.

We found 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 Duty of Candour policy and procedure. The Director of Corporate Affairs and Governance was responsible for the duty of candour process and the Medical Director was responsible for clinical decision making in relation to duty of candour. Cases triggering a duty of candour were monitored by the Serious Incident Review Sub Committee on a monthly basis. The incidents we reviewed showed that a duty of candour discussion took place with the patient or relative. Once the investigation report was approved, there was further communication with the patient or relative followed by a formal letter if the patient chose. In the last 12 months duty of candour had been applied to 64 incidents.

There was a system to monitor patient safety alerts through the integrated risk management system. When an alert was circulated this information was recorded on the trust incident reporting system and sent to the appropriate people for review. Timescales were monitored to ensure completion on a weekly basis in the risk management team meeting and bi-monthly at the risk management subcommittee. If actions were required for the patient safety alerts this was reviewed and reported at the Risk Management Subcommittee.

Risk management was further embedded within the trust through service management responsibilities; equality impact assessments were carried out against core business policies, and risk assessments, including quality and equality impacts which were completed on proposed business activities and changes. All project initiation documents and quality impact assessments were signed off by the medical and nurse director. The Safety Quality and Standards Committee reviewed assessments quarterly to ensure there was no impact on quality. A biannual report was presented to the Board.

Performance management at ward level was flagged by matrons through quality dashboards and one to one meetings with ward sisters. Ward sisters attended the safety and quality standards meetings. There was a standard agenda which included performance metrics, finance, operational issues, and policy and business cases. The local governance meetings fed into monthly directorate performance meetings chaired by the Director of Nursing, Performance and Quality and the Director of Finance.

The Director of Nursing, Performance and Quality was the executive lead for safeguarding adults and children. The Trust Board received an annual safeguarding report. There was a clear structure to support safeguarding concerns. We discussed the reasons for non-compliance with safeguarding training targets. The trust was aware of this and was looking at alternative ways for staff to access training. The named and designated professionals for safeguarding met regularly with the Director of Nursing to review policy, lessons to be learned from reviews both locally and nationally and the safeguarding agenda. There were audit programmes to ensure that safeguarding systems and processes were functioning effectively.

There was an Annual Infection Prevention and Control report. This demonstrated progress against the annual infection prevention programme and in achieving compliance with national standards and performance indicators. The trust participated in NHS Improvement Infection Prevention and Control 90 day improvement programme which sought to improve staff understanding regarding

isolation procedure and priorities. The outcome of the project was that staff on the pilot wards felt more empowered to make decisions on isolation and subsequent cleaning requirements supporting improved care for patients.

Medication incidents were reported and reviewed at the Safe Medicines sub-group. Audit of existing practices such as NPSA alerts related to medicines management, safe prescribing of high risk medicines, controlled drugs, antibiotic point prevalence studies, out-patient prescribing were undertaken and reported at the Safe Medicines Group.

There was a New Clinical Interventions Procedures policy. All medical practitioners planning to undertake a new interventional procedure, or an interventional procedure which they had only used outside the NHS, were required to seek approval from the trust's Safety, Quality and Standards Committee before doing so.

The 2016/17 financial outturn position was a deficit of £15,149k which was better than plan by £4,451k. The improvement in the financial position was as a result of pay under spend and over achievement of income, this resulted in an additional Sustainability and Transformation Funding (STF) incentive payments. The total STF funding received by the trust was £7,421k.

	Historical data		Projections	
Financial metrics	**Previous Financial Year (2015/16)**	**Last Financial Year (2016/17)**	**This Financial Year (2017/18)**	**Next Financial Year (2018/19)**
Income	£172.3m	£165.6m	£147.1m	£143.2m
Surplus or (deficit)	(£23.9m)	(£15.1m)	(£20.2m)	(£19.4m)
Full Costs	(£196.2m)	(£180.7m)	(£167.4m)	(£162.7m)
Budget (or budget deficit)	(£6.4m)	(£19.6m)	(£20.2m)	(£19.4m)

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

The trust was currently on track to deliver against the planned deficit of £20,241k which included STF of £4,028k. The trust did not achieve the A&E 4 hour wait performance target in Q1 and therefore did not receive £90k of related STF and similarly for Q2 will forego £242k - the trust was confident that the planned deficit could still be delivered. The trust was under spent on pay and was £1,362k better than NHS Improvement agency ceiling target.

The Director of Finance reported that the current financial position had stabilised and was on an improvement trajectory. A number of services which were not clinically sustainable had moved such as stroke and single handed consultants to other trusts. The trust was looking to re-negotiate other service contracts with their clinical commissioning groups to gain increased income.

The trust had a financial plan and was aware of the need to work in partnership with other health economies in Greater Manchester.

The trust had systems for identifying risks, planning to eliminate or reduce them and coping with both the expected and unexpected. Risks were overseen by the various committees and were owned by an executive who was accountable to the Chief Executive and Non-Executive Directors. Each risk had a control and timeframe.

Directorates had a 'risk register' which highlighted areas of risk to the effective management of the service. These ranged from risks of staffing shortages to the risk of delays in treatment. Each ward also had a risk register that contained the ward level risks. We saw that these risks were escalated through the matrons for inclusion on the directorate risk register as necessary. Moderate and high level risks from the directorate risk registers were included on the trust risk register which was split into the specialities. Risks had review dates.

There were two risk registers which covered the wider trust medicines optimisation risks and pharmacy risks. Specific pharmacy risks were reviewed at the operational monthly meeting and more in depth each quarter. Skill mix and staffing had been reviewed where gaps were identified. Gaps remained with seven day pharmacy service, Saturday and Sunday service was limited and dispensary based.

The trust provided a document detailing their five highest profile risks. Each of these have a current risk score of 12 or higher. All the risks detailed below were reviewed in November 2017.

Strategic objective 1: Empower, develop and value staff in providing innovative patient focused care

Risk description.	**Causes and effects**	**Risk score (initial)**	**Risk score (current)**
Leadership of Strategic Transformation -If the collective leadership across the integrated care system is not well led and unable to effect the changes required with pace and support of key regulators and stakeholders then there is a risk to the sustainability of the trust and the wider Health and Social Care economy.	(**Causes):** • Insufficient financial support • Lack of decisive action. • Insufficient capacity and capability, • Lack of effective communication, involvement and engagement. • (**Effects):** • Inability to deliver strategic objectives**.** • Poor team and partnership working. • Lack of credibility with staff, stakeholders and regulators**.** • Inability to achieve or improve financial performance	20	20

Strategic objective 2: Provide the best services to our population through improvements to safety, productivity and patient experience

Risk description.	**Causes and effects**	**Risk score (initial)**	**Risk score (current)**

Quality & Compliance: patient safety, patient experience and effectiveness If quality is not maintained in line with regulatory standards during and after transition then this could impact on services the trust provides and ability to provide services that are caring, safe, and responsive and safeguard the health & wellbeing of the local population.	**(Causes):** • Poor professional practice • Inappropriate behaviours • Inadequate or inappropriate staffing levels • Inadequate infection, prevention controls • Sub-standard estate/facilities • Poor systems and processes • Failure to learn from mistakes **(Effects):** • Compromised standards of care • Poor patient experience • Regulatory intervention • Reputational damage	16	12

Strategic objective 3: Effectively provide services that are sustainable both now and in the future

Risk description.	**Causes and effects**	**Risk score (initial)**	**Risk score (current)**
Financial Stability – If the trust cannot meet its part of the requisite financial regulatory standards and operate within agreed financial resources and transformation schemes do not deliver sufficient savings then the proposed health economy wide service model will not be fully or effectively implemented.	**(Causes)** • Failure to control pay and non-pay cost. • Failure to optimise income. • Lack of identification and delivery of QIPPs. • Services not being delivery cost effectively. **(Effects):** • Inability to transform services. • Reduction in level and standard of services. • Loss of business market share. • Reputational damage.	25	25

Strategic objective 4: Empower, develop and value staff in providing innovative patient focused care

Risk description.	**Causes and effects**	**Risk score (initial)**	**Risk score (current)**
People - If the trust does not attract, develop, and retain a resilient and adaptable workforce with the right capabilities and capacity then there may be an impact on achieving mandatory service standards, and delivering an integrated system.	**(Causes):** • Difficulty in recruiting high quality staff in some areas. • Difficulty in retaining high quality staff in some areas. Inappropriate attitudes and behaviours. • High sickness levels. • Low levels of staff engagement	20	16

	and awareness of priorities. Low morale • Non-compliance with systems and processes. • Ineffective training and development. **(Effects):** • Poor service experience • Inadequate staffing levels. • High agency costs. • Demotivated staff. • Inability to deliver safe services		

Strategic objective 5: Effectively provide services that are sustainable both now and in the future

Risk description.	Causes and effects	Risk score (initial)	Risk score (current)
Infrastructure - If the Information Technology/Information Systems and Estate infrastructure are not sufficiently invested in and adapted to align with the health economy strategy then there will be an impact on the quality of the delivery of clinically & financially sustainable services	**(Causes):** • Age and deteriorating physical assets**.** • Poorly maintained assets. • Inadequate investment • Poor IT systems and infrastructure **(Effects):** • High levels of hospital acquired infection**.** • Poor patient experience**.** • Assets not being used effectively**.** • Poor staff morale**.** • Sub-standard patient care.	16	12

(Source: Board assurance framework)

Information management

The trust was trying to progress the digital agenda, however the pace of change was slow because of insufficient investment. The trust used multiple IT systems, some of which were aging, this resulted in slow systems which impacted on service delivery. An example given by medical staff was delays in accessing diagnostic tests. Staff said there were not enough computer terminals on the wards. Staff reiterated that systems were slow and disjointed. This meant they had to spend more time waiting for information to load or navigate through different systems.

The poor IT infrastructure resulted in ‘work rounds’ and again posed potential clinical risks and inefficient working practices

The Trust Board fully accepted the need for electronic records and this was identified as a high risk in the corporate risk register and Board Assurance Framework. There was approximately £800,000 for IT projects this year and the trust was working to improve areas such as the use of a single sign in.

Although the trust had been infected by last year's Cyber-attack they had not been affected as much as other organisations. Computer screens contained messages for staff about the action to take to minimise cyber-attacks. There was an action plan which showed most areas were completed or on were on track.

The trust had prepared a business case for the implementation of electronic prescribing; however this required significant investment to achieve this. In the interim the trust completed medicine audits and there was a plan to review old alerts and audit these against current practice.
The trust used an information system which provided information about chemotherapy drugs and their side effects. This showed the trust was 100% compliant against those standards.

The Neighbourhood Integrated Medicines Optimisation team could access the Cheshire Care Record. This record enabled direct communication with GPs. Work was ongoing to use the National Institute of Health and Care Excellence, evidence patient decision aids.

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

There were arrangements to ensure the availability and integrity of identifiable data, records and data management systems in line with data security standards. However during the inspection there was some patient identifiable information being seen in a number of medical ward areas.

The trust had completed the information governance toolkit assessment, which described how the trust saw its management and security of information. The trust assessed itself on measures of assurance, including confidentiality and security of records, the quality of information, the secondary use of information, and a measure for the overall performance. The trust achieved the required level across standards of the Information Governance Toolkit.

Engagement

There was a Patient Experience Strategy 2017/2020. The trust used several mechanisms to capture patient feedback and improve the patient experience. There were Board assurance walkabouts; this allowed board members to seek patient, staff and carer feedback for themselves. The trust participated in national patient survey programmes and reviewed complaints or concerns which ensured that a more proactive approach was taken to facilitate early resolution of concerns.

The trust recognised for example that noise on wards at night had caused unnecessary disturbance to patients. A noise at night initiative was introduced based upon patient feedback to provide patients with eye masks and ear plugs.

The Equality and Patient Experience Manager held monthly patient reference groups covering differing topics. Meeting minutes from October 2017 showed the trust was implementing actions such as the implementation of ward Wi-Fi.

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. Examples of support included an email helpline and pre-admission visits to the hospital.

For the community adults service local surveys of care provided by the community nursing teams, and the podiatry teams showed that over 90% of patients rated their care and treatment as excellent or good overall.

The National NHS Staff Survey 2016 showed that staff engagement scores at the trust had risen for the fifth year running. Results showed that staff motivation at work and staff ability to contribute towards improvements at work were above (better) than average when compared to national results. The trust had an Engagement, Wellbeing and Inclusion Plan 2017/2018 to improve in areas such as the quality of appraisal, staff working long hours and staff reporting experience of violence.

The Safe Medicines Group had patient and junior doctor representation. The patient representative identified the opportunity to engage with patients by a promotional label attached to discharge prescription bags. This label signposted the patient to contact pharmacy through the Patient Advice and Liaison team if they required information about medicines. Customer care also visited wards daily to obtain feedback from patients. A weekly and monthly report was produced and reviewed by the Safe Medicines Group.

There were a number of initiatives to improve staff wellbeing. This included building engagement through the development of champions and staff led initiatives, increased utilisation of reward and recognition schemes and the roll-out of a 'thank you' cards project. The trust had also made improvements to multi-faith facilities and development of chaplaincy services, the 'Call to Action' project to improve the levels of reporting experience of violence and improved leadership training with a focus on staff wellbeing.

We spoke with a number of staff side representatives. They described a good working relationship with the Chief Executive. Monthly partnership meetings were held with executives and human resources.

The Hospital Pharmacy Transformation Project linked with the Greater Manchester Hospital Pharmacy Transformation Collaborative. This was established as part of health and social care devolution in Greater Manchester. Relationships were maintained with Cheshire and Mersey.

Learning, continuous improvement and innovation

The Neighbourhood Integrated Medicines Optimisation team followed up patients in the community by telephone or face to face. The trust had piloted Pharmacy Technician administration of medicines; we were told that this had reduced omitted and delayed doses. Pharmacy supported winter pressures by facilitating a discharge team, the team was mobile and worked flexibly where it was most needed, and work was ongoing to officially prioritise this.

External reviews were commissioned to establish and generate new ways of working. For example, the SAFER patient flow initiative. Staff and managers at all levels had embraced a new way of working to reduce capacity and demand in order for patients to receive the best possible care and treatment.

The muscular skeletal service worked with the Advanced Quality Alliance on shared decision making. This work helped the service to map patient pathway journeys to identify were pressure points impacted on quality standards.

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 days for standard complaints & 45 days for complex complaints	94%
If you have a slightly longer target for complex complaints please indicate what that is here	N/A	
Number of complaints resolved without formal process in the last 12 months?	942	From August 2016 to July 2017.

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

The trust received 116 complaints from August 2016 to July 2017. Surgery core service received the most complaints with 37.

Core Service	Number of complaints	Percentage of total
Surgery	37	32%
Medical care (including older people's care)	32	28%
Urgent and emergency services	23	20%
Gynaecology	7	6%
Services for children and young people	5	4%
Diagnostics	4	3%
Maternity	2	2%
Outpatients	2	2%
Sexual Health	2	2%
Community Dental	1	1%
Other	1	1%

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

On receipt of a complaint staff in the Customer Care Team reviewed the complaint and identified the appropriate Lead Investigators. The complaint was sent for investigation to the appropriate staff. This was done in the form of a Complaints Investigation Template and the Lead Investigator was named on this document. All complaints were logged onto the trust incident reporting system.

Complaints were reviewed monthly at the trust Safety, Quality and Standards meeting. The non-executive Chair of the committee provided a verbal update at the Trust Board meeting. A Scrutiny Group developed from service users met quarterly to review complaints handling.

The trust had set up Patient Advice and Liaison Outreach team. The Customer Care staff, on working days, visited a ward on a daily basis and spoke with patients and their relatives asking them how they were and if they had any concerns. Any issues were resolved immediately. A record of the daily visits were recorded and sent to the Director and Deputy Director of Nursing, the Matrons and Ward Sisters on a weekly basis.

We looked at ten complaints. The complaints met the trust response targets in most cases. Each complaint was signed by the Chief Executive. There was evidence of learning at individual ward and at the trusts Safety, Quality and Standards meeting.

Seven complaints were referred to the Parliamentary Health Service Ombudsman between August 2016 and July 2017. Two complaints were still being investigated by the Ombudsman, four were closed with no recommendations and one complaint was upheld.

NHS trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

The table below shows which of the trust's services have been awarded an accreditation.

Accreditation scheme name	**Service accredited**
Joint Advisory Group on Endoscopy (JAG)	Endoscopy 16/08/2016
Clinical Pathology Accreditation and its successor Medical Laboratories ISO 15189	(Service provided by Mid Cheshire NHS Foundation Trust) Haematology - 16/01/2015 Biochemistry - 16/06/2015 Microbiology - 12/05/2015
MacMillan Quality Environment Award (MQEM)	MacMillan Cancer Resource Centre 15/08/2017

(Source: Routine Provider Information Request (RPIR) – Accreditations tab).

Acute services

Medical care (including older people's care)

Facts and data about this service

East Cheshire NHS Trust was established in 2002. It consists of three hospitals; Macclesfield District general hospital; Congleton War Memorial hospital; The Fountains and Knutsford and District General Hospital. Macclesfield District general hospital was purpose-built in the early 1980s, replacing a much older traditional infirmary.

Since 1 April 2011 East Cheshire NHS Trust has been an integrated community and acute trust providing healthcare across central and eastern Cheshire and surrounding areas, in hospital, at home and in community settings.

The trust's services are managed through three clinical directorates supported by corporate functions.

Medical services were part of the acute integrated care directorate. All medical wards were based at the Macclesfield district general hospital.

East Cheshire NHS Trust serves a population catchment area of approximately 220,000.

East Cheshire NHS Trust has 186 medical inpatient beds located across eight wards: Coronary Care Unit (CCU), Medical Day Case Unit and Wards 3, 4, 7, 8 (medical admissions unit), 9 and 11.
(Source: Routine Provider Information Request - Acute-Sites)

The trust had 13,815 medical admissions from August 2016 to July 2017. Emergency admissions accounted for 8,284 (60%), 160 (1.2%) were elective, and the remaining 5,371 (38.8%) were day case.
(Source: Hospital Episode Statistics)

The inpatient areas consist of the following:

- Ward 3 gastroenterology/general medicine (28 beds)
- Ward 4 respiratory medicine (28 beds)
- Ward 7 endocrinology and general medicine (18 beds) and Cardiology (10) 28 beds,
- Coronary care unit (7 beds)
- Ward 9 elderly care (24 beds)
- Medical day case unit (5 beds)
- Ward 8 medical admissions unit (28 beds)

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

There was a process in place to ensure that all staff employed at the service had received their mandatory training in order for them to carry out their role within the organisation.

There was a training policy to provide staff with guidance on their mandatory requirements and managers were accountable for ensuring compliance with legislation, policy requirements and trust training targets.

Mandatory training was made available to all staff to enable them to provide safe care and treatment to patients. Some of the training was completed through face to face learning or through self-directed e-learning. Staff we spoke with told us that they had access to training, although at times training was cancelled due to staffing shortages and bed pressures at the trust.

Training included basic life support (BLS), fire training, moving and handling, adults safeguarding, and equality and diversity training. Staff reported that the training they received was adequate to meet their learning needs. All staff working on the coronary care unit had completed advanced life support training.

Ward performance and quality dashboards provided managers with the numbers of staff who had completed their training against the trust target of 90%. Mandatory training compliance varied across all wards we visited. We reviewed each wards performance against the trust target, and found that compliance for nursing staff across the medical wards ranged from 79% to 100%. Mandatory training for medical staff across the medical wards ranged from 75% to 83%. Managers we spoke with were aware of their current performance and plans were in place to improve individual ward performance to meet the trust target.

Safeguarding

There was a system in place to ensure that patients were protected from abuse and improper treatment. However, training compliance across all staffing levels did not meet the required trust target.

Safeguarding training was provided to all nursing and medical staff on a yearly basis to support their knowledge. Information supplied by the trust in January 2018, showed that compliance with training at level 1 and 2 for adults and children safeguarding varied across all medicine wards. Overall, 92% of nursing staff had completed safeguarding adult's level 1 training, and 84% had competed level 2 safeguarding adult's training.
The data range for nursing staff that had completed adults safeguarding level 1 ranged from 79% to 100% and level 2 adults ranged from 85% to 100%. The trust target was 90%.

Data supplied by the trust showed medical practitioners (across all medicine specialities) overall compliance with safeguarding adults level 1 training was 84% and 48% (11 out of 23 staff had completed the training) for safeguarding adults level 2 training.

Overall compliance with children's safeguarding level 2 training for nursing staff was 80% and for medical practitioners was 58% (14 out of 24 staff had completed the training). The trust target was 90%.

Although safeguarding training compliance across the service did not meet the expected target of 90% for many of its staff, we found that staff were aware of their safeguarding responsibilities and support was available 24 hours per day to ensure patients were appropriately safeguarded from abuse.

The trust had a safeguarding adults and children's policy to provide support and guidance to staff in ensuring all patients were protected from abuse.

All staff we spoke with at all grades were aware of their responsibilities in regards to safeguarding

patients who attended the hospital, and informed us that they reported any signs of abuse to their immediate manager for escalation. All staff were aware of the need to refer to the safeguarding team and were aware of their contact details. Managers we spoke with were aware of the processes to follow in the event of a safeguarding and the links with local authorities in the area.

Safeguarding concerns were discussed at staff handovers and in board round discussions to ensure that the relevant staff were aware of any safeguarding's. We saw that any safeguarding concerns were noted on the board round white board and staff we spoke with were conversant with the safeguarding concern.

The trust had a safeguarding team, a safeguarding lead for adults with a separate lead for children. There was also a board level director with delegated accountability and responsibility for safeguarding to ensure all statutory requirements were implemented to protect those patients who were vulnerable.

The trust had a female genital mutilation policy in place which included guidance for staff on recognising, recording and reporting. The policy included a proforma to guide practitioners as to what information to gather and what to do. We were informed incidences of female genital mutilation would be recorded on the patient's record and reported on the trust electronic incident reporting system, with referrals made to relevant social care providers and the police as appropriate.

The trust completed safeguarding awareness and policy audits. We reviewed audits completed in August and October 2017. The audit showed that staff could recognise signs of abuse and were aware of how to raise concerns.

Cleanliness, infection control and hygiene

At the last inspection although we found good practices with regards to infection control, some communal areas and equipment were unclean. At this inspection the findings were similar.

Wards we visited were generally visibly clean and we observed most staff to adhere to infection control and hygiene policies and procedures.

There were processes in place to protect patients and staff from acquiring an infection whilst receiving treatment on medical wards. There was a policy and procedures for staff to follow, and staff were aware of their roles and responsibilities to minimise the occurrence of infection. This included schedules of cleaning with oversight from managers to ensure compliance.

We found that not all wards were kept clean throughout the day. The wards were large and provided care for up to 28 patients, and keeping the wards clean throughout the day was challenging. We found that floors were not always kept clean throughout the day and saw dirty linen in bags had not always been removed promptly from the wards. We were informed that cleaning was provided by an external contractor with oversight from a housekeeper and the ward management team. There was usually one cleaner attached to each ward. From our observations throughout the day, we saw that ward cleanliness was variable. For example during an afternoon visit to ward 9, ward 3, ward 7 and ward 8 the flooring was visibly soiled.

In the 2017, patient led assessments of the care environment audit 99% of patients reported they were satisfied with the cleanliness of the trust.

There were daily cleaning schedules for all ward areas and we saw that these had been completed. Managers of the service had oversight to ensure the environment remained clean and tidy throughout the day. We observed 'I am clean' stickers were used to denote that equipment and trolleys were clean and ready for use.

The trust monitored each ward to ensure the wars remained infection free. This data was provided back to each ward via a performance and quality dashboard. We reviewed infection rates for each ward and found each ward manager was aware of their current performance. This performance data was posted on the wall for all staff to view.

The performance data across the acute and integrated care directorate showed that between April 2017 and October 2017 there had been a total of one confirmed case of MRSA. (MRSA is a type of bacterial infection and is resistant to many antibiotics), and four cases of Clostridium difficile (a bacterium that can infect the bowel and cause diarrhoea). We saw minutes of a team meeting that discussed ward performance with regards to infection prevention following a patient infection attributed to the hospital, and saw that handwashing procedures were raised and extra hand hygiene audits undertaken to ensure compliance. This was a two tiered process with the clinical areas submitting audits and then verification audits undertaken quarterly by the infection prevention control team.

We saw there was prominent hand washing stations on the entrance to wards, which contained clear instructions to those entering the wards of the requirements to wash hands and prevent the spread of infection. We observed good compliance with this process from most staff and members of the public. There was adequate access to hand gels and handwashing sinks in clinical areas and also at the point of care. However, on ward 3, we observed a staff nurse move between two patients without washing their hands between providing care and treatment.

We observed that staff adhered to the infection control policy and used personal protective equipment (PPE), such as plastic aprons and gloves, when delivering personal care to patients. We observed that not all medical and nursing staff followed ‘bare below the elbows’ guidance in clinical areas. On ward 8 and ward 3 we saw that one member of staff on each ward did not adhere to bare arms below elbows.

We saw that staff used an Aseptic Non Touch Technique (ANTT).This minimises the occurrence of infection transmission between patients. Aseptic technique is used during clinical procedures to prevent microbial contamination of aseptic parts and sites by ensuring that they are not touched either directly or indirectly.

The service had infection prevention nurses to support and advise the medicine wards to ensure that infection control principles and organisational polices for infection control were adhered to.

Infection control audits were completed routinely as part of an audit schedule. The audits were undertaken monthly by ward managers and matrons to ensure compliance with infection control and minimise the spread of any infection.

The trust had an action plan for 2018 in reducing the occurrence of infections across all areas and promoting harm free care for patients. The plan included objectives with key priorities for achievement.

There was an infection prevention and control group to provide update and assurance across a range of infection prevention and control areas. We reviewed the November 2017 report to the committee and saw it included infection control incidents, auditing data and verification spot checks of the environment to ensure cleanliness alongside the contracted cleaning company.

Hand hygiene audits were completed to ensure compliance with hand washing. Observations were carried out to ensure correct hand washing technique were used. We reviewed all hand hygiene audits from April 2017 to December 2017 and found good overall compliance across all medicine wards. All wards, with the exception of ward 7 hand hygiene audit results ranged from 99% to 100% compliance. Ward 7 compliance ranged from 87% to 100% with hand hygiene compliance.

We reviewed the matron's quality checklists and found that any areas of compliance with infection control were immediately addressed to ensure the safety of patients on the wards.

Environment and clinical practice audits included intravenous cannula insertion and on-going care, were carried out by infection prevention and control nurses to ensure compliance with National Institute of Health and Care Excellence (NICE) guidance to reduce the risk of infection.

The decontamination of endoscopes was undertaken on site and the unit had attained Joint Advisory Group on gastrointestinal endoscopy accredited status in 2016.

We saw that where patients were subject to isolation precautions due to a potential infection, appropriately signage was present to advise those entering the room of the precautions to take.

We looked at cleaning cupboards on a variety of wards, and saw that cleaning equipment was available and stored correctly. Cleaning chemicals had the appropriate instructions for storage and usage in line with control of substances hazardous to health national guidelines.

Although curtains on the wards appeared visibly clean, some were made of material that was not disposable. We were informed that a system was in place to ensure that curtains were cleaned. However, staff we spoke with were unsure when they had been cleaned and there was no date to suggest they had recently been changed.

Environment and equipment

At the last inspection we identified concerns with unsecured cleaning agents and storage facilities. At this inspection we found cleaning agents were safely stored, yet the lack of storage facilities remained.

There were systems and processes in place to ensure that the premises and equipment used by the service were secure, maintained and suitable for the purpose for which they were being used. However, we found that some wards were cluttered with equipment, storage areas were overfull, and fire exits were not kept clear.

All wards lacked storage space to keep the ward floor areas free from clutter and provide a suitable environment for patients to move around freely. There were many trolleys and pieces of equipment left out across all wards we visited.

We found equipment, including hoists, stands, stackable chairs, and mobility aids stored in front of fire escapes on ward 4, ward 9, ward 7, and ward 8. We escalated this to managers of the wards to ensure all fire escapes remained clear. This had been risk assessed and approved to store wheeled equipment in front of fire escapes. However, due to the wards being interconnected if equipment is stored on either side of the fire escapes then sideways evacuation would be difficult.

We found storage cupboards to be over full, and although staff had arranged stocks tidily the storage rooms were over filled and made it difficult for staff to access the required equipment. The kitchen area between ward 8 and ward 9 was left open to the main corridor and posed a theft risk. We saw that milk cartons had not been placed in cool storage and had been left on the worktop.

We found extra bed spaces had been provisioned on wards to accommodate extra patients due to the current bed shortages at the trust. On ward 3 and ward 7 an extra bed had been placed in a patient bay to accommodate an extra patient. As this was an extra bed on the ward it did not have all the equipment necessary to ensure all their needs could be met. For example, there was no access to piped oxygen. We saw that risk assessments were completed daily to ensure

patient safety and we were informed should a patient require oxygen then the patient would be moved to accommodate their needs.

On the respiratory ward 4 an extra bay for six patients had been opened to ensure respiratory patients received their care on an appropriate ward. However, there was no piped oxygen to all of the beds. From our observations we saw that all the patients who required oxygen received this through the piped oxygen route and not through portable oxygen. We were informed by staff and managers that if a patient required oxygen they were moved to support their needs.

We saw the use of extra bed spaces on wards was included in the full capacity protocol, standard operating procedure, which had been revised in December 2017. We saw that wards were following this protocol in line with the guidance issued.

Access to the wards was controlled, and patients were required to press a call bell to gain access to aid security and patient privacy.

There were bathroom facilities suitable for patients who required a wheelchair. We saw that the bathrooms had grab rails to aid independence.

On ward 7 the flooring required replacement. We found the flooring was damaged and tape had been used to minimise a tripping hazard. The tape used posed an infection risk. We were informed that a program of replacement of flooring had been authorised and the ward was awaiting confirmation of its replacement. On ward 4 were found rust coloured marks on the floor covering, and the shower holder was broken.

We saw there was routine yearly electrical equipment safety testing. This is a process by which electrical appliances are routinely checked for safety. However, we found that some portable equipment such as a radio and heater on ward 9 had not been tested.

We found all equipment on the ward to have appropriate servicing dates to show when the equipment had been serviced. A register was kept to ensure all equipment was serviced appropriately within the given timescales. There was also a process in place for staff to report to broken equipment to the estates department. Staff we spoke with reported all the equipment on the ward was working appropriately.

Waste and clinical specimens were handled and disposed of in a way that kept people safe. Staff used the correct system to handle and sort different types of waste and these were labelled appropriately.

Emergency resuscitation equipment was accessible in the ward areas. Records showed that equipment and consumables were checked daily in line with hospital policy. We checked a sample of consumables and these were in good order and in date. The emergency trolleys were equipped with a defibrillator, oxygen, portable suction and a selection of emergency items. Emergency drugs and fluids were kept in tamper evident cases on the emergency trolleys.

Portable oxygen was stored in appropriate controlled areas within the ward and was ready for use if required.

We observed that all stocks, for example dressing, were in date and the stock was rotated to ensure the stock with the shortest expiry date was used first.

There was a process in place to alert or receive notifications from the Medicines and Healthcare products Regulatory Agency (MHRA). The MHRA ensures that medicines, medical devices and blood components for transfusion meet applicable standards of safety, quality and efficacy. The ward manager checked equipment and devices to ensure that any alerts concerning any equipment or products used at the clinic were identified.

Sepsis tool kits were available on the wards for use if a patient required intervention for sepsis. We found all wards had the required toolkits. However, on ward 8 and ward 9 the toolkit was shared between the two wards. We found two out of date stocks and it was not readily available due to items being stored on top of it. We escalated this to the trust, and the stocks removed and replenished. We did not see there was a risk assessment for the sharing of the sepsis toolkit between wards. For example, for if both wards required its use at the same time.

In the Patient-Led Assessments of Care Environment 2017, 95.9% of patients reported the trust condition, appearance and maintenance was suitable to meet their needs.
The aim of PLACE is to provide a snapshot of organisational performance measured against a range of non-clinical indicators which impact on the patient experience of care

Assessing and responding to patient risk

There were processes in place to ensure care and treatment was provided in a safe way to patients. However, risks to patients were not always well managed.

The risk of patient deterioration was identified through a process of monitoring observations and vital signs. These were formulated into a scoring system called an early warning score. An early warning score is a recognised and widely used system to quickly determine how poorly a patient may be and this is matched against an appropriate clinical response depending on the score. Staff were able to explain how the process worked and what action to take when scores indicated a patient's condition was deteriorating.

Early warning scores were completed using an electronic system to record and monitor a patient's condition. These scores could also be reviewed by managers from desk top computers and by the critical outreach team. Any score above three was automatically highlighted to the critical outreach team so they could be reviewed quickly if necessary.

Ward managers monitored the compliance in monitoring patient early warning scores to ensure they were completed at the right time. The trust target was 90% of observations to be completed on time. We observed compliance times and found the coronary care unit, and ward 3 and 9 consistently met the trust compliance target for required observations to be completed on time. From August 2017 to December 2017, Ward 7 did not meet the trust target of 90% of observations completed on time. Ward 8 had not met the target from April to December 2017, and ward 4 did not meet the target from July to December 2017.
Although all wards were close to meeting this target, it meant that there was an increased risk if a patient deteriorated they would not be escalated promptly.

The trust had been identified as having a higher rate of deaths from sepsis than similar hospitals. There was ongoing work to identify and treat sepsis patients in a timely way. The trust had introduced a sepsis pathway, and had been providing additional training. Staff we spoke with demonstrated knowledge of the process and stated they would refer to a doctor when observations scores were elevated.

There was a nominated sepsis lead and a multidisciplinary steering group at the trust to monitor and guide the management, education and evaluation of sepsis within the trust. Sepsis training was mandatory for all trained staff. All staff we spoke with were aware of the signs of sepsis and the use of the sepsis tool kits and pathway on the ward. We saw the pathway provided step by step guidance with flow charts for staff to follow.

We reviewed the sepsis auditing results from April to June 2017, July to September 2017, and October to December 2017 for acute inpatient admission (for administration of antibiotics within 1 hour). The results showed a decline in results. From April to June 2017, the overall percentage of patients who received antibiotics within one hour was 73%. Results from July to September 2017

showed an overall percentage of 65%. In October to December 2017 the overall percentage of patients across acute in patient wards who received antibiotics was 63%. The trust target was 90%.

This risked patient safety, as not all patients were not receiving antibiotics at the right time. Although there was evidence the trust had taken steps across all inpatient areas by implementing a sepsis pathway and provided the necessary learning, the measures taken did not ensure patient safety as there was little improvement over a nine month period and fell short of the trust target.

However, we observed from patient records that patients who required sepsis treatment were on the appropriate sepsis pathway.

Upon admission to the wards, nurses undertook a series of risk assessments. These included nutritional, pressure ulcer, falls, and venous thromboembolism. We found that patient risk assessments were routinely completed in records and reviewed and updated regularly.

Venous thromboembolism audits were completed on a monthly basis to ensure patients upon admission were screened for venous thromboembolism. Results from the audits from October to December 2017, showed ward 3 consistently (100%) screened patients for venous thromboembolism. However, ward 4 results were consistently below 100% and ranged from 57% to 66% within this period. We saw no evidence that plans were in place to address low compliance on ward 4.

Patients deemed at risk of falls were highlighted and measures put in place to reduce the risk following a falls risk assessment. This included use of slipper socks, cohorting patients in one area with a member of staff being present, or one to one supervision. The trust had recruited a falls co-ordinator to provide support and advice to the wards to reduce the risk of falls in susceptible patients. However, some staff we spoke with reported it was not always possible to provide the level of care needed to ensure patients at risk of falls received this level of support due to the staffing shortages.

Staff on ward 4 piloted the use of sensor mats with personal alarms carried by staff to ensure a rapid response when the mat was activated.

We observed that patients who required pressure relieving equipment were on suitable mattresses, and the trust had a pressure ulcer prevention campaign with ward champions to educate people about pressure ulcers and the steps that can be taken to avoid them. To improve accuracy of staging pressure ulcers the service had introduced the use of digital images to support assessment, identification and treatment of pressure ulcers. Staff informed us that images were sent to the tissue viability team for prompt identification and treatment planning.

Allergies were checked as part of the admission assessment checklist and patients with allergies wore a coloured wrist band as an extra safety alert to the medical team to ensure they checked the patient allergy status prior to intervention.

The trust reviewed the time to first consultant review within 14 hours of admission. In the 2017 review the overall proportion of patients seen and assessed by a suitable consultant within 14 hours of admission was 80%. This was a marked improvement on the 73% recorded in the September 2016 review.

The review also highlighted the overall proportion of patients who required twice daily consultant review, and were reviewed twice by a consultant was 100%. The overall proportion of patients who required a daily consultant review and were reviewed by a consultant was 94%. The review showed that for those patients who required daily review by a consultant, 99% was achieved during a week day, and 81% was achieved on a weekend.

The trust had a critical care outreach team which was operated Monday to Friday from the critical care department. They responded to emergencies on the medical wards and those who were identified through the early warning score process as being at risk of deterioration.

A medical emergency response team was available 24 hours per day in the event of a patient requiring emergency intervention, such as a cardiac arrest.

Consultants and medical staff were available 24 hours per day via an on call rota to provide support should a patient deteriorate overnight.

Emergency pull cords were available in areas where patients were left alone, such as toilets and changing areas. All emergency pull cords were designed to break if they were used as a ligature point.

Call bells were available on wards and we saw that these were placed within reach of patients' hands to help make sure they could access help should it be required. On wards where extra beds were being used, remote call bells were in use.

In endoscopy there were processes in place to ensure patients who were clinically unwell were reviewed by a medical or surgical consultant and admitted to hospital for further care and treatment.

Records showed that ward staff referred patients to the psychiatric liaison service, that they responded in a timely manner and provided guidance and input to ward staff to ensure that patient's mental health needs and risks were considered and met.

Where psychiatric liaison staff had recommended changes to risk management for patients' mental disorders, ward staff had acted on this advice in a timely manner. Where regular reviews were needed, we saw that the psychiatric liaison team had completed these as planned and provided a summary and plan in the medical notes.

The trust was registered to detain patients under the Mental Health Act, when this was required. This was rarely used although we were told of instances where this had worked well.
For example, staff on medical wards had worked with patients who had neglected their physical health as a result of serious mental health problems. A multidisciplinary approach involving psychiatric liaison staff had been adopted to ensure treatment for both physical and mental health problems. Nurses were aware of holding powers under the Mental Health Act and where to seek advice if needed.

Where staff were concerned about the risks patients posed, they used enhanced observations. These were care planned by senior ward staff. The enhanced care risk assessment was used to assess risk and plan for management. Staff also told us they would contact the psychiatric liaison team for urgent advice, and they also on occasion would contact the on call psychiatrist based on site.

Nurse staffing

Staffing levels and skill mix were planned, implemented and reviewed to keep people safe. Any staff shortages were responded to quickly. The trust recognised staffing was a risk across the medical wards, and providing the correct skill mix of staff was challenging.

We observed staffing levels and skill mix were planned and reviewed so that patients could receive safe care and treatment, in line with relevant tools and guidance. The wards used an acuity tool to determine the numbers of staff that were required on a daily basis to provide safe

care and treatment to patients. The service provided three shifts; a long day, an early shift and a night shift to ensure adequate numbers of staff, and continuity for patients. The medical wards were currently reviewing their staffing establishments using a safer staffing tool to ensure there was enough staff to provide care to an increasing higher dependency of patients.

All wards we visited with the exception of Ward 7 and the coronary care unit had vacancies in the numbers of trained nurses to provide care and treatment to patients. The medical assessment unit had three trained nurse vacancies, ward 8 had two vacancies, and wards 3, 4 and 9 each had five trained nurse vacancies. Staff informed us that this created a challenge to ensure there were sufficient numbers of nurses to provide care and treatment to patients.

The ward managers and matrons monitored staffing levels throughout the day and escalated staffing shortfalls due to unplanned sickness or leave. Managers we spoke with told us staffing levels were based on the dependency of patients and this was reviewed daily. Staffing levels on the wards were increased when necessary so patients needing 1:1 care could be appropriately supported. Some staff we spoke with reported that it was not always possible to have increased support on wards as there were too few staff to call upon.

We saw there was a matron used on a daily basis to assess and monitor staffing on each ward to safely deploy staff to the areas that required extra staff. This also included moving staff from one ward to work on another to fill any shortfalls. Staff we spoke with confirmed they were often asked to move to another ward to provide support, but this left their own ward short. From June to December 2017, we saw seven incident reports where staff had escalated their concerns of short staffing following staff members being moved to cover other wards.

Staffing levels were maintained by staff working overtime and with the use of agency staff. Ward managers informed us there was routine use of bank and agency staff to support the vacancies across the wards. We were informed that where possible they block booked agency staff to ensure continuity on the wards.

We saw that nursing staff reported incidents where they felt there was insufficient nursing staff on the ward. Staff told us there was a good culture of reporting of low staffing levels to ensure quality and safety of the wards in which they worked, and once reported managers acted quickly to support the staffing numbers to ensure patient safety. We saw from June to December 2017, 35 incident reports were made by nursing staff escalating concerns regarding staffing levels on their ward.

Nursing staff handovers occurred at every shift handover and included discussions about patient needs, and any staffing, or capacity issues.

We were informed, recruitment campaigns for nursing staff were ongoing. However, a national and regional workforce shortage and an ageing workforce locally impacted on the recruitment and retention of nursing and healthcare staff. To mitigate supply shortages, the service was pursuing recruitment and retention initiatives including rolling recruitment campaigns for staff nurses and healthcare assistants, attendance at local and national recruitment fairs, targeted incentive packages, and development of new roles to attract applicants to hard-to-fill vacancies. There was also a national pilot scheme for the nursing associate roles. We were informed that one member of staff had been recruited into this role so far across medical wards.

All managers we spoke with highlighted that staffing was a risk and we saw that staffing was included on the wards and directorate risk register.

We reviewed staff fill rate data for September 2017 presented at the board meeting in November 2017,and found during the day wards 3 and 4 met the 100% establishment and wards 7, 8, and 9 fell below full establishment with a range of 95% to 97% of nurse staffing shifts filled. During the night, wards 3 and 9 showed full establishment of nursing shifts filled. Wards 4, 7 and 8 were

under established with nursing staff with a range of 97% to 98% of nursing staff shifts filled.

In November 2017, the monthly fill rate for qualified staff, during the day on the medical wards, ranged from 97% (ward 9) to 102% (ward 7). Fill rate data for the evening shifts showed that all ward shifts had been covered. These fill rates were sustained by using bank and agency workers. Staff we spoke with reported that this did not include the extra staffing needed on an adhoc daily basis to ensure those patients with high dependency received the level of care they required.

We saw rotas were completed in advance to plan staffing resources. We observed that any gaps in the staffing rotas were escalated to managers to support with ensuring adequate numbers of nursing staff on each ward.

In order to ensure there were enough nursing staff to fill the necessary shifts to ensure patient safety, the trust used high numbers of bank and agency staff. Data provided by the trust showed that from September 2016 to August 2017, the medical wards used high numbers of bank and agency staff. The numbers of shifts covered by agency staff ranged from zero (coronary care unit) to 1103 shifts (ward 8). The number of shifts covered by bank staff ranged from one (coronary care unit) to 186 (ward 8).

The trust monitored the number of shifts that had not been covered throughout the year. Data provided by the trust showed that from September 2016 to August 2017 a total of 373 shifts had not been covered across the medical wards (5 shifts on coronary care unit, 61 shifts on ward 3, 25 shifts on ward 4, 50 shifts on ward 7, 133 shifts on ward 8, 99 shifts on ward 9).

From September 2016 to August 2017, Macclesfield District General Hospital reported a vacancy rate of 15% in medicine, this was worse than the trust target of 7%. Overall vacancy rates at the trust for nursing staff were 12.6%.

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

From September 2016 to August 2017, Macclesfield District General Hospital reported a turnover rate of 9.7% in medicine, this was better than the trust target of 15.6%. Overall turnover rates for the whole trust for nursing staff were 7.2%.

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

From September 2016 to August 2017, Macclesfield District General Hospital reported a sickness rate of 5.7% in medicine, this was worse than the trust target of 4.63%. Overall sickness rates for nursing staff for the trust as a whole were 4.9%.

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

Medical staffing

The trust recognised medical staffing numbers was a risk across the medical wards and providing enough medical staff was challenging.

Staffing levels and skill mix for medical staff were planned, implemented and reviewed. Any staff shortages were responded to ensure the safety of patients.

Medical and nursing staff reported incidents when there were not enough medical staff on the wards. From June to December 2017, we saw there were nine reported incidents where there was not enough medical cover on the wards.

We reviewed rotas from October 2017 to December 2018 and found that there were consistent

shortfalls in the numbers of doctors allocated to each ward throughout the period. For example, rotas from 18 December to 22 December showed there were 19 unallocated medical staff shifts in the period (out of 154 shifts).

Managers informed us they reported shortfalls in staffing as they occurred to the medical staffing team to ensure patients were reviewed. All records we reviewed showed patients including outliers had been reviewed.

The trust informed us that recruitment for medical staff was an on-going process and they had recently appointed a consultant on ward 3. However, there were shortages of consultants across medical specialities to provide care and treatment to patients and the service was reliant on the use of medical locums to fill the vacancies in medical professionals across the directorate.

Speciality	Grade	Number of vacant positions
Care of the Elderly	Consultants	2 posts
Gastroenterology	ST3+	1 post – vacant up to 31st July 2018
Rheumatology	ST3+	1 post – vacant up to 31st July 2018
Care of the Elderly	ST3+	1 post – vacant up to 31st July 2018
Care of the Elderly	Trust Grade	1 post

Treatment was consultant led at the hospital. Following admission, the continued care of the patient remained the responsibility of the medical consultant with input from specialist nurses as required.

Consultant medical cover was available across medical wards from 9am to 5pm with cover from a consultant on site until 8pm during the week. Outside of these hours an on call system operated. There was no consultant ward round at weekends and patients were only reviewed if they were new patients or there was a request to do so. On the medical admissions unit there was senior medical cover 24 hours a day to provide care and treatment to patients.

For all medical wards where consultants were not present on site, access to consultant and senior advice was always available by telephone. All senior staff we spoke with reported that if consultant advice and support was required they were able to access support quickly.

We saw from records that patients were routinely seen by consultants, middle grade doctors and junior doctors. Each patient was reviewed at least once daily by a junior doctor and any identified problems escalated back to the care of the consultant.

Due to limited success in recruitment nationally the trust was also exploring international recruitment as a means of addressing high priority vacancies, in particular those specialties where the national supply is low.

The trust was also launching a new initiative to assist in retaining foundation year 2 doctors for another year to support and address grade gaps within the directorate.

From the 20 records we reviewed we found that all (100%) patients had been reviewed within 12 hours of admission to hospital, all had diagnosis and management plans in place, and there was evidence of daily ward rounds.

From September 2016 to August 2017, Macclesfield District General Hospital reported a vacancy rate of 9.6% in medicine, this was worse than the trust target of 7%. Overall vacancy rates at the trust for medical staff were 9.4%.

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

From September 2016 to August 2017, Macclesfield District General Hospital reported a turnover rate of 7.7% in medicine, this was better than the trust target of 15.6%. Overall turnover rates at the trust for medical staff were 6.6%.

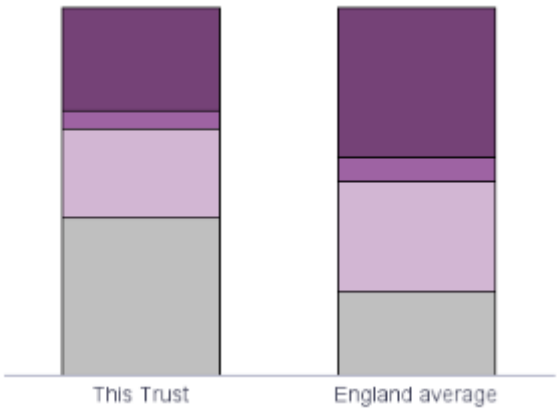
(Source: Routine Provider Information Request (RPIR) P18 Turnover)

From September 2016 to August 2017, Macclesfield District General Hospital reported a sickness rate of 2.9% in medicine, this was better than the trust target of 4.63%. Overall sickness rates across the trust for medical staff were 1.6%.

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

In August 2017, the proportion of consultant staff reported to be working at the trust was lower than the England average and the proportion of junior (foundation year 1-2) staff was higher.

Staffing skill mix for the 57 whole time equivalent staff working in medicine at East Cheshire NHS Trust



	This Trust	England average
Consultant	28%	41%
Middle career^	5%	6%
Registrar group~	24%	30%
Junior*	43%	23%

^ 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 (01/08/2017 - 31/08/2017)

Records

At the last inspection, the quality of records varied. Some essential care documentation, including observational records, was completed poorly. Evidence-based practice was used. However, some people's care plans were not effective in providing guidance to staff on how to safely provide care and treatment to meet patients' assessed needs.

At this inspection we found information was available that was accurate and up to date, and was shared with those involved in the care of patient. However, we found records were not always stored securely to prevent unauthorised access.

Patient records were stored on the wards in records trolleys. We observed staff to replace records back into the trolleys to ensure unauthorised access. However, although the trolleys were equipped with a locking mechanism, we found the trolleys on ward 3, ward 4, ward 8 and ward 9 were not locked to prevent unauthorised access.

On ward 3, ward 4, ward 7 and ward 8, computers had not been placed into screen saver mode following use. This meant that there was a risk that confidential patient information could be viewed by unauthorised people. For example on ward 3, a patient x ray was visible even though staff were not present at the terminal. We raised this with the trust and they took action to improve data security; however it was acknowledged that this had to be balanced with access to the required records. Data supplied by the trust showed that with the exception of ward 8 staff training in information governance met the 95% trust target.

Patient paper records contained a patient admission booklet that contained the necessary information to start treatment at the hospital. We saw that the admission booklet was completed by a range of professionals in order to build a picture of the needs of the patient. This included patient demographics, past medical history, allergies and a range of risk assessments in order to ensure patient safety.

We reviewed 20 patient records across the medical wards and found that nutritional, falls and pressure ulcer risk assessments were completed appropriately across the wards.
We found evidence that patients were being reviewed by the medical team and nursing staff completed observations rounds to ensure the comfort of patients.

Nursing staff completed comfort rounds at pre-determined times dependent on the needs of each individual patient.

Records indicated the individual needs of the patients that included previous diagnosis of dementia, learning disability or mental health related diagnosis.

All 20 records we looked at were structured, legible, signed and contained a diagnosis and management plan.

Patient records included risk assessments, such as for falls, venous thromboembolism, pressure care and nutrition and were reviewed and updated on a regular basis.

Matrons undertook sample records checks as part of their monthly quality assurance audit. This ensured staff compliance with records completion. However, from reviewing matron checklists completed on ward 8 for September 2017 through to December 2017, we found that although there were omissions in records completed there was nothing noted in the main themes or key issues for escalation. This did not provide assurance that any themes for learning were identified or mistakes or omissions escalated to ensure compliance with record keeping.

Medicines

Staff did not manage medicines consistently and safely. Medicines were not stored correctly, and safely. Storage of medicines on medical wards did not always follow best practice medicine guidelines.

Medicines requiring refrigeration were stored in locked fridges, which were monitored daily. However, there was inconsistency across the medical division with accuracy of recording fridge temperatures. We found 15 gaps in daily recording for the fridge for ward 3 and ward 4. (October 2017 to December 2017). Wards did not record the minimum and maximum temperatures in accordance with hospital policy. We observed two fridges not being recorded properly, which meant there was no assurance that the medicines were safe to use. For example, a fridge temperature in the clinic room between ward 3 and ward 4 had been recorded as 2° centigrade for the past three months, yet upon opening the door for a specified period of time the temperature did not change. An independent thermometer measured the temperature at 7.9°centigrade. This was reported to the trust.

On ward 7, the fridge temperatures were recorded as 7° centigrade for the past two months and did record the minimum and maximum fridge temperatures. Using independent thermometers the actual fridge temperature was 10° centigrade. This was reported to the trust. We also found a box of tablets which were out of date from November 2017. We saw during the inspection that new temperature checklists were introduced with extra training to ensure compliance with temperature recordings.

Clinic rooms were secured with key coded locks and medicines were in locked cabinets or in secure automated cabinets. Staff reported operational issues with the automated cabinet as these were shared between wards and caused delays in access to medicines during busy administration times.

The medicines storage area for ward 8 and 9 was combined and staff entered the area via a door either ends of room. The room was small and cramped. The medicines storage consisted of many drawers that were kept locked. Each drawer had separate compartments that could hold up to 10 different medications. We found that medications were not always kept separate. For example, atenolol 25mg and levothyroxine 100mcg were stored in same compartment. We also saw that due to the problem of space, some medicines are stored out of the original packet and so did not have a patient information leaflet. For example, we found Lorazepam injections not stored in their original packaging. This did not follow the medicine guidelines for safe storage of medicines.

On some wards, medicines currently in use were stored in a secure trolley and the date opened was recorded on each container where appropriate. We found two medicines that were out of date. Pharmacy support was provided to replenish and manage stock and staff reported no issues with supply. Patients own medicines were administered where possible.

On ward 3, we found medicines left out on a patient table. The medicines had been dispensed at 8am and at 9.50am they were still on the table. The patient was asleep. This was not safe practice and the medicine could have been inadvertently taken by another patient or visitor.

Controlled drugs were checked daily by ward staff and quarterly as part of the pharmacy audit system. Controlled drug stationary was secure and stock and records were accurate.

Medicines and equipment required in an emergency were readily available and regularly checked and replenished as needed. We inspected the emergency equipment and found equipment was appropriate and in date.

A clinical pharmacist and a pharmacy technician visited the wards Monday to Friday to complete medicines reconciliation, review prescription charts and provide prescribing advice. The prescription charts we inspected showed evidence of pharmacist review and clinical input where necessary. The prescription charts were clearly presented and patient details including allergy status and weight were completed on all wards apart from the admissions ward.

Pharmacist and technician support meant that on weekdays, medicines were dispensed on the wards, so prescription charts did not leave the ward. Additionally, the trust had introduced a discharge team across the hospital to prepare take home prescriptions promptly and prevent delays. This team was a recent addition as a response to winter pressures.

Outside of these hours, inpatient dispensing and clinical advice was provided via an off-site on-call pharmacist. During weekends and bank holidays the department opened from 10.30am until 2.30 pm and provided dispensing services from within the pharmacy department

Ward 8 had recently employed a medicines administration technician. They were trained to administer medicines and ensure patients medicines were managed on the ward. Staff we spoke with were positive about the role and recognised the value of their knowledge.

Where psychiatric liaison staff had recommended changes to medication for the treatment and risk management for patients' mental disorders, ward staff had acted on this advice in a timely manner.

Psychiatric liaison staff reviewed any proposed medication changes, assessed for effects and side effects. Where psychiatric liaison staff advised that monitoring was required, for example, electrocardiogram monitoring when initiating antipsychotic treatment, we saw that this was done.

Where patients were prescribed psychiatric medication, we saw that this was started at a low dose and only increased following reviews of efficacy and side effects. When doctors had prescribed as needed anxiolytic medication we saw that staff would use alternative strategies with patients and that these medicines were not being regularly used.

However, we saw in the records on one ward that a patient had been given rapid tranquillisation in the form of intramuscular medication prior to transfer to the ward. Ward staff had not completed physical monitoring as per the trust policy. The records on the ward did not contain details of all medicines which had been administered or the times these were given. This was raised with the trust and a review of the care was undertaken to identify lessons to be learned.

Incidents

The trust encouraged openness and transparency about identifying and reporting incidents. Staff members were actively encouraged to report incidents and understood their responsibilities to raise concerns, report incidents and near misses.

The trust had an up to date trust incident reporting policy for staff to follow, which was available to them through the hospital intranet.

All staff we spoke with on the medicine wards had a good understanding of the reporting system and could access the system from the ward. All incidents, accidents and near misses were entered onto an electronic system. Staff gave examples of the type of incidents they reported. For example the top three risks staff reported were, falls, pressure ulcers and insufficient staff on the wards.

Data we reviewed regarding incidents made by staff at the trust showed a broad spread of incident reporting and confirmed that staff awareness of their reporting requirements. Staff we spoke with reported that they were encouraged to report incidents.

Staff and managers we spoke with were aware of the main risks and incidents associated to their ward. However, not all staff reported they received feedback once an incident report had been made, although agreed some learning from incidents was disseminated through a range of newsletters and team meetings. The staff on ward 7 also told us of the improvements made in falls prevention by using falls alarms.

We saw serious incident summary sheets were used to provide staff with an overview of incidents, lessons learnt and recommendations. We reviewed six incident summary sheets that were shared with the wards and the safety, quality standards meetings and found they contained learning points and implemented changes.

Incidents were reviewed and investigated by the appropriate managers to look for improvements to the service. Moderate and severe incidents were also investigated through a process of root cause analysis (RCA), with outcomes and lessons learned shared with staff. We saw evidence of root cause analysis reports and found they had been completed to include recommendations, action plans, and lessons learnt which confirmed the process.

Patient safety alerts issued via the central alerting system (CAS), were monitored through an integrated risk management system. The system was checked daily and the information is recorded on the incident reporting system and circulated to the appropriate people for review. Timescales were monitored to ensure completion on a weekly basis in the risk management team meeting and bi-monthly at the risk management subcommittee. (Central alerting system is a web-based cascading system for issuing alerts, important public health messages and other safety critical information and guidance to the NHS and other organisations, including independent providers of health and social care).

Up to December 2017, there were no central alerting system alerts closed late in preceding 12 months. This meant that all alerts were actioned and closed within the reporting timescales.

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

The medicine directorate reported 14 incidences of using the duty of candour processes. We reviewed a sample of these and found that the process had been applied correctly, in line with trust policy and an apology given. Staff we spoke with were aware of duty of candour and what this meant.

Any unexpected deaths or potentially avoidable deaths that occurred in the department were reviewed and discussed at mortality meetings. This meant any patterns and trends could be reviewed and lessons to maintain safety could be identified.

Following a mortality review any extra learning should be shared with staff to learn and improve performance. However, staff we spoke with reported they did not always receive feedback following a mortality review of a patient from their ward.

Never Events

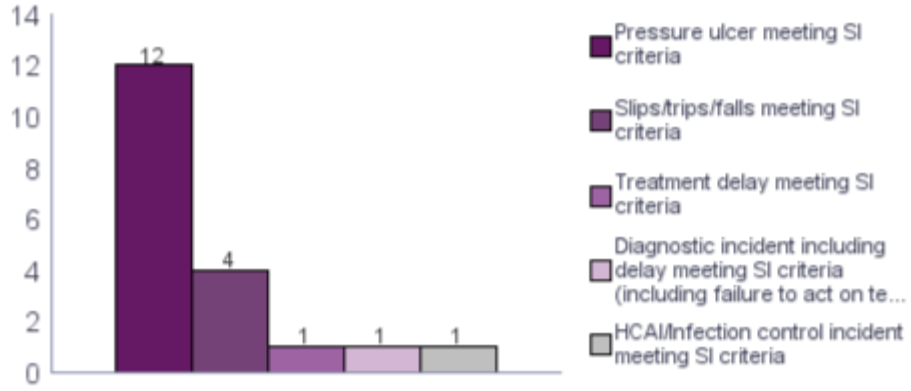
Never Events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From November 2016 to October 2017, the trust reported no incidents classified as never events for medicine.

Source: NHS Improvement - STEIS (01/11/2016 - 31/10/2017)

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported 19 serious incidents (SIs) in medicine which met the reporting criteria set by NHS England from August 2016 to July 2017.



Of these, the most common types of incident reported were pressure ulcers with 12 (63% of total incidents), falls with four (21% of total incidents), and one each of the following three incident types, treatment delay, diagnostic incident including delay and Infection control incident.

(Source: Strategic Executive Information System (STEIS)

Safety Thermometer

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

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

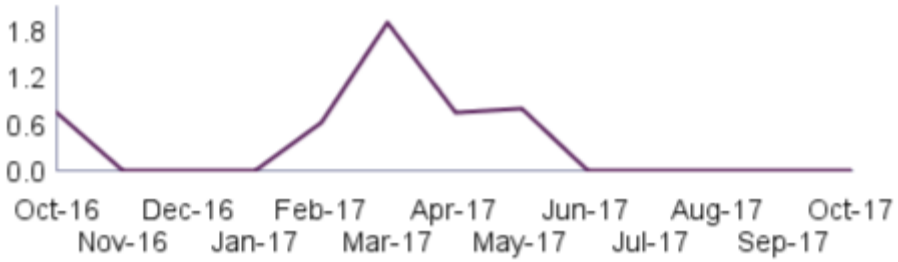
Data from the Patient Safety Thermometer showed that the trust reported 17 new pressure ulcers, three falls with harm and seven new catheter urinary tract infections from October 2016 to October 2017 for medical services. Pressure ulcers showed a variable trend over the period, catheter urinary tract infections peaked in March 2017 and the three falls occurred in December 2016, May 2017 and October 2017.

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

Total Pressure ulcers (17)

Total Falls (3)

Total CUTIs (7)



Source: Safety thermometer - Safety Thermometer

Is the service effective?

Evidence-based care and treatment

There were processes in place to assess, evaluate and improve practice on medical wards to ensure that patients received care and treatment to meet their needs and reflect good practice.

Care and treatment was delivered to patients in line with evidence-based practice and national guidance, such as those from the National Institute for Health and Care Excellence (NICE). For example, patients were assessed for venous thromboembolism (VTE). This is the blocking of a blood vessel by a blood clot dislodged from its site of origin. This was in-line with national guidelines from the National Institute for Health and Care Excellence (NICE) Quality Statement 1. From the 20 records we reviewed we found that venous thromboembolism was assessed appropriately. The trust monitored and audited records to ensure compliance with assessing patients for venous thromboembolism.

We saw that there was an audit schedule to ensure all staff complied with policy and procedures to maintain patient safety. The audit schedule included hand hygiene, aseptic technique, patient records, consent, and infection control.

The service had developed pathways to ensure that patients received safe care and treatment. We saw for example, the service had developed a patient admissions pathway to ensure that all patient needs were addressed and stored using a single document. The document included risk assessments that followed National Institute for Health and Care Excellence guidance.

The latest National Institute for Health and Care Excellence guidance was downloaded on a monthly basis and was available to staff using their electronic systems. This ensured that staff had the most up to date guidance in order to ensure best practice when providing care and treatment to patients.

Ward quality dashboards contained data performance in relation to a number of metrics that included falls, pressure ulcers and early warning score completion on time. We found that staff were aware of how to access their current ward performance results.

The medical wards had introduced an ‘end pyjama paralysis national campaign.’ End pyjama paralysis is a national campaign which encourages hospital patients, where appropriate, to dress in their own clothes and mobilise as much as possible in attempt to aid recovery. However, although there were posters on walls in corridors and on the wards, and staff were aware of the scheme, we found many patients were still in their pyjamas and not sat out. For example, on ward 9, only one patient in a six bedded bay was sat out in their own clothing. In another bay, two patients were sat out and only one patient was in their own clothing. This did not provide assurance that the campaign was being successfully implemented. Staff members reported some patients preferred to stay in bed. We did not see that all patients were being encouraged to sit

out.

In line with best practice, ward staff were supported to care for patients with presenting mental health conditions through the provision of psychiatric liaison staff employed by the nearby mental health trust. The psychiatric liaison service worked 24 hours a day, seven days a week with patients of all ages who required mental health input. At night, the priority was for assessments in the emergency department. Staff on wards told us they rarely required liaison services at night, as referrals were often made and patients seen during the day. Staff would contact the team at night if needed, and there was also access to night sisters, senior nurses and the on call psychiatrist if needed.

Nutrition and hydration

Patients had comprehensive nutritional assessments and plans completed to meet their needs. The expected outcomes were identified and care and treatment was reviewed and updated as needed.

The patient's records we checked included all appropriate assessments for nutritional intake which highlighted those at risk of malnutrition and we saw that these were reviewed at appropriate intervals. We found patients on food charts and fluid balance charts had these completed and updated appropriately.

Wards had access to a dietitian during the day who provided advice and support for those people who were highlighted to be at risk of dehydration or malnutrition. We saw evidence that those at risk were referred to and reviewed by a dietitian. Staff we spoke with reported that upon referral to the dietitian team they responded quickly.

Patients told us they were happy with the quality and choice of food and that was provided. They stated the food was warm and palatable.

In the 2017, patient led assessments of the care environment 93% of patients reported the ward food and drink was suitable for their needs. The food domain includes a range of organisational questions relating to the catering service, for example choice of food, 24-hour availability, meal times and access to menus. It also includes an assessment of food at ward level including the taste, texture and appropriateness of serving temperature. The national average was 89.7%.

We observed most staff supported those patients with their dietary requirements as needed, and a team of volunteers supported handing out meals to ensure patients received their meals quickly. They also supported with cutting up food if the patients wished. However, on ward 8 we observed four out of six patients in a bay required some assistance with their dietary requirements. Support for them was slow and risked food going cold.

Pain relief

The service made sure that staff provided pain relief to patients that met their individual needs care based on using national guidance and evidence in order to achieve positive outcomes for patients.

Wards assessed pain as part of the early warning score system. We saw that pain scores were completed as part of that process.

The medical wards had access to a dedicated pain team with specialist nurses within core working hours. Out of hours and weekends, pain advice could be sought from the on-call anaesthetist.

For those patients who were unable to make their needs known a specialist assessment was used to support with identifying and assessing pain.

Specific tools were available for patients with dementia, including specialist pain scales. Although these were not used regularly, it was clear from records that when patients required pain relief or pain reviews, these were completed promptly.

The patients we spoke with were satisfied that their pain was assessed and treated appropriately.

Patient outcomes

At the last inspection we found there were some measures of patient outcomes, but not all staff were fully aware of these.

At this inspection we found patients care and treatment outcomes were routinely collected, monitored and used to improve care. However, following collection of national audit data to improve outcomes, staff reported they did not receive feedback in relation to trust performance

Outcomes for patients' were generally positive, consistent and met expectations.

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

There was a programme of auditing in place across the trust medical wards. Audit meetings took place and results discussed through safety, quality and standards meetings, sub committees and audit committees. We saw that these meetings were attended by senior managers at the trust. However, staff we spoke with informed us results from these audits were not cascaded down to the wards. For example, on the cardiology and diabetes ward, data was collected for the national heart failure audit and diabetes audit. Staff were not aware of the results from the audit and the actions to improve compliance in the audits.

Relative risk of readmission

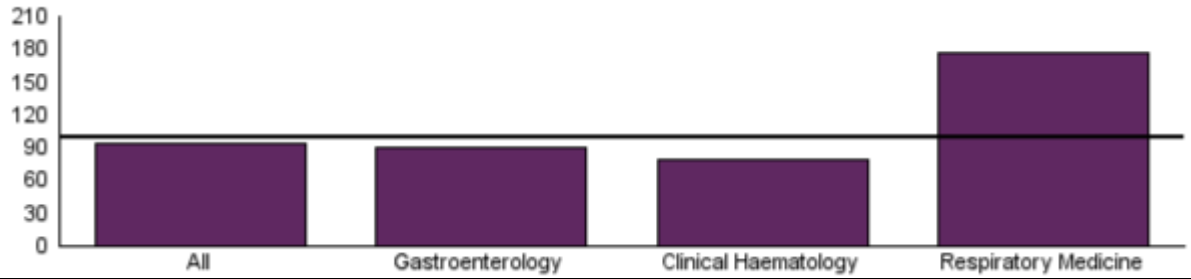
Macclesfield District General Hospital

From July 2016 to June 2017, patients at Macclesfield District General Hospital had a lower than expected risk of readmission for elective admissions and a lower than expected risk of readmission for non-elective admissions when compared to the England average.

For elective admissions:

- Patients in Gastroenterology had a lower than expected risk of readmission.
- Patients in Clinical Haematology had a lower than expected risk of readmission.
- Patients in Respiratory Medicine had a higher than expected risk of readmission.

Elective Admissions - *Macclesfield District General Hospital*



Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity.

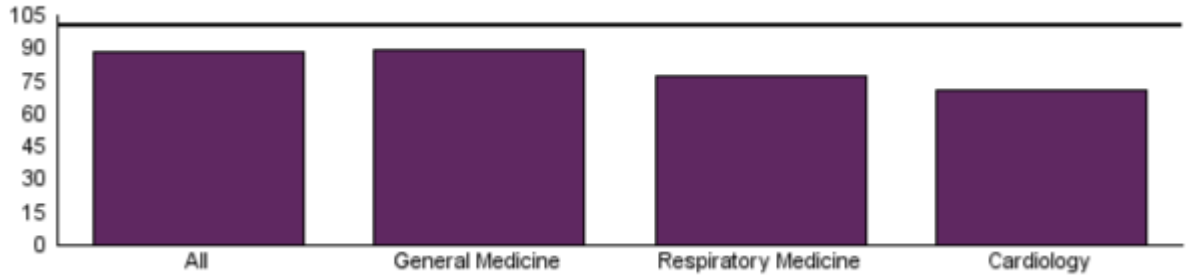
Information provided by the trust showed from April 2017 to December 2017, there were 23 patients who were readmitted within 30 days in respiratory medicine out of a total number of 181 patients. From September to December 2017, the service has seen a reduction in the numbers of patients being readmitted to this speciality.

30 Day Readmission Rates - Elective						
Month	Emergency Medicine			Respiratory		
	Number of Readmissions	Total Number Of Patients	Percentage	Number of Readmissions	Total Number Of Patients	Percentage
Apr-17				1	14	7.14%
May-17				4	29	13.79%
Jun-17				4	14	28.57%
Jul-17				3	19	15.79%
Aug-17				4	26	15.39%
Sep-17				2	18	11.11%
Oct-17				1	23	4.35%
Nov-17				2	18	11.11%
Dec-17				2	20	10.00%

For non-elective admissions:

- Patients in General Medicine had a lower than expected risk of readmission.
- Patients in Respiratory Medicine had a lower than expected risk of readmission.
- Patients in Cardiology had a lower than expected risk of readmission.

Non-Elective Admissions - *Macclesfield District General Hospital*



Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity.

(Source: Hospital Episode Statistics)

Sentinel Stroke National Audit Programme (SSNAP)

Macclesfield District General Hospital takes part in the quarterly Sentinel Stroke National Audit programme. On a scale of A-E, where A is best, the trust achieved grade B in the latest audit, April 2017 to July 2017. Performance was generally strong across both patient centred and team centred performance, except for the stroke unit and speech and language therapy. Over time, a notable variance occurred in thrombolysis between January 2016 and November 2016.

In October 2016, the district stroke centre and associated stroke services transferred from the

East Cheshire NHS trust to a neighbouring trust. This meant patients who suffered a stroke at the Macclesfield district general hospital were stabilised and transferred to the neighbouring trust to receive specialist care and treatment. We saw there was a transfer policy with flow diagrams to aid clinicians in decision making for transfers.

Overall scores

Overall Scores	Jan-Mar 16	Apr-Jul 16	Apr-Jul 16	Aug-Nov 16	Dec 16 -Mar 17	Apr 17 - Jul 17
SSNAP level	B↑	C↓	A↑↑	B↓	B	B
Case ascertainment band	A↑	A	A	A	A	A
Audit compliance band	A↑↑↑	D↓↓↓	A↑↑↑	D↓↓↓	A↑↑↑	C↓↓
Combined Total Key Indicator level	B	B	A↑	A	B↓	A↑

1 Included in IM reporting, indicator SSNAPD02

Best A B C D E Worst N/A No assessment

Patient centred Performance

	Oct-Dec 15	Jan-Mar 16	Apr-Jul 16	Aug-Nov 16	Dec 16 - Mar 17	Apr 17 - Jul 17
Domain 1: Scanning	B	C↓	B↑	A↑	B↓	C↓
Domain 2: Stroke unit	C↓	D↓	C↑	C	D↓	D
Domain 3: Thrombolysis	C↑	B↑	E↓↓↓	B↑↑↑	C↓	B↑
Domain 4: Specialist assessments	B	B	B	B	B	C↓
Domain 5: Occupational therapy	A	A	A	A	A	A
Domain 6: Physiotherapy	A	B↓	A↑	B↓	B	B
Domain 7: Speech and language therapy	C↑↑	C	C	C	D↓	C↑
Domain 8: Multi-disciplinary team working	B	C↓	B↑	B	B	B
Domain 9: Standards by discharge	A↑	B↓	A↑	A	A	A
Domain 10: Discharge processes	A	A	A	A	A	A
Patient-centred Total Key Indicator Level	A↑	B↓	B	A↑	B↓	B

Team centred Performance

	Oct-Dec 15	Jan-Mar 16	Apr-Jul 16	Aug-Nov 16	Dec 16 - Mar 17	Apr 17 -Jul 17
Domain 1: Scanning	D	NA	NA	NA	NA	NA
Domain 2: Stroke unit	E↓↓↓	D↑	B↑↑	B	C	C
Domain 3: Thrombolysis	E	NA	NA	NA	NA	NA

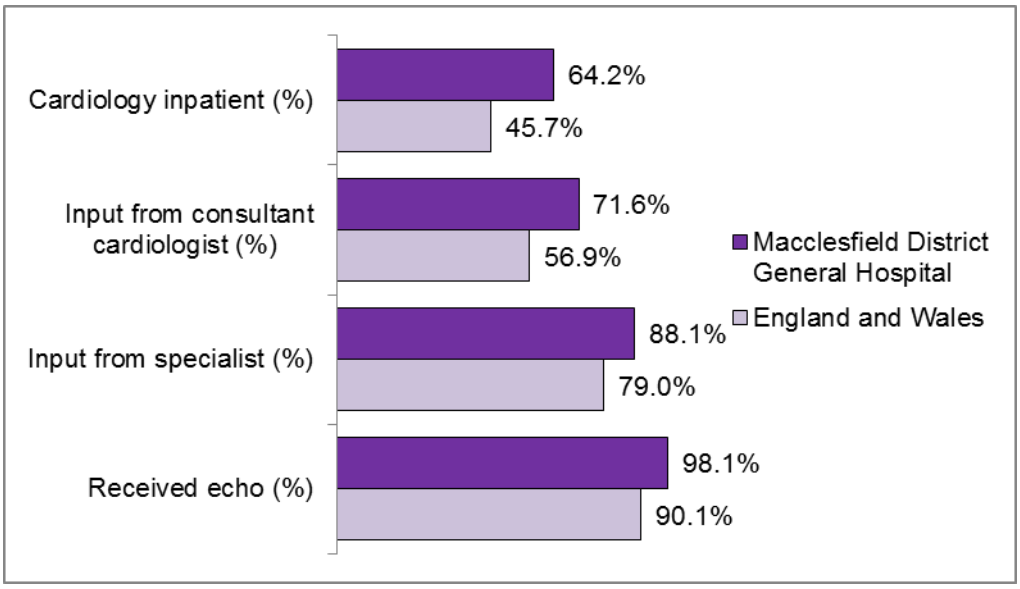
Domain 4: Specialist assessments	E	NA	NA	NA	NA	NA
Domain 5: Occupational therapy	A	A	A	A	A	A
Domain 6: Physiotherapy	B↓	B	A↑	A	A↑	A↑
Domain 7: Speech and language therapy	D↑	E↓	D↑	E↓	C↑	C↑
Domain 8: Multi-disciplinary team working	C	NA	NA	NA	NA	NA
Domain 9: Standards by discharge	A↑	B↓	A↑	A	A	A
Domain 10: Discharge processes	A	A	A	A	A	A
Team-centred Total Key Indicator Level	D↓↓	B↑↑	A↑	A	A↑	A↑

Source: Royal College of Physicians London, SSNAP audit)

Heart Failure Audit

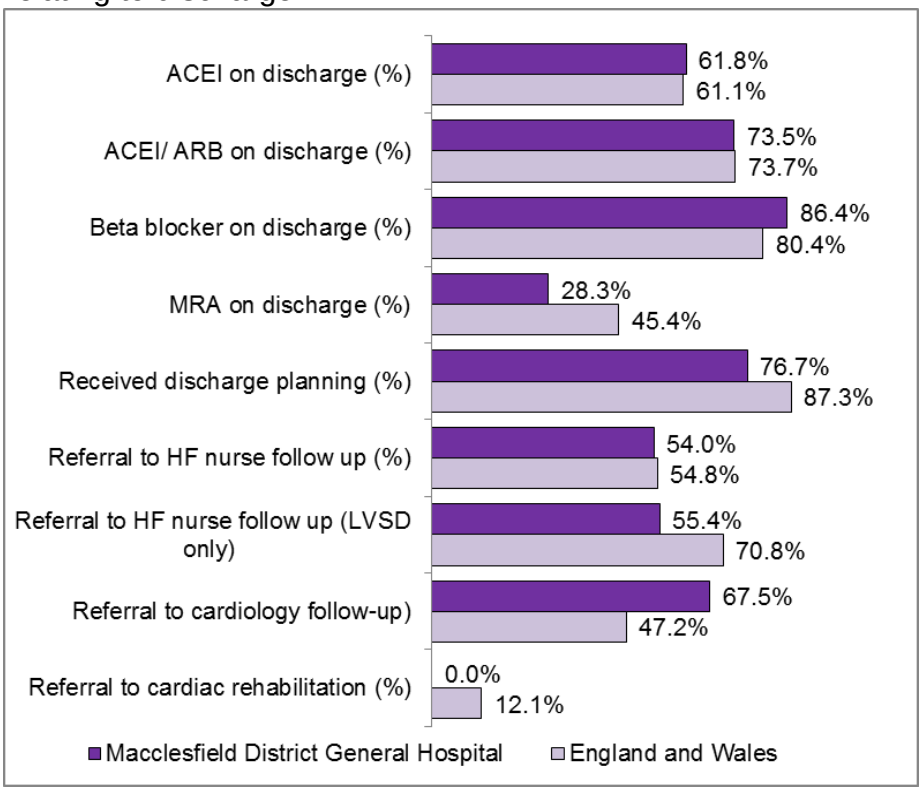
In-hospital Care Scores

Results for East Cheshire NHS Trust in the 2015 Heart Failure Audit were better than the England and Wales average for all four of the standards relating to in-hospital care.



Discharge Scores

Results for East Cheshire NHS trust results were better than the average for England and Wales for two of the seven standards relating to discharge, worse than the average for England and Wales for two and similar to the average for England and Wales for three of the seven standards relating to discharge.



SOURCE: NICOR - Heart Failure Audit 2015.

National Diabetes Inpatient Audit

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

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

The 2016 National Diabetes Inpatient Audit identified 55 in patients with diabetes at Macclesfield District General Hospital. This was equal to 20.8 per cent of the beds audited, which places Macclesfield District General Hospital in Quartile 4.

In Macclesfield District General Hospital in 2016, 82.7 per cent of patients with diabetes reported that they were satisfied or very satisfied with the overall care of their diabetes while in hospital, which places this site in Quartile 2.

(Source: NHS Digital)

Myocardial Ischaemia National Audit Project (MINAP)

All hospitals in England that treat heart attack patients submit data to MINAP by hospital site (as opposed to trust).

From April 2015 to March 2016, 64.0% of nSTEMI patients were admitted to a cardiac unit or ward at Macclesfield District General Hospital and 93.7% were seen by a cardiologist or member of the team compared to averages for England of 55.8% and 96.2%.

The proportion of nSTEMI patients who were referred for or had angiography at Macclesfield District General Hospital was 91.5% compared to an England average of 83.6%.

2015/16	nSTEMI patients seen by a cardiologist or a member of team	nSTEMI patients admitted to cardiac unit or ward	nSTEMI patients that were referred for or had angiography (including after discharge)
Macclesfield District General Hospital	111	111	82
	93.7%	64.0%	91.5%
England: overall	47,039	47,039	39.082
	96.2%	55.8%	83.6%

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

Lung Cancer Audit

The trust participated in the 2016 Lung Cancer Audit and the proportion of patients seen by a cancer nurse specialist was 85%, which was worse the audit aspirational standard of 90%. The 2015 figure was 92%.

The proportion of patients with histologically confirmed Non-Small Cell Lung Cancer (NSCLC) receiving surgery was 25.9%; this is not significantly different from the national level. The 2015 figure was 32%.

The proportion of fit patients with advanced NSCLC receiving chemotherapy was 47.6%; this is not significantly different from the national level. The 2015 figure was 68%.

The proportion of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy was 86.7%; this is not significantly different from the national level. The 2015 figure was 69%.

The one year relative survival rate for the trust in 2016 is 42.9%; this is not significantly different from the national level.

(Source: National Lung Cancer Audit)

National Audit of Inpatient Falls 2017

In the 2017 National Audit of Inpatient Falls, Macclesfield District General Hospital performed as follows:

The crude proportion of patients who had a vision assessment (if applicable) was 0% this below the national aspirational standard of 100%.

The crude proportion of patients who had a lying and standing blood pressure assessment (if applicable) 22% this was below the national aspirational standard of 100%.

The crude proportion of patients assessed for the presence or absence of delirium (if applicable) was 0% this was below the national aspirational standard of 100%.

The crude proportion of patients with appropriate mobility aid in reach (if applicable) was 55% this was below the national aspirational standard of 100%.

(Source: Royal College of Physicians)

Competent staff

Staff, including volunteers were appropriately recruited, qualified and had the skills they need to carry out their roles. Their performance was monitored to make sure that they were able to deliver appropriate care and treatment to patients.

There was a process in place to ensure that all staff employed at the service had the right qualifications, competence, skills and experience necessary in order for them to carry out their role within the organisation. Training was monitored by managers and courses were available for staff to attend. Staff also reported they received in-house training and support from a range of specialist staff.

Staff we spoke with reported they worked within the scope of their practice and were aware of their roles and responsibilities.

Staff told us they received training in learning disability and autism as part of their mandatory training. Staff could clearly explain the need for careful consideration of the patient needs, and the assessments that would be completed. We saw in patient records that booklets were used to gather information regarding the extra needs of the patient which included information from carers.

The trust had funded time each week for the liaison psychiatrist to provide mental health awareness training for staff. The sessions were scenario based within the hospital simulation suite. Staff on medical wards who had attended gave positive feedback for this training and the effect on their own knowledge and skills. There were also set sessions provided for junior medical staff training.

Staff on ward 3 had attended bespoke conflict resolution training following two incidents on the ward; this was developed between the trust and the psychiatric liaison team.

Staff across the medical wards attended mental health clinical skills simulation training days. These training days were run every three months for inpatient staff, led by the liaison team psychiatrist.

Staff across the medical wards attended one day dementia training and training for end of life care in dementia developed with a local clinical commissioning group. Data provided by the trust showed 174 (80%) staff across the acute wards (3,4,7,8,9) had attended the annual clinical mandatory update sessions during 2017, which included a two hour session on dementia and end of life.

At the time of inspection, 71% of nursing staff working in wards 3, 4, 7, 8, 9 had completed learning disability awareness training.

Staff reported that due to staffing levels it was not always possible to attend training and some training days were cancelled due to the continued bed pressures at the hospital. However, staff reported the training they received was adequate to meet their needs and provided them the skills required to fulfil their role.

Ward managers kept records of those staff that had completed any further training including blood transfusions and cannulation. This was added to the staff personnel file.

There were a number of specialist nurses across the trust to provide the support needed and training to support staff to deliver safe care and treatment. Staff reported patient falls was a risk on the wards they worked, and reported a falls co-ordinator role had been developed to support them with advice and support.

Medical and nursing staff were supported through the revalidation process. Revalidation is the new process that all nurses and midwives in the UK will need to follow from April 2016 to maintain their registration with the Nursing and Midwifery Council (NMC) and allow them to continue practicing. We saw that ward managers held a database of those staff who had either been through or were nearing the revalidation.

Appraisal rates

From April 2016 to March 2017, 90% of staff within medicine at the trust had received an appraisal which was similar to the trust target. No information regarding appraisals of Medical and Dental staff at this trust has been provided.

A split by staff group can be seen in the table below:

Staff Group	Number of staff appraised	Number of staff applicable	Completion	Target	Met Target (Yes/No)
Estates and Ancillary	5	5	100.0%	90.0%	Yes
Additional Clinical Services	92	99	92.9%	90.0%	Yes
Administrative and Clerical	7	8	87.5%	90.0%	No
Nursing and Midwifery Registered	101	116	87.1%	90.0%	No
Allied Health Professionals	4	5	80.0%	90.0%	No
Grand Total	209	233	89.7%	90.0%	No

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

Data provided by the trust showed that medical appraisal rates varied across the medical specialities. Within the gastroenterology and cardiology speciality, 100% of medical staff had received their appraisal. However, in care of the elderly and respiratory specialities the number of medical staff that had received an appraisal was 67% and 50%. This did not meet the required 90% trust target.

We saw that appraisal rates for each ward was monitored and as part of the ward quality performance dashboard. Data supplied by the trust to December 2017 showed all wards with exception of ward 3 (85%) and ward 8 (84%) met the trust target (90%) for the numbers of staff who had received an appraisal.

Multidisciplinary working

Staff worked well together in order to meet the range and complexity of patients' needs.

There is a range of professionals working together to ensure safe care and treatment to patients across medical wards. These included consultants, doctors of various grades, nurses, specialist nurses, therapists, healthcare workers and volunteers. We saw from records and through observations that these teams of professionals worked together cohesively to care and treat all

patients.

There was access to a wide range of specialist staff such as palliative care and tissue viability specialists, which could be requested for advice and input.

We observed positive working relationships between managers and the staff groups. We observed managers across the department to have close professional relationships with the staffing groups, and provided them with advice and guidance as required.

There were ward-based board rounds to discuss patients' pathway of care, and monitor progress towards estimated dates of discharge. We saw the board rounds involved medical, therapy, nursing, and social services staff.

Occupational and physiotherapists worked with patients to assist in their recovery and rehabilitation. We saw they worked alongside the nursing staff to ensure patients did not lose their independence. However, due to the low staffing numbers across the therapy teams it was difficult for the therapists to see all the patients daily. There was recognition from senior therapy managers that more therapy staff was required to ensure satisfactory therapy input is given.

Ward staff had access to specialised support from the psychiatric liaison team consisting of a consultant liaison psychiatrist, clinical lead and registered mental health nurses.

A hospital alcohol liaison nurse was based within the team. Their input was valued across medical wards.

Staff within the psychiatric liaison team and staff on the wards valued each other’s input and commented that the service worked well together to meet patients’ physical and mental health. Staff worked together in a co-ordinated way to ensure patients received appropriate treatment which helped promote patients’ mental wellbeing and alleviated distressing mental health symptoms.

Staff worked together in a co-ordinated way to ensure patients received appropriate treatment which helped promote patients’ mental well-being and alleviated distressing mental health symptoms.

A dementia steering group had been developed by the trust and membership included multidisciplinary input from the trust and the mental health trust as well as patient and carer involvement.

We saw that the frailty team regularly reviewed patients who presented with confusion or had an increased risk of falls. The team was a healthcare operated service to support elderly patients to return home quickly, avoid an unnecessary hospital admission or ensure they were cared for on the most appropriate ward. We saw the service lacked a social care worker to support in the discharging of patients before they entered the hospital system.

We saw examples of information provided by the pharmacy team to assist the ward staff when prescribing or preparing medicines for administration in accordance with national guidance. There were also posters in the clinic rooms providing guidance to ensure medicines were used safely. All staff had access to the hospital medicines policy, which provided information and guidance on specific medicines related topics such as self-administration.

Seven-day services

Not all relevant staff, teams and services were available seven days per week in assessing, planning and delivering patients’ care and treatment.

There was no consultant led ward round on medical wards at the weekend. Patients who required a review at the weekend were highlighted for inclusion at a weekend ward round.

Only newly admitted patients and those patients who required a medical review were routinely seen at weekends by a senior clinician.

The psychiatric liaison service worked 24 hours a day, 7 days a week with patients of all ages who required mental health input.

Not all specialist services operated over a 7 day period. The speech and language team operated from Monday to Friday. This meant that if a patient required an urgent swallow review it meant they were likely to remain nil by mouth over a weekend until they could be seen. Staff we spoke with confirmed this and reported that if a patient required an urgent review on Friday this would be escalated to ensure the review took place.

On the coronary care unit, patients were only reviewed Monday to Friday and there was no routine practice to review patients at the weekend. This was not in line with the British cardiovascular society guidance that states all patients on an acute cardiac care unit to be reviewed daily by senior member of cardiology medical team, seven days a week. We were informed that there were not enough consultants at the trust to be able to provide a full seven day service. However, each patient had a weekend plan of care, so a review could be arranged if it was required. There was also 24 hour on call arrangements in place for evenings and weekends for a medical registrar to review patients if required, and there was a fast bleep system for escalating deteriorating patients.

Health promotion

There was a focus on early identification, prevention and on supporting patients to improve their health and wellbeing.

The medicine division had access to a range of health promotion advice services. This included smoking cessation. This could be obtained through a referral from the wards.

All directorate staff were encouraged to have a flu vaccination to help reduce the spread of flu between staff and patients. Performance with the uptake of the flu vaccination from September 2016 to February 2017 was 62%. The national average was 67% for the same period.

Health and condition specific advice was provided in leaflets and posters which were in place at various points around the medicine wards and corridors and other areas in the hospital such as canteen and entrance areas.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

At the last inspection, staff understanding and awareness of assessing people’s capacity to make decisions about their care and treatment was variable.

At this inspection, we found patients were supported to make decisions and, where appropriate, their mental capacity was assessed, recorded and acted on in line with relevant legislation.

The trust had a policy to guide staff in understanding their responsibilities under the Mental Capacity Act. This also contained guidance on deprivation of liberty safeguards, advanced decision and power of attorney.

A deprivation of liberty means taking someone's freedom away. A recent Supreme Court judgement decided that someone is deprived of their liberty if they are both 'under continuous

supervision and control and not free to leave'. This may occur when a person who has been assessed not to have capacity to consent to their care and treatment, is cared for in such a way that restricts it impacts on their freedom. This may be done following a decision which confirms the care provided is in the best interests of the patient and that actions taken are the least restrictive. This is then authorised if appropriate by the local authority.

Upon depriving a person of their liberty there is a requirement to send a notification to the Care Quality Commission. We found that these notifications were being made in line with reporting requirements.

Patients who were deemed to lack capacity over ongoing treatment decisions for physical health problems had capacity assessments completed, along with deprivation of liberty safeguards applications when needed, on all medical wards visited.

We saw good practice in that applications were discussed with patient's relatives and carers.

Where a standard application was made for deprivation of liberty, we saw two forms from a total of seven reviewed where the urgent authorisation had not been completed.

In three files, there were no copies of the deprivation of liberty applications, but these were located as copies sent to the legal team. There is no guidance for staff within the policy about whether copies should be kept in the clinical records, although there may be occasion where staff may need to evidence that urgent authorisation is in place.

Data provided by the trust showed that Mental Capacity Act and deprivation of liberty safeguards audits were completed. We reviewed five records audited in March 2017 and in October 2017. We found in the March 2017, the audit was not accurately completed as the final section which checked staff knowledge was not completed. This did not provide assurance that staff were aware of the processes to follow. However, the October 2017 audited records showed full compliance with the audit.

Staff were required to complete Mental Capacity Act and deprivation of liberty safeguards training as part of their mandatory training. Staff we spoke with were conversant with the principles of the Mental Capacity Act and had an understanding of the deprivation of liberty safeguards procedures.

All adults are presumed to have sufficient mental capacity to decide on their own medical treatment, unless there is evidence to suggest that their mind is impaired or disturbed in some way, and this might indicate that the person is unable to make a specific decision at that time.

We saw an example of a well completed capacity assessment and best interest decision made for an incapacitated adult for urgent medical treatment which was in line with the principles of the Mental Capacity Act. This included consultation with an independent mental capacity advocate.

We saw that the trust had completed a consent audit in February 2017 that included the endoscopy unit. The audit looked at 13 different parameters which included consent form in the front of the records, and information given to the patient.

Results from the audit highlighted areas of non-compliance and made comparisons from the audit completed in February 2016. Results indicated that from the 13 parameters reviewed only six had improved, five had decreased in compliance and two had remained the same. Although we saw an action plans had been developed to increase compliance it did not provide assurance that learning from the 2016 audit had been fully implemented due to the fact that the issues prevalent in the 2016 audit were still present in the 2017 audit. The findings did not also provide a breakdown of the department or wards with the worst compliance in order to target compliance issues from the audits.

Is the service caring?

Compassionate care

Friends and Family test performance

The Friends and Family test response rate for medicine at Macclesfield District General Hospital was 40% which was better than the England average of 25% from October 2016 to September 2017.

			Percentage of patients recommending the service as a place to receive treatment												
Ward name	Total Resp	Avg. Response Rate	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 16 - Oct 17
CCU	109	54%	100%	100%	100%	100%	100%	100%	100%	100%		100%	88%	93%	98%
Endoscopy	1,402	37%	97%	96%	94%	96%	96%	97%	97%	96%	97%	97%	95%	96%	96%
Ward 3	433	62%	98%	83%	92%	91%	91%	88%	87%	100%	93%	94%	100%	96%	93%
Ward 4	429	44%	79%	100%	95%	96%	83%	85%	94%	85%	88%	100%	91%	91%	87%
Ward 5	33	22%					83%								83%
Ward 7	221	33%	90%	100%	90%	86%	96%	94%	100%	94%	100%	90%	93%	100%	93%
Ward 8	526	34%	94%	98%	93%	100%	91%	100%	90%	93%	91%	100%	88%	96%	94%
Ward 9	290	70%	100%	100%	100%			97%	93%	100%	100%	83%		100%	97%
Ward 11	83	27%	93%	100%	100%	100%		100%	80%			71%	80%	100%	93%

	Highest score to Lowest score		
Key	100%	50%	0%

Note - The formatting above is conditional formatting which colours cells on a grading from highest to lowest, to aid in seeing quickly where scores are high or low. Colours do not imply the passing or failing of any national standard.

Note: sorted by total response

The coronary care unit performed the best overall with 98%. Ward 5 scored 83% however figures were provided for only one month by the trust.

(Source: NHS England Friends and Family Test)

At the last inspection, we found staff were committed and passionate about providing good care. All of the patients we spoke with were positive about their experience. Interactions were mostly positive. However, in some areas staff were task oriented and did not always provide a person-centred care approach.

At this inspection feedback from patients was positive about the way staff treat people. Overall, patients and their relatives told us they were treated with dignity, respect and kindness.

We spoke with 26 patients and five visitors and carried out observations during our inspection. Patients were overall complimentary about the care they had received from staff at all levels. They told us that they felt safe, the care was excellent, and they were treated with kindness and compassion.

We observed positive and supportive interactions between patients and staff. Cubicle curtains were drawn and single room doors were closed during patient care to protect the privacy and dignity of patients. We saw that staff asked permission before entering side rooms and cubicles or when the curtains were drawn.

Patients told us that the staff were ‘very nice and make time for you’ and felt ‘comforted and

looked after' whilst in hospital.

We observed staff greeting patients on their arrival and introducing themselves. Staff were polite friendly and helpful in their approach.

We saw that staff respected patient dignity and privacy and ensured discussions and care needs took place behind privacy curtains. Overall, patients we asked reported that their dignity and privacy was maintained throughout their stay.

We observed many positive interactions between staff and patients during our inspection. We saw that staff were very professional, welcoming, approachable and friendly. Overall patients we spoke with were very positive about the way staff treated them.

We saw skilled interactions by nurses with patients who were distressed and required reassurance. When patients became distressed and agitated, staff interventions were individualised and nursing staff clearly knew what helped.

Care delivered to patients with learning disabilities was patient centred and focused on ensuring decisions for treatment were made in line with the patient's best interests.

The service routinely asked for feedback from patients using the friends and family feedback questionnaire and a variety of surveys. These results were used to establish how well the ward cared for its patients and were reported on through the ward quality and performance dashboards. We saw each ward displayed the results so staff could see how the well they were performing.

On ward 7, wash bags containing body care products had been made up by a local guide group for patients who were admitted and did not have any washing products.

Despite the wards being at full capacity, we saw evidence of staff taking time to care for patients. We observed a housekeeper preparing drinks who knew each patient personally and remembered each patient's preference, and made them feel special.

Emotional support

Staff responded compassionately when patients or their relatives needed help. Support was given by caring staff as and when required to meet their individual needs.

Staff provided emotional support to patients to minimise their distress.

A chaplaincy and spiritual care team was available to patients and relatives 24 hours every day.

The trust had raised staff awareness in relation to noise at night and had introduced using sleep packs including eye masks and ear plugs to reduce noise at night on the wards.

Bereavement advice and support were available to relatives and carers through the trust bereavement service.

All wards we visited had 'thank you' cards from patients and visitors. We saw comments thanked staff for their 'kind and thoughtful care'.

Understanding and involvement of patients and those close to them

Patients and their relatives were involved and encouraged to make decisions about the care and support their received.

All staff we observed communicated respectfully and effectively with patients.

We saw evidence that treatment plans were discussed with carers, including discharge plans. There was evidence in some records of good collaborative planning with families.

On the medical day case unit we observed a staff member talking through a treatment plan and the tests being carried out to support the patient's understanding.

Staff communicated with patients so that they understood their care, treatment and condition. Overall patients confirmed that staff explained their care and treatment, and kept them up to date with any required information. However, some patients reported that the staff were under a lot of pressure and often too busy to spend time with patients and their families.

We saw evidence in care records that staff had included relatives in involving them in the care planning of patient needs.

Is the service responsive?

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

Services provided reflected the needs of the population they served, and there were a variety of medical services offered to meet the needs of patients. These included diabetes, respiratory, care of the elderly, cardiology and gastroenterology services.

The medicine directorate recognised the needs of the local population and used various sources of data such as public engagement and the use of local data and statistics to design and plan the services provided. This included an understanding of the demographics of the patients. For example there was an understanding of an ageing population with increased health needs. In order to support these patients there were specialist nurses employed and a social work team to support patient's transfers back into the community.

However, the service were not always able to provide care in facilities and premises appropriate for the care delivered. For example, due to the numbers of patients who required hospitalisation extra patient beds were placed on wards in areas that were not suitable. For example, there was an extra bed placed on ward 3 in a six bedded bay that did not have access to piped oxygen and did not have privacy screens. This required the patient to move if they needed oxygen and required the staff to bring portable privacy screens if the patient required care and treatment. At the time of inspection, we observed patients that required oxygen were in ward areas that accessed piped oxygen, and screens were available for use where needed.

On ward 9 an extra bed had been located that was very close to a wash hand basis. This bed had previously been risk assessed and removed due to it being too cramped in the bay and too near a wash hand basin that splashed the curtains. This had been re-risk assessed and deemed appropriate for use.

Although the extra bed spaces had been risk assessed, extra staffing authorised, and patients visited daily by the patient advice and liaison service, this created further lack of space on already cramped wards with little storage space.

On the medical day case unit they were trialling an intravenous therapy service. This meant that patients who required intravenous therapy over a number of sessions for a specified time were able to go home and attend the unit on a daily basis to receive treatment. This freed bed spaces for those patients being admitted.

There were four beds on the coronary care unit which offered up to level 2 care (enhanced care

for those patients requiring more detailed observation or intervention). The unit provided one staff member to two patients at all times. Although the unit was not able to provide single sex occupancy, we saw there were controls in place to reduce the need for mixed sex care on the unit. These included, the option of providing telemetry monitoring on ward 7 (cardiology) in a side room or use of a high dependency unit bed. Telemetry is a way to watch the electrical signals from your heart. Patches are placed on your chest which pick up the electrical signals from your heart and send them through wires to a monitor. At the time of inspection we found all patients receiving care and treatment were of the same sex.

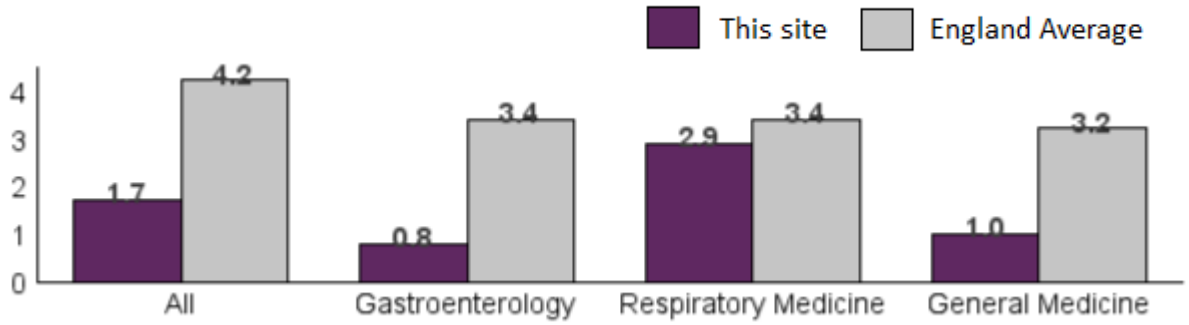
We found there was a short term mixed sex breach on ward 8. We were informed this was for a short time until another bed for the patient could be found. We saw the patient was moved as soon as another bed was made available.

Average length of stay

Macclesfield District General Hospital

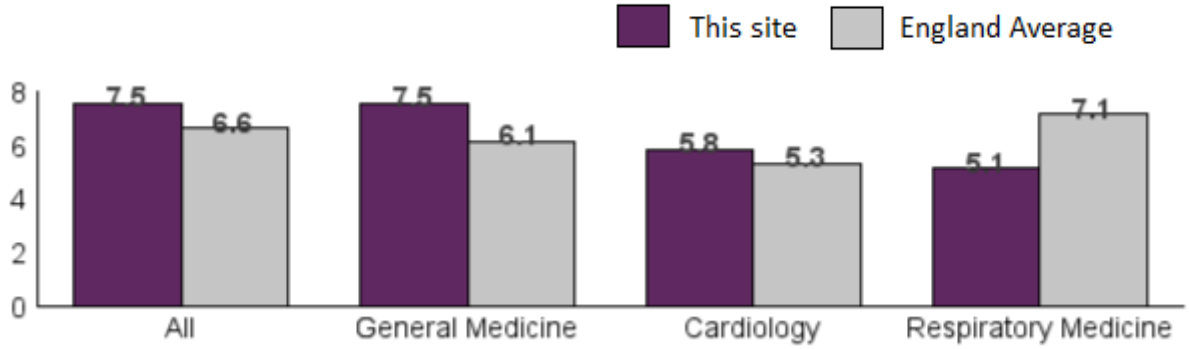
From August 2016 to July 2017 the average length of stay for medical elective patients at Macclesfield District General Hospital was 1.7 days, which is lower than England average of 4.2 days. A breakdown for the top three specialties based on a count of activity is below.

Elective Average Length of Stay - Macclesfield District General Hospital



For medical non-elective patients, the average length of stay was 7.5 days, which is higher than England average of 6.6 days. A breakdown for the top three specialties based on a count of activity is below.

Non-Elective Average Length of Stay - Macclesfield District General Hospital



Note: Top three specialties for specific trust based on count of activity.

(Source: Hospital Episode Statistics)

Meeting people's individual needs

The service had made some adaptions to the facilities and premises to meet the individual needs of patients.

All areas of the medical wards were wheelchair accessible, and there were bathrooms which had been adapted for patients with mobility difficulties which were large enough to enable carers to support if needed.

There was an interpreter service available for patients for whom English was not their first language. Staff were aware of the service and how to access it. This included access to sign language for those patients who had hearing difficulties.

Due to the diverse staffing population, many of the staff spoke different languages so were able to support patients who did not speak English.

There was also a hearing loop system in for those patients with a hearing impairment. We did not observe this being in use.

The hospital provided a range of information leaflets about different conditions and treatments. The information was in English; however we were informed that other language formats could be available if required.

Patients were cared for by a named nurse who oversaw their care from admission through to discharge. This ensured continuity of care for the patient.

We saw that some patients with a diagnosis of dementia had a dementia passport, the “This is me” document, but these were not in place for all patients with a diagnosis of dementia. We reviewed clinical records for five patients with dementia. In three records we found dementia care bundles in records, but these were all blank. Two records did not have these in, although one patient was newly admitted. Three records contained “This is me” forms which had been completed by carers. The ‘This is me’ document is designed to be used in conjunction with the dementia care bundle.

Specific tools were available for patients living with dementia to capture detailed information. On ward 9, we saw that much of this information was captured in a comprehensive form compiled by named nurses. These “information to support health and social care planning” forms were patient centred, detailed and individualised with specific plans for managing agitation or challenging behaviour. They included information about patient’s families, past employment and hobbies and how this could be used practically by staff to alleviate distress.

The trust had a policy relating to the care of patients with a learning disability. This stipulated that staff should complete a reasonable adjustments care plan within 24 hours of admission. Bedside signs were used to alert staff to a reasonable adjustment care plan in use. We saw one example of this which was completed well. We also saw that a hospital passport had been completed and was in use.

Staff on ward 9 had made changes to the ward to develop a dementia friendly environment. They had changed the layout of the main ward entrance to make a small seating area were patients could sit and participate in activities or take resting breaks if they preferred to walk around the ward.

A large conservatory attached to ward 9 provided space where volunteers could run activity sessions during the week, including breakfast and lunch groups, art sessions and other activities. Staff on the ward used some aids such as twiddle muffs when patients were anxious. Patients could be engaged in individual activity with staff which helped manage distress and confusion.

Staff on ward 9 were based within patient bays to offer support and ensure patient safety. Staff were able to offer some activities on the ward, for example, with the use a large screen television which could be moved between bays to watch films or listen to music. There had been changes

made to the environment, for example, black and white pictorial signs on bathroom doors and colour differentiation in terms of walls and woodwork between bays. Best practice guidance would be for these to be in strong contrast colours, whereas many of the colours were muted and pastel. Staff were keen to continue to explore options for improving the environment for patients with dementia, and were liaising with staff within the mental health trust who provided care for patients with dementia.

Across the other medical wards we saw little evidence that environment improvements had been made to cater for the needs of patients living with dementia.

Not all patients had access to televisions. Although no patients raised this as an issue, it did mean that patients who wished to watch television were required to watch television via their own portable devices.

Staff used symbols at the patient bedside to indicate specific conditions, for example, the flower symbol for patients diagnosed with dementia and a leaf symbol for patients at risk of falls. We saw these were in place for patients who needed them.

Therapists were present at board rounds and proactively sought patients that required input rather than wait for referrals to be received.

Trust data showed they admitted and discharged 1238 patients living with dementia over the past 12 months, averaging 46 patients at any one time. However, there was no dementia specialist nurse to help support and advise staff on the wards and provide the steer required to ensure compliance with documentation, environment improvement and support with assessment.

There was access to mental health support if patients required a review and assessment.

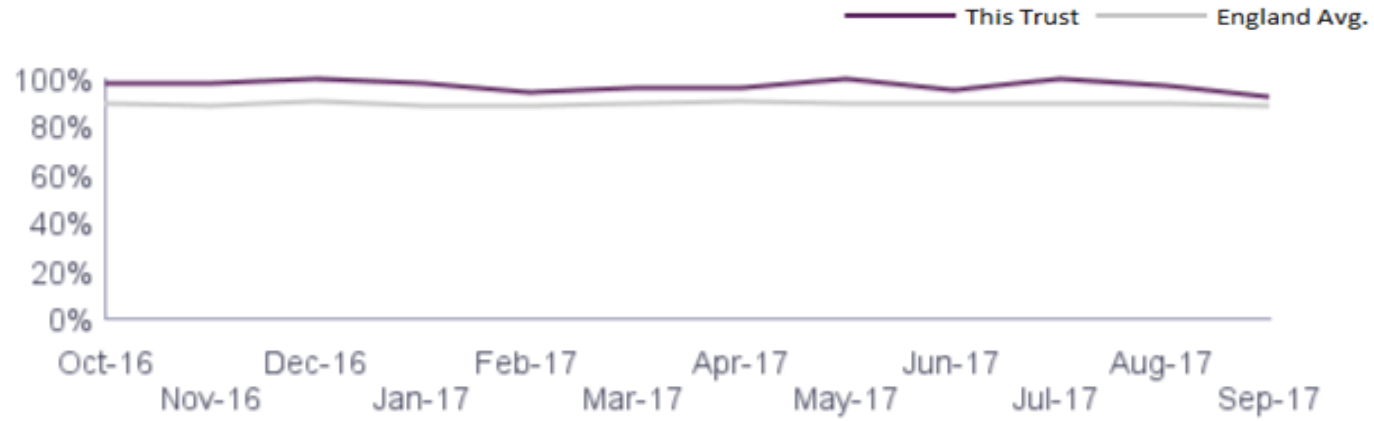
Patients who needed assistance or encouragement with eating and drinking were highlighted by use of the red tray system. We saw evidence that patients were assisted at meal times by staff.

On the medical day case unit, appointment times were flexible to support the needs of the patients. However, patients reported difficulty in parking at the hospital as there were too few spaces.

Access and flow

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

Referral to treatment for this trust remained around 100% from October 2016 to September 2017, approximately 7% above the average for England.



(Source: NHS England)

Referral to treatment performance was better than the England average for all four applicable

medical specialties.

Referral to treatment (percentage within 18 weeks) – by specialty

Specialty grouping	Result	England average
Rheumatology	100%	93.5%
Thoracic Medicine	98.5%	93.7%
Cardiology	88.4%	83.4%
Gastroenterology	97.4%	94%

(Source: NHS England)

Waiting times, delays and cancellations were minimal and managed in a manner that met patients' needs.

Referral to treatment times (admitted performance) were consistently above the national average from October 2016 to September 2017.

The trust had implemented strategies to increase patient flow throughout the medical wards, yet delays in transfers of care, outliers, and bed occupancy remained problematic for the trust.

The trust had implemented a SAFER patient flow bundle. This is a practical tool to reduce delays for patients in adult inpatient wards.

The SAFER patient flow bundle blends five elements of best practice in patient flow. This included all patients to have a senior review before midday by a clinician. All patients to have an expected discharge date and a systematic multi-disciplinary team review of patients with extended lengths of stay above 7 day.

We saw that the SAFER patient flow was in operation and wards worked hard to ensure patients were discharged as soon as they were able to. A discharge lounge had been opened which was able to cater for independently mobile patients and those who required a bed.

The SAFER patient flow bundle was regularly monitored through a SAFER bundle improvement programme and action plans were developed to improve performance. Although the program was in place from early 2017, we observed that the hospital had reached near full capacity, extra beds were being allocated to wards, and patients were outliers on wards not appropriate to their needs.

All patients had an expected day of discharge, and we saw that consultant ward rounds started early to ensure patients were reviewed promptly.

Weekly meetings took place with managers to discuss all patients whose length of stay had exceeded seven days to review assess and review their care, and expedite any delays in diagnostic testing or on going referrals.

Daily board rounds were in place for the multi-disciplinary team to review patients daily to highlight any delays or waits and discuss expected dates of discharge.

Regular bed meetings were held to identify patients being discharged and to consider flow throughout the trust.

The ward had also introduced a programme of red and green patient days. Red and green days' are a useful approach to optimising flow. The multi-disciplinary team discuss for every patient whether the day ahead is 'red' (a day where there is little or no value adding care) or 'green' (a day of value for the patient's progress towards discharge). If 'red', actions need to be agreed by

the team to create a ‘green’ day instead. We saw the board round white boards contained those patients whose days were red and green and staff were conversant with any barriers towards a patient delay. We observed that any delays in the system were escalated by managers.

Bed occupancy rates were high. Medical wards occupancy was near 100% capacity. Data provided by the trust showed in December 2017 the medical wards occupancy rate was 99.2%. Evidence shows that when bed occupancy rises above 85% it can start to affect the quality of care provided to patients and the orderly running of the hospital. The occupancy rate from April 2017 to December 2017 had not fallen below 96%. The England average bed occupancy was 89%. This meant that beds were nearly always occupied, which made it more difficult to find beds for new patients being admitted. This also risked that that service and delivery of care to its patients could be compromised and fall below expectations.

Medical patients were not always cared for on the specialist ward best suited to their needs. Medical speciality wards frequently had patients whose medical condition did not always match the speciality of the ward they were placed. These are known as outliers. For example, a gastroenterology patient on a surgical ward. This risked that patients were not being seen and treated by staff that were skilled in providing their care. During our inspection we found there were 31 outlying patients on wards not specialised in their needs. All these patients were receiving care and treatment on a ward that did not cater for their medical needs.

Medical outliers were reviewed daily by medical staff and there was a co-ordinator to ensure patients were reviewed and either moved back to a medical ward as a bed was available or discharged. From rotas we saw there were two medical professionals to review these patients.

All wards we visited had patients who were medically fit to leave hospital but were delayed in leaving. We found the majority of delays were due to waiting for package of care or care placements. The service monitored the numbers of discharges and the number of bed days lost due to delays in transfers of care (DToC). From the August 2016 to July 2017 there had been a total of 3635 bed days lost due to patients being medically ready to leave hospital but were delayed. Ward 9 the care of the elderly ward had the highest number of lost bed days.

Discharges and Delays August 2016 to July 2017

Ward	Number of discharges	Bed days lost
3	746	551
4	987	722
7	684	463
8 MAU	1674	N/A
9	444	1899
		Excludes April 17 figures as they were not available.

Patient moves per admission

From September 2016 to August 2017, 58% of individuals did not move wards during their admission, and 42% moved once or more.

(Source: Trust Routine Provider Information Request (RPIR) - bed moves tab)

The service monitored the number of times a patient moved throughout their hospital stay. Multiple moves is not considered best practice, it also indicates that a patient may be moved to a medical speciality in which is not best suited to their needs. The number of patient moves can also impact on patient experience and may prolong hospital length of stay.

The number of bed moves whilst patients are receiving care and treatment had risen over the past 12 month period. More patients across all medical wards are experiencing bed moves of once or twice throughout their journey.

Ward	Number of moves 01/09/2016	Number of patients 31/08/2017	% of patients	Number of moves 01/09/2015	Number of patients 31/08/2016	% share of patients
Ward 3	0 1 2 3 4+ Total	788 402 33 1 1 1225	64% 33% 3% 0% 0%	0 1 2 3 4+ Total	843 239 24 2 3 1111	76% 22% 2% 0% 0%
Ward 4	0 1 2 3 4+ Total	1104 536 26 1 1 1668	66% 32% 2% 0% 0%	0 1 2 3 4+ Total	1206 311 14 3 0 1534	79% 20% 1% 0% 0%
Ward 7	0 1 2 3 4+ Total	745 392 21 5 0 1163	64% 34% 2% 0% 0% 100%	0 1 2 3 4+ Total	877 225 9 0 0 1111	79% 20% 1% 0% 0%
Ward 9	0 1 2 3 4+ Total	No details	No details	0 1 2 3 4+ Total	No details	No details

The service also monitored the number of bed moves past 10pm in the evening. Patients should be protected from bed moves at night as rest is an important part of recovery and can impact on patient experience.

Between September 2016 and August 2017, the trust reported the following numbers of bed moves after 10pm.

Ward	Number of moves after 10pm
3	53
4	59
7	54
8 MAU	790
9	5
CCU	22

Learning from complaints and concerns

Staff members were aware of how to support patients to make a complaint or raise a concern. All complaints were taken seriously and treated compassionately.

From August 2016 to July 2017 there were 32 complaints about medical care. All of the

complaints were responded to within either the 25 or 45 day internal trust standard in accordance with their policy.
(Source: Routine Provider Information Request (RPIR) P61 Complaints)

There were processes in place to ensure that any complaint received was investigated and necessary proportionate action taken.

In the reporting period from August 2016 to July 2017 the trust had received 115 complaints. Of these, 32 complaints were made regarding medical care.

The Chief Executive had overall responsible for complaints at the trust, with a customer care manager responsible for the day to management of complaints.

The trust reported that they had an internal target of responding to complaints within three days and their performance was 100% in meeting this standard within the reporting period.

We saw that complaints were discussed at safety, quality and standards (SQS) meetings to ensure complaints and learning was shared with the wider team.

Numbers of complaints were also monitored using ward quality and performance dashboards. We found that staff were aware of complaints made and any actions that had been taken.

Ward staff reported they escalated any patient concerns to their immediate managers so they could be resolved quickly before escalating to a formal process of complaint. Managers confirmed they attempted to resolve any patient or relatives concerns in order to provide good outcomes for patients. The trust reported that 942 complaints were resolved within the reporting period without the need to use the formal complaints procedure.

There was a patient liaison and advice service based within the hospital to support patients with any concerns they may have. The service also had an outreach team that visited the wards daily to speak to patients and their relatives in order to resolve any concerns immediately.

When complaints remained unresolved, complainants were advised about the opportunity to take their complaints to the Parliamentary and Health Service Ombudsman for review. Between August 2016 and July 2017, seven complaints were made to the ombudsman regarding the trust. Four of these complaints have been investigated and closed; two complaints were ongoing (September 2017); and one complaint had been investigated and recommendations made.

Is the service well-led?

Leadership

At the last inspection, staff generally felt supported and valued. Although, staff views on the trust's leadership and vision were varied. Services were well led at a local level in some areas but not all staff had a clear understanding of the trust's vision. In some areas, staff felt they were not engaged in decision making about their service and that there were no effective two-way communication streams.

At this inspection we found that leaders at every level were visible and approachable. The leadership was knowledgeable about issues and priorities for the quality and sustainability of services.

The leadership of the service was provided by senior managers and clinicians. The directorate was split into medical specialities in order to provide specialist care to patients. We saw there was an organisational structure that defined who was responsible for each area including the staffing.

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

Staff were aware of the management structure and who they were accountable to. The service had a service lead; and there was an established management team who managed specific areas of the service. The quality standards of the wards were managed by a small team of matrons and ward managers who were passionate in ensuring safe care and treatment for all patients. We observed these managers on the wards and found them to be forward thinking, and knowledgeable on ward performance and quality standards.

Staff we spoke with were positive about their relationships with their immediate managers, matrons and clinicians of all specialities. Staff felt they could be open with colleagues and managers and felt they could raise concerns and would be listened to.

We saw that leadership of the service was extremely good; there was excellent staff morale even though all services we visited were under pressure due to staffing vacancies, and internal bed pressures. All staff told us they felt supported to be able to deliver safe care and treatment to patients although staff did raise concerns regarding the hospital capacity to deliver the right care to patients due to the high demands on the services.

Staff told us the management team had an ‘open door’ approach, and were available to provide advice and guidance as needed.

Many of the staff had worked at the trust for many years and although the trust was small it provided opportunities for progression and development.

Vision and strategy

The service had a vision for what it wanted to achieve and workable plans to turn it into actions. These were developed with involvement from staff, patients and key groups representing the local community.

There was a vision and strategy plan for the service to help shape the direction of the organisation. The plan set out the vision and strategy, the strategic goals they were going to achieve. Staff we spoke with were aware of the vision and strategy and the direction of the organisation.

We saw that the vision and strategy encompassed patients, people, partnerships, and resources. There was an understanding that to deliver the best, safest care for patients and its workforce the delivery of this vision would require service transformation and strategic realignment of clinical care services. There was recognition that good quality care is best delivered when worked in partnership with patients and partner organisations across the whole health and social care system.

There was a commitment across the organisation from ward staff through to senior managers to provide safe, effective care, reduce levels of harms and improve patient experience. This was challenging for the service due to capacity and demand for its services and the shortage of skilled staff at all levels.

Culture

Managers promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Staff described the culture within the service as open and positive.

The trust had appointed a freedom to speak up guardian. Every NHS organisation now has someone dedicated solely to giving all staff the support and freedom to speak up for themselves, their patients and all staff. Overall, we found not staff were aware of who the person was and how to access their support. Staff also reported if they had any issues they were able to speak to their line manager or matron who would support their needs.

During 2016 to 2017 there had been five concerns raised to the speak up guardian across the trust. We saw that an annual speak up report was produced to provide assurance in terms of the measures in place to support staff to speak up safely. There were governance arrangements that ensured the trust responded appropriately.

Staff told us that the culture of the service was good. Overall staff reported there was an open and honest culture, and were supported if they had any concerns.

From our interactions with staff and our observations, we found staff to be friendly, professional and hardworking and worked together to provide the best possible care.

Governance

The board and other levels of governance in the organisation functioned effectively. Governance arrangements were set out, understood and effective. Staff members were clear about their roles and accountabilities to provide a quality service that meet patient' needs.

There was a process in place to assess, monitor and mitigate risks relating to the health and safety and welfare of the patients and staff.

There was a clear governance structure, led by a director of corporate affairs and governance within the trust.

There was evidence of clinical governance procedures and quality measurement processes. These ensured risks were identified and escalated through different committees and steering groups. The trust recognised it has a responsibility to embed a culture of good governance and there was a corporate governance manual that set out those arrangements and objectives which had been put in place to help manage that process. These included care which is equitable, safe, patient centred, effective, and timely.

We reviewed risk management subcommittee meeting minutes and saw that health and safety, specific policies and risks were discussed.

We saw there were up to date policy and procedures in place to guide all staff in providing safe care and treatment to patients.

Unexpected deaths or potentially avoidable deaths that occurred in the department were reviewed and discussed at mortality meetings. Mortality reviews were completed by consultants, supported by mortality support nurses to ensure consistency in completing mortality reviews. The reviews were a two stage process with a supporting policy and standard operating procedure to clearly identify how the reviews were to be documented. We reviewed six mortality reviews and found they were fully completed.

Monthly medicine directorate and subcommittee safety, quality, and standards meetings were held which were well attended by senior staff including matrons.

We reviewed minutes from these meetings and found the discussions agenda included risk, audits, clinical effectiveness, serious incidents, and patient experience. There was evidence that information was shared with other committees and groups to share learning.

Consultants led group meetings were held to discuss performance within their given speciality. We saw from meeting minutes that members of the multidisciplinary team attended. For example, the respiratory group meeting was attended by two consultants, a senior physiotherapist, a cardio respiratory physiologist, a respiratory team nurse, and lung cancer specialist nurses.

At ward level, there was a varied approach to team meetings. We were informed that team meetings did not always occur on a monthly basis. This was often due to capacity and demand of the service, others found it was difficult to get staff together due to staffing shortages. Managers informed us that team meeting minutes were e-mailed to those who could not attend, and important messages were passed through daily huddles and notice board messaging. Staff confirmed this process. However, we found that key risks identified by the wards and quality ward dashboards, for example pressure ulcers, late observations and falls were not agenda items for team meetings. This did not provide assurance that key issues related to ward performance, was being addressed sufficiently through a formal documented meeting process to ensure staff compliance with trust policy and drive forward ward improvement.

There were ward quality dashboards to provide managers and staff with key performance indicators compliance over the year. These included the number of patient falls, pressure ulcers and late observations. We saw that each indicator was RAG rated from red to green and was displayed in the manager's office for all staff to review. Staff we spoke with were aware of their wards current performance.

The service produced monthly quality governance data sets, to provide managers with key performance data in order to improve performance. We saw the latest reports included incidents, complaints, risk register, and patient feedback information.

The trust had a service level agreement in place with the local mental health trust to ensure they worked within the Mental Health Act, when this was used. This meant that the trust received specialist medical and administrative support to ensure they met their obligations under the Mental Health Act and Mental Health Act Code of Practice.

The trust had regular meetings with the liaison team and mental health trust managers to review any issues and identify further actions needed.

Management of risk, issues and performance

The service had a comprehensive process to identify, understand, monitor and address risks. Risks were monitored and reviewed in order to maintain quality of care to patients and were understood by staff.

The medicine directorate had a 'risk register' which highlighted areas of risk to the effective management of the service. These ranged from risks of staffing shortages to the risk of delays in treatment. Each ward also had a risk register that contained the ward level risks. We saw that these risks were escalated through the matrons for inclusion on the directorate risk register as necessary.

We saw that moderate and high level risks from the directorate risk register were included on the trust risk register which was split into the specialities. These included medicine, surgery and accident and emergency. We observed that risks had review dates included.

Each ward had a quality and performance dashboard, these were placed on the ward for all staff to view. These dashboards formed a collective view on a directorate quality and performance dashboard.

The dashboards provided data on key metrics such as training performance, patient harms and compliance with patient safety. The service recognised and monitored that observations were required to be completed on time to ensure early detection of a deteriorating patient. However, the trust target on one ward had not been met for nine months, and on two wards had not been met for five months. This did not provide assurance that key risks were being sufficiently addressed in a timely manner to ensure patient safety.

Each ward had completed risk assessments in relation to the activities carried out on the ward. We found not all risk assessments had been reviewed and up dated yearly in line with the trust policy. For example on ward 9 the fire safety and COSHH risk assessments had passed their review date.

Due to the demands of the service, matrons and ward managers were utilised to ease the pressures of the operational aspects of the service which left them less time to focus on the quality of the service. We saw that matrons, ward managers and staff were highly motivated, professional, and passionate in ensuring the highest possible care to the patients. Extra demands on their time ensuring the operational functions of the hospital were maintained, risked a decline in service quality.

Matrons completed audits on each ward to check on the quality of the care, and staff competency, this included gathering feedback from patients and checking procedures were being followed. The audit was to provide assurance and make improvements in practice. However, the audit did not always provide assurance that procedures were always being carried out to the right standard. For example, the matrons audited to ensure resuscitation equipment had been checked by the staff but they did not check themselves to see if all the items on the resuscitation trolley were all in date. This did not provide them with the full assurance they required that the resuscitation equipment was fully operational in the event of it being required.

Daily handovers included a briefing of any issues highlighted by managers. We observed the handovers included any patient risks and increased care needs.

There was a documented major incident and business continuity policy in place and a strategy for dealing with major incidents and emergencies such as terrorist threats, flood, and fire or process management failures. Staff we spoke with were aware of the actions to take and actions cards were used to support the strategies in place.

We saw there was process to minimise risk and improve services following incidents that had occurred. The trust used an SBAR which is an acronym for Situation, Background, Assessment, Recommendation; a technique that can be used to facilitate prompt and appropriate communication. This communication model should provide initial assurance and immediate actions taken to ensure the incident does not reoccur whilst the investigation is on-going and should be widely shared. We reviewed six SBAR’s and found they did not provide information of immediate learning or immediate changes recommended.

Information management

Staff and managers confirmed that a secure login was required that was unique to the individual before they could access confidential information. Staff also confirmed that they had been given guidance on information governance and maintaining the security of the system such as not opening emails that were suspicious. We saw information governance training was provided to all staff and the performance statistics monitored. Data supplied by the trust showed all wards with the exception of ward 8 had met the trust target of 95% of staff completing the training.

Senior staff told us that they had access to the information they needed to monitor performance to ensure there was a sustained or improvement to standards of care. Information included performance in relation to quality, performance as well as finance. All managers we spoke with were aware of the areas to improve their wards performance.

A quality governance data set was produced monthly and collated information, including audits, staffing, complaints and patient feedback and used this information to understand and respond to issues across the directorate.

Important information such as safety alerts, minutes of meetings and key messages were displayed on notice boards in staff areas to help keep staff up to date and aware of issues.

Staff had access to the information they needed to undertake their roles effectively. Policies and procedures were available and accessible via the trusts intranet facility.

Not all staff agreed there were enough computer terminals on the wards. Staff also reported that systems were slow and disjointed. This meant they had to spend more time waiting for information to load or navigate through differing systems.

Staff had access to patients' records and diagnostic tests.

Engagement

The services was transparent, collaborative and open with all relevant stakeholders about performance taking into account the needs of the population to design improvements.

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

The trust engaged and commissioned external reviews to support with improving trust performance, and redesign services to improve patient care. For example, the trust had undertaken two external reviews to support performance improvements. We saw from the reviews the service had implemented changes to support improvements. These included a frailty model of care and a patient flow intervention. We saw that this was in operation at the trust.

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

The service completed a 'you said', 'we did' engagement programme. Feedback from staff across the directorate included they wanted better quality appraisals, better communication between management and staff. We saw the service had implemented actions in response to the needs of the staff.

The Equality and Patient Experience Manager held monthly patient reference groups (PRG), covering differing topics. We saw from the meeting minutes from October 2017, the service was implementing actions from the meeting which included the implementation of ward Wi-Fi.

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

Feedback was also obtained via the trust social media accounts and reviews on NHS Choices.

There were display boards highlighting relevant information such as the vision and strategy and key members of the management team in order to identify them to staff and public. The website also provided key contacts on specific wards so patients could directly contact individuals.

Matron assurance audits included gaining feedback from visitors/carers and patients using the service to help further inform and develop actions.

Response rates to the friends and family test (October 2016 to September 2017) response rate in medicine were 40% which was significantly better than the England average of 25%.

Learning, continuous improvement and innovation

There were systems to support improvement and innovative work, including staff rewards.

External reviews were commissioned to establish and generate new ways of working. For example, the SAFER patient flow initiative. Staff and managers at all levels had embraced a new way of working to reduce capacity and demand in order for patients to receive the best possible care and treatment.

The trust recognised that noise on wards at night had caused unnecessary disturbance to patients. A noise at night imitative had been introduced based upon patient feedback to provide patients with eye masks and ear plugs to address patient feedback.

The service was building clinical partnerships with other trusts in recognition for the need to work in a more integrated way across provider and partner organisations for the benefit of patients.

Macclesfield District General Hospital was the first acute hospital in the UK to gain the National Autistic Society's Access Award. This work has resulted in improved access and experience for patients with autism and their carers. Examples of support include an email helpline and pre-admission visits to the hospital.

The trust held a yearly awards ceremony to celebrate successes within the trust. The awards celebrated individual successes and team performance.

The service was one of very few hospitals that had developed an endobronchial ultrasound and thoracoscopy service. (Endobronchial ultrasound aids rapid diagnosis of lung cancer. Based around ultrasound 'mapping' of the lungs. Thoracoscopy helps to diagnose and treat patients who have fluid accumulation in the lung lining due to cancer or suspected cancer).

Respiratory medicine at the trust was ranked number one in the country along with another trust by the General Medical Council (GMC) following a survey of 15 different parameters including satisfaction in the post, workload, senior support and multi-disciplinary team working.

Students from local schools came to the trust as part of a funded skills club programme to learn about values and behaviours of nursing, alcohol awareness, first aid and dementia. In addition they gained an understanding the role of healthcare professionals.

Surgery

Facts and data about this service

East Cheshire NHS Trust provides surgical services to patients at Macclesfield District General Hospital. There are six surgical wards incorporating 110 inpatient beds and seven theatres where surgery takes place.

The trust's surgical units cover a range of specialities including orthopaedic surgery, gynaecology, breast cancer, bowel cancer, hernia repair and ear, nose and throat.

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

The trust had 13,767 surgical admissions from August 2016 to July 2017. Emergency admissions accounted for 2,819 (20.48%), 9,675 (70.28%) were day case, and the remaining 1,273 (9.25%) were elective.

(Source: Hospital Episode Statistics)

Is the service safe?

Mandatory training

The service provided mandatory training in key skills to all staff. Topics included health and safety, safeguarding for adults and children, infection control, fire safety, equality diversity, human rights and preventing radicalisation. Training was refreshed annually so that knowledge could be updated.

Clinical staff completed extra training for topics including consent, Mental Capacity Act, Deprivation of Liberty safeguards, basic life support, blood transfusion, learning disabilities awareness and record keeping. Mandatory training for sepsis had been developed and was being introduced at the time of our inspection.

Staff knew when training was due to be completed. The trust's electronic system sent them a reminder and they could access this system at any time to review current training status.

In May 2015 we reported that mandatory training rates were below target. However we saw improvements for surgical wards during this inspection where compliance met the target on most occasions. Ward one, two and ten consistently met the compliance target of 90% for compliance between April and November 2017 except for one month when compliance on ward ten fell to 89%.

In theatres staff narrowly missed the target with 89% compliance between October and November 2017 and met the target with 90% compliance in December 2017.

Training compliance was monitored monthly by managers with figures reviewed at monthly quality safety standards meetings.

Safeguarding

There were arrangements in place to help safeguard adults and children from abuse and neglect. These included an up to date safeguarding policy and procedures which were in line with national guidance. Staff were familiar with the process for reporting safeguarding concerns.

A lead nurse for female genital mutilation and child sexual exploitation was available should staff have any queries about these areas.

Staff completed level one and level two safeguarding training for children and adults which was in line with national requirements.

Managers checked how many staff were up to date with training each month, with figures reviewed at monthly quality safety standards meetings.

We reviewed training compliance over time and saw that following occasional months where wards were not compliant, three out of four inpatient wards were now meeting the target of 80%. Latest figures for December 2017 showed that ward one and 1A were 83% compliant and ward two was 90% compliant.

Ward ten was not meeting the target with 70% compliance. The ward had not met the target for some time. Records we reviewed going back to April 2017 showed the compliance target of 80% had not been achieved since this time.

Theatre staff were not meeting the target for safeguarding training compliance. Between October and December 2017, only 67% of staff were trained in level two adult safeguarding training and only 55% were compliant with level two child safeguarding training.

Cleanliness, infection control and hygiene

The service generally controlled infection risks well and used control measures to prevent the spread of infection.

All the areas we inspected were visibly clean and tidy. Domestic staff worked between 7.30am and 8pm. They used colour coding systems to make sure cloths for certain areas (such as toilets and sinks) were not mixed up and used schedules listing required tasks for each day of the week to keep areas clean. Domestic staff told us that all tasks on the schedule were completed prior to finishing duty. No records were kept to confirm this. However we saw no evidence to suggest that areas were not being regularly cleaned.

During our previous inspection we reported that the wear and tear of the environment meant there was a potential infection control risk due to exposed plaster in theatres. This issue had now been rectified.

Staff used flushing regimes to help prevent the build-up of infectious disease such as legionella.

Disposable curtains were used in most areas and those checked were within their expiry date for changing.

Handwashing stations and gel dispensing units were placed at ward and theatre entrances to encourage people to clean hands before entering. The dispensers we examined were full and in good working order. Taps used touchless motion technology to reduce the spread of contaminants.

Following our previous inspection where we witnessed staff not washing hands regularly enough, we now saw that staff adopted good practice such as being 'bare below elbows' with sleeves rolled up, no watches and ties tucked in. Theatre staff used the World Health Organisation's Five Moments of Hand Hygiene process which helped ensure hands were cleaned effectively.

Theatre staff wore uniforms including 'theatre scrubs' and hair nets to reduce contamination during surgery.

Staff in the pre-operative clinic advised patients about cleanliness prior to surgery and assessed their risk of carrying particular infections such as Meticillin-resistant Staphylococcus aureus and Clostridium difficile. In theatres, infectious patients were placed last on the list to allow the theatre to be fully cleaned before other patients were brought in for surgery the following day.

Staff used sterile techniques when cannulating patients (putting needles into a vein) to reduce infection risk. They gave patients detailed instructions to help keep skin clean and identify early signs of infection.

Equipment was either sent away for cleaning or decontaminated on site. For endoscopic equipment (a thin, flexible tube with a camera at one end which is inserted into the body) cleaning involved a one way cycle which mitigated the risk of dirty and clean items getting mixed up. The scopes were automatically disinfected using technology which confirmed when cleaning was complete. If the machine did not confirm this, staff undertook a manual cleaning cycle. Scopes were disinfected again after three hours even if they had not been used.

In the pre-operative assessment area we saw a chair for patients with exposed sponge which could harbour infection and a corkboard (rather than a whiteboard) was used in one of the consultation rooms which limited the options for cleaning. In one of the consultation rooms we saw clear plastic bags clipped to a trolley to collect clinical waste, rather than staff using yellow bags which are used nationally. This increased the risk that waste may not be disposed of correctly.

In theatres bins holding used needles and other sharp instruments had lids which opened automatically, limiting the need to touch and reducing the risk of cross infection.

Surgical site infections were monitored and reviewed by a trust committee and ward managers reported all cases of Meticillin-resistant Staphylococcus aureus and Clostridium Difficile which occurred.

Ward one reported one case of Clostridium Difficile which occurred between April and November 2017. Wards two and ten reported no cases during this time period.

Monthly audits were completed to provide assurance that areas were clean. Records we reviewed showed that theatre and ward areas were always above 95% for cleanliness. Theatres areas scored 98% between August and December 2017.

Environment and equipment

During our previous inspection we found that older equipment such as operating tables in theatres were not being replaced regularly enough. However, during this inspection we saw improvements.

A ward used during our previous inspection had been changed and a new ward area created which removed the issues we highlighted in 2015. Now the service had suitable premises and equipment and staff looked after them well.

Each area was clearly signposted to help people locate the correct unit or ward.

Theatre and wards areas were situated in different areas of the hospital. Surgical wards, day case and main theatre areas were co-located together on the first level with the orthopaedic ward and theatre located on the ground floor.

Ward layouts differed depending upon the age of the unit. The orthopaedic ward had been built more recently and was spacious and light. Other surgical wards were less so and space was further restricted because the hospital was struggling to cope with the demand for beds.

Whilst some paediatric surgery took place, the recovery bay area had no decoration suitable for children.

Theatre access should be restricted via an electronic access control system but we found occasions when this was not the case. In main and day case theatres during the inspection, we saw open doors leading directly to anaesthetic rooms. Managers told us access was usually monitored by a receptionist but in main theatres this person was absent. Staff in day case theatres told us they relied on 'restricted access' signs at the entrances to stop unauthorised people entering. The manager also said that a risk assessment had been completed for main theatres and plans were in place to install swipe access to main theatres which would reduce the risk of unauthorised access.

The right equipment was available for staff to care for patients and items were stored in an organised way. Staff used a mixture of reusable and disposable equipment. Disposable equipment such as laryngoscopes were only used once before being discarded. This reduced the risk of cross contamination.

Resuscitation trolleys were checked weekly or after use. Items with a limited period for use were all within expiry dates. Electrical items were safety tested annually.

Bariatric equipment was available if required, including an operating table and bed.

On ward ten mattress motion sensors were being trialled for orthopaedic patients which reduced the risk of falling by alerting staff when patients got out of bed. The motion sensors alarmed on movement enabling staff to provide immediate assistance and reduce the risk of falls.

We saw staff used warming blankets during surgery to reduce the risk of hypothermia (dangerously low body temperature).

Staff said anaesthetic equipment was checked daily. However records for January showed three dates where checks had not been recorded despite the theatre being used. Not checking vital equipment regularly increases the risk that failures may not be identified promptly.

Other equipment was electrically tested annually in all the areas we inspected. Each theatre was reviewed annually to check ventilation and clean air flow was effective. We reviewed a sample of reports which all showed theatres were compliant with national guidance about the design and management of specialised ventilation systems.

Sluices and rooms storing equipment were accessible by digital lock to prevent unauthorised access.

Assessing and responding to patient risk

Risks to people using services were assessed, monitored and managed on a day to basis. This included signs of deteriorating health and medical emergencies.

Staff recorded clinical observations on electronic tablets which calculated early warning scores. An early warning score system uses clinical observations to produce an overall score to indicate how unwell a patient may be. Higher scores indicate that a patient is unwell and observations should be increased accordingly.

Audits showed that between April and November 2017 wards completed observations in line with trust policy.

In the pre-operative clinic, specialist nurses assessed potential risks to patients having surgery using questionnaires. Patients were also graded based on physical health status using an internationally used system which gave an overall indication of suitability for surgery based on a patient's current health.

Staff marked surgical sites before starting surgery to reduce the risk of operating on the wrong site.

Staff used an up to date trust 'toolkit' to help identify warning signs and start treatment for patients with sepsis. Sepsis is a life-threatening condition where a severe infection spreads through the body in the bloodstream.

Managers monitored how well staff managed patients with potential sepsis. Audits were completed each month which measured how many staff used the trust toolkit and provided antibiotics within one hour.

The results for use of the sepsis toolkit were provided for each ward. These showed that between July and August 2017, 85% of patients on ward one and 1A, 75% of patients on ward two and all patients on ward ten were correctly screened.

The results for providing antibiotics within one hour were provided for all acute wards but not individually. These showed that in July 2017 only 26% of patients had antibiotics within the hour. The percentage increased to 74% in August and to 81% in September.

Despite requesting details of any action taken to improve scores the trust did not provide evidence.

Staff used the World Health Organisation checklist called 'five steps to safer surgery' which reminded them to confirm; patient details, procedure, surgery site and equipment items present. This helped reduce the risk of making mistakes. Checks took place before, during and after surgical procedures so that anomalies could be addressed immediately.

We observed the checklist being undertaken and recorded correctly in all theatres. Compliance was audited weekly by observing a sample of them. Results between April and December 2017 showed theatre staff were 99.8% compliant in using the checklist against a target of 100%.

An up to date protocol supported staff managing patients suffering major haemorrhage. This was prominently displayed for quick reference.

Post-surgery other risks were assessed including the risk of blood clot, falls and pressure ulcers. Where risks were high staff took mitigating action such as applying pressure pads to help prevent pressure sores or special boots providing intermittent pressure to reduce the risk of blood clot.

Patients at risk of falling were placed in one area and monitored continually or on a one to one basis.

Staff used a leaf symbol to identify patients at risk of falling. However on ward ten staff used a different symbol. We were concerned that using different symbols could create confusion amongst staff.

Patients on waiting lists were reviewed weekly by managers and clinical staff to identify and prioritise those at risk of worsening.

Environmental risks were identified and staff took action to minimise them. We saw this done in relation to bed capacity during our inspection. Staff assessed areas that could safely accommodate extra beds. Any areas with fire exits were excluded.

On ward 1 and 1A we saw one extra bed added to each bay. This meant the bays had seven rather than six beds and lessoned the space particularly around three beds.

Managers said the area was risk assessed daily but on the day we visited a risk assessment had not been completed. We reviewed the assessment for the previous day. This described the environmental risks and mitigating action to reduce it. For example, the extra bed did not have piped suction or oxygen close by like the other beds. To mitigate this risk, portable oxygen and suction were placed close by.

The assessment also documented and mitigated risks to other beds associated with limited space which included placing patients deemed to be at lower risk of worsening (for instance; less unwell and more mobile) into these areas. However, during our inspection we saw that two of the patients placed in these beds had cardiac problems including pacemakers and recent heart attacks. There was no record of clinical risk assessments to confirm these patients were well enough to be placed into these beds.

We escalated our concerns to senior managers. They confirmed this practice occurred when capacity began to exceed the number of available beds in the hospital and had been approved by the trust board. An escalation process was in place which helped ensure extra beds were only used when appropriate, and that only suitable patients were placed into these beds. However they acknowledged that one of the patients we identified with cardiac problems had been placed there in error. The following day we saw that all the patients placed into extra beds had been moved to other areas and no extra beds were being used.

Nurse staffing

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

Nurses worked 24 hours a day to care for surgical patients on wards and in theatres. Electronic rotas were completed six weeks in advance to ensure short-falls could be addressed.

Staffing was calculated on wards twice annually using a recognised staffing calculation tool to account for the number of patients being cared for and how ill they were.

We reviewed staffing levels on randomly chosen dates; records confirmed that staffing was in line with or above the recommended requirement on all day and night shifts. Matrons confirmed the ratio never exceeded a ratio of one nurse to eight patients during the day.

During our inspection we saw theatres fully staffed with scrub nurses, operating department practitioners and recovery nurses. However senior managers told us that four staff had suddenly begun long term sickness absence which had reduced staffing levels. To counteract this, long terms agreements were in place with a local agency to ensure enough staff were available and a matron was being recruited to provide longer term management.

A designated matron received details of staffing over the next five days across the hospital to ensure action could be taken to address shortfalls.

Matrons had monthly meetings with finance staff to review staffing budgets and requirements.

Vacancies were monitored monthly by ward managers and during safety quality standards meetings attended by managers and senior clinical staff.

From September 2016 to August 2017, the trust reported a vacancy rate of 8.8% in surgery, this was worse than the trust target of 7.01%.

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

Managers confirmed that staffing had improved since this time. Ward 1 and 1A reported 1.3 whole time equivalent vacancies for nurses and 0.2 vacancies for healthcare assistants at the time of our inspection.

On ward ten the latest figures showed seven whole time equivalent vacancies. Two extra healthcare assistants had been employed to try to bridge the gap until staff were recruited.

On ward two there were 2.6 whole time equivalent vacancies and 1.8 healthcare assistant vacancies.

To manage these effectively, vacancies were being advertised alternately between nurses and healthcare assistants each month.

From September 2016 to August 2017, the trust reported a turnover rate of 3.2% in surgery, this was better than the trust target of 15.6%.

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

From September 2016 to August 2017, the trust reported a sickness rate of 5.1% in surgery, this was worse than the trust target of 4.6%.

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

From September 2016 to August 2017, the trust reported a bank and agency usage rate of 12% in surgery.

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

Staff used an up to date policy to identify when bank and agency staff were required which helped manage the process effectively.

Handovers took place each morning and evening so that information could be shared between day and night staff. Nurses and healthcare assistants attended. Staff passed details of patients with particular attention to infectious patients, those requiring hourly comfort rounds or feeding assistance, at risk of falling, particularly unwell, or under a Deprivation of Liberty safeguard. Confirmation of completed equipment and medicine checks was also highlighted.

At 2pm nurse 'huddles' took place on wards to review patients and address any issues or required tasks for the afternoon.

In theatres, nurses and medical staff discussed each patient listed for surgery that day before lists started.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and provide the right care for patients.

Consultants, doctors and junior doctors worked together each day. For example, the surgical treatment unit had a team of six junior doctors, a registrar and two consultants. They cared for patients between 7.30am and midnight Monday to Thursday and until 8.30pm on Friday and at weekends. On call cover was provided outside of these hours.

In anaesthetics, nine consultants provided care between 7am and 5.30pm. Outside these hours, on call cover was provided by two consultants who were supported by three associate specialists and eight middle grade doctors.

From September 2016 to August 2017, the trust reported a vacancy rate of 3.3% in surgery, this was better than the trust target of 7.0%.

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

Senior doctors confirmed the vacancies were for consultants and middle grade doctors which reflected the national picture. Vacant shifts were supplemented by bank staff. Bank staff had substantive posts in other NHS trusts but worked additional hours for this trust.

From September 2016 to August 2017 the trust reported a turnover rate of 2.6% in surgery, this was better than the trust target of 15.6%.

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

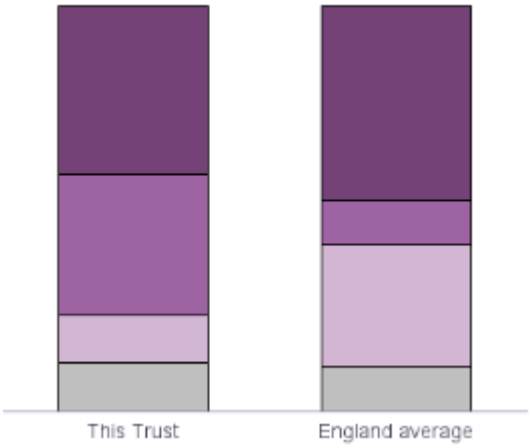
No information for staff sickness has been provided for this service for medical staff.

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

In August 2017, the proportion of consultant staff reported to be working at the trust was lower than the England average and the proportion of junior (foundation year 1-2) staff was about the

same as the average for England.

Staffing skill mix for the whole time equivalent staff working at East Cheshire NHS Trust



	This Trust	England average
Consultant	41%	48%
Middle career^	35%	11%
Registrar Group~	12%	30%
Junior*	12%	11%

^ 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)

Senior managers expressed concerns about medical staffing levels and in particular the difficulties with middle grade recruitment. To address this, the service was recruiting additional consultants because they were easier to recruit and more likely to stay in the long term. This would also add to the numbers of consultants available for on call cover which had been limited recently as only a small number of consultants were able to provide services out of hours.

Medical handovers and surgical rounds took place daily, including weekends.

Records

Staff kept appropriate records of patients' care and treatment. Records were clear, up to date and available to staff providing care.

Records were mostly paper based with some assessments, observations and early warning scores recorded electronically.

Managers reviewed a sample of three patients' records each month to check that prescription charts, risk assessments and reassessments, admission details and pain relief were all recorded correctly. Results were generally in line with good practice. For example in November 2017, reviews of nine records on wards 1, 1A, 2 and 10 found all fluid balance charts, pain scores and 44 out of 54 risk assessments were completed correctly.

Where managers identified issues during reviews, action was taken immediately to limit recurrence.

We reviewed ten patients' records which supported the findings of managers. They were legible and accurate throughout and contained no loose sheets except on the surgical treatment unit where all records contained loose sheets. Loose sheets could increase the risk of information being mislaid.

Information which enabled staff to deliver safe care and treatment such as risk assessments, allergy details, previous medical history, and consent were all included. However we identified minor omissions where in one record staff had not confirmed whether an independent mental capacity advocate was required, and in another a surgery checklist question was ticked but required additional details which had not been included.

We reviewed three records specifically from a medical perspective. We saw evidence that doctors from a range of specialities provided details. Diagnosis and management plans were included and we saw evidence of daily ward rounds and medical reviews within 12 hours of admission taking place.

Medicines

The service prescribed, gave, recorded and stored medicines well. Patients received the right medication at the right dose.

The trust clinical pharmacy team supported the service from Monday to Friday between 9am and 5pm. Outside of these hours staff contacted on call pharmacists.

Pharmacy staff visited wards to review stock levels, restock, assess patients' needs and dispense medicines.

Medicine stocks were reviewed and ordered weekly or on an ad hoc basis by nurses. Nurses said they had adequate stock levels to treat patients and that the ordering process was simple and efficient.

Medications were dispensed and distributed from the main pharmacy, and pharmacists could dispense directly from wards if required.

Medicines were stored correctly in all the areas we reviewed. They were stored securely and a designated senior nurse held keys to access medicine cupboards. This was in line with trust policy.

We saw records of controlled drug checks were kept, and drugs were dispensed correctly and in-line with trust policy.

Staff recorded patients' allergies and took precautions to limit the risk of allergic reactions. Theatre staff applied red arm bands to patients with allergies as a visible warning to staff.

Prescription charts provided evidence of pharmacist reviews and actions which ensured patients received the right medicines. They were legible and contained the right details including allergy status and weight. However, whilst oxygen was prescribed and included the required saturation on most wards, it was not always included in charts on ward ten.

When giving fluids or medicines to patients, two staff checked type and dosage to reduce the risk of mistakes.

Medicines requiring storage at low temperature were kept in fridges. To make sure temperatures did not exceed the required temperature staff were required to monitor and record fridge temperatures daily. We saw this done in all the areas we visited except ward ten and ward 1A. On ward 1A, two dates out of the ten we reviewed were missing and on ward ten no temperatures were being recorded at weekends. This was because the staff member responsible for this task only worked on weekdays and no one was completing the task in her absence. When we highlighted this to senior nurses they assured us they would review the process.

We also identified that whilst current temperatures were recorded, the facility to note minimum and maximum temperatures over the previous 24 hour period was not used. This was not in line with trust policy or best practice guidance which states minimum and maximum temperatures should be recorded to gain assurance that temperatures have not breached suitable range at any time.

Rooms storing medication should not exceed 25 degrees Celsius. Air conditioning units were installed in these rooms which helped maintain temperatures. However, room temperatures were not being recorded which meant staff could not be assured that temperatures were always within suitable range. Despite this, staff knew what to do should temperatures fall out of range; and the majority of room temperatures checked were within suitable range.

We also reviewed the storage of intravenous (IV) fluids. On ward 10 we saw IV potassium fluids being stored on the same shelf as other IV fluids. This was not in line with trust policy, which states they should be stored separately. We raised this with a senior nurse who stated she would review practice.

Pharmacy staff checked medicines were being stored correctly on wards (monthly) and in theatres (three monthly).

We reviewed checks done between January and March 2016. These identified any issues but despite having a box to record corrective actions, these were not completed. This meant we could not be assured that when issues were identified, action was taken to correct them. For example, the January 2016 audit identified that medicines were not locked away but no action was recorded to address this. In February, patients' own medicines were not all stored securely due to space restrictions but there was no action to address this. Additionally, the audits did not provide overall scores which made it more difficult to help staff quantify performance or assess improvement over time.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with wider teams. When things went wrong, staff apologised and gave patients honest information and suitable support.

Managers checked staff knowledge and documented this each month, with actions recorded to improve knowledge if required.

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 November 2016 to October 2017, the trust reported one incident classified as a never event for surgery.

During a sub-total colectomy and end ileostomy a guide wire was left inside a patient's body. This incident was reported to have occurred on 7 March 2016 (reference number 2016/6683/RJN).

(Source: Strategic Executive Information System (STEIS)

Following the never event, a new checklist was introduced to improve team work and focus during these procedures to reduce the risk of recurrence.

In accordance with the Serious Incident Framework 2015, the trust reported three serious incidents (SIs) in surgery which met the reporting criteria set by NHS England from November 2016 to October 2017.

One of these incidents was a confidential information leak/information governance breach meeting SI criteria. One was a pressure ulcer. One was a surgical/invasive procedure incident.

(Source: Strategic Executive Information System (STEIS)

Serious incidents were investigated using the Serious Incident Framework (2015). Patients were informed and supported when mistakes were made and investigations were being undertaken.

Managers ensured lessons were learned following incidents and that information was disseminated to limit recurrence. This was done on a one to basis with those involved, during daily handovers or at monthly meetings which were scheduled to make sure as many staff as possible could attend

Staff understood the principles of duty of candour legislation and gave examples of incidents which had triggered the process. The duty of candour is a legal duty to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. The incident reporting system prompted staff to review whether duty of candour should be applied.

Mortality incident reviews were undertaken and discussed at safety quality standards meetings every month. This provided an opportunity for managers and clinical staff to reflect on the care provided and identify actions to improve if required.

Safety thermometer

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

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

Data from the Patient Safety Thermometer showed that the trust reported three new pressure ulcers, 15 falls with harm and four new catheter urinary tract infections from October 2016 to October 2017 for surgery. The four new catheter urinary tract infections occurred in April 2017.

Reports were generated each month for safety quality standards meetings, attended by senior nurses and service managers. Data was also displayed in ward areas for patients and staff to

view.

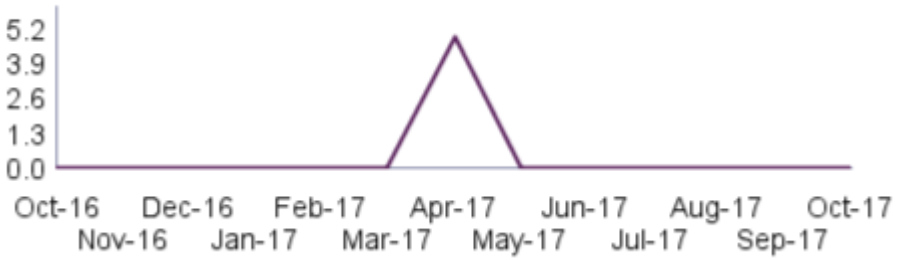
Safety thermometer incidents were investigated by senior staff who were trained to conduct root cause analysis, and action was taken to improve performance if required. For example, following an increase in falls on ward one, a falls coordinator was employed to help staff manage patients at risk more effectively. This led to trials for new sensors on beds which was ongoing at the time of our inspection.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter urinary tract infections at East Cheshire NHS Trust

Total Pressure ulcers (3)

Total Falls (15)

Total CUTIs (4)



(Source: NHS Digital)

Is the service effective?

Evidence-based care and treatment

In line with findings from our previous inspection, the service continued to provide care and treatment based on national guidance and evidence of its effectiveness. This included guidance

and standards set by the Association of Anaesthetists of Great Britain and Ireland and the National Institute for Health and Care Excellence.

National guidance was reflected in local guidelines to help staff care for patients. These included guidelines to manage patients with suspected sepsis which was based on up to date national guidance by the UK Sepsis Trust. They also used recognised scales to determine health status prior to surgery with the American Society of Anaesthesiologists physical status classification system and the Revised Cardiac Risk Index which is a tool used to estimate a patient's risk of heart complications during surgery.

Staff used clinical pathways to support them with standard processes like referring patients to other medical professionals before surgery. They specified the conditions for implementing the pathway such as abnormal blood results or electrocardiograph readings. For non-urgent surgery patients were referred back to their GP. Anyone listed for urgent surgery was referred to the surgeon or the anaesthetist to avoid delay.

Changes to guidance were discussed at monthly meetings and disseminated to staff in daily handovers or staff meetings. Updated guidance was also available on the trust computer system for other staff to access and review.

Managers reviewed the care of a sample of three patients each month to help make sure care was being provided in line with guidance and best practice standards. They looked at completion of records, medicine storage and adherence to uniform guidelines.

Nutrition and hydration

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

Leaflets explained that patients could be given special drinks prior to surgery to build up levels of carbohydrate in the body and aid recovery.

Staff could provide anti-sickness medication if required post-surgery.

Water was available but fluids could also be provided through a vein until patients could drink for themselves. Light meals were offered on the first day after surgery.

Post-surgery, food and refreshments were provided for patients on the ward including hot and cold options. Patients described a ‘good choice’ of food which was ‘alright’ and ‘very good’. They said staff encouraged them to drink plenty of fluids which were readily available.

Malnutrition screening tools were used to assess nutrition and hydration needs electronically. Where issues were identified staff sourced input from qualified dieticians who were available to visit and assess patients’ needs during office hours.

Senior nurses reviewed whether nurses were assessing feeding and hydration regularly in monthly audits. In November 2017 the audit showed fluid balance was recorded 86% of the time, and nutrition was recorded 78% of the time. We saw evidence that immediate action was taken to speak with staff and complete assessments when the audit identified they had not been done.

Pain relief

Staff assessed patients’ pain levels and provided pain relieving medicines when required.

A pain team worked within the trust to provide care for patients. The team were available from Monday to Friday between 9am and 5pm. At weekends anaesthetists undertook the role of the pain team on their behalf. The team cared for patients experiencing both chronic and acute pain.

Staff used recognised pain scales to identify patients' pain levels and a range of medicines were available to reduce pain including paracetamol and morphine.

Patients told us pain was managed well by staff who assessed needs and provided relief in a timely way.

Senior nurses audited pain assessments each month. In six audits we reviewed pain assessments were completed when required. Pain scores and details of medicines given were also evident in the patients' records we reviewed.

Pain relief was prescribed by medical staff or pharmacists with prescribing rights.

The need for pain relief was determined using a pain scale ranging from one to ten or a pictorial scale ranging from happy to sad faces for patients experiencing difficulties with communication.

In theatres, staff wrote instructions detailing pain relief to be administered immediately following surgery, after transfer to the ward and if required thereafter.

Patient outcomes

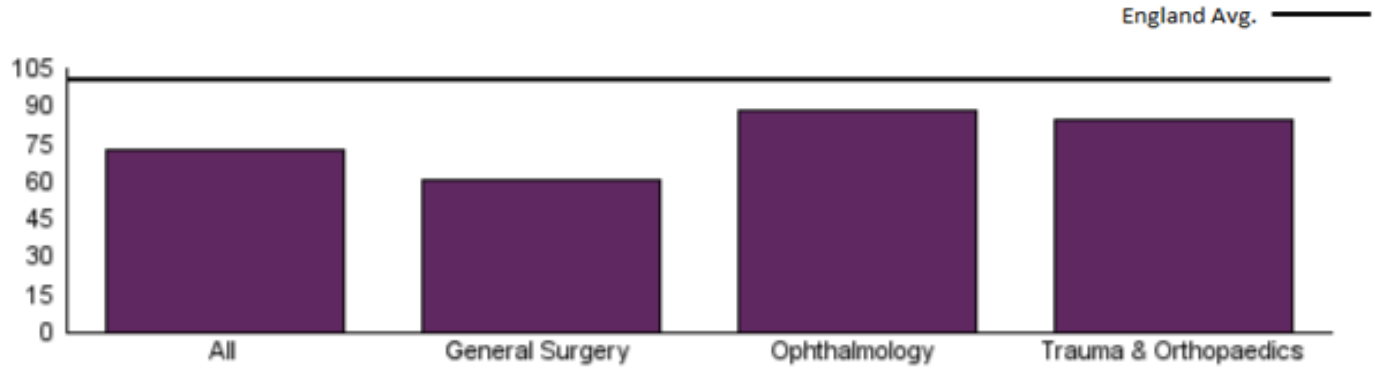
In line with findings from our previous inspection, the service continued to monitor the effectiveness of care and treatment and used findings to improve them.

Relative risk of readmission

Macclesfield District General Hospital

From July 2016 to June 2017, all patients at Macclesfield District General Hospital had a lower expected risk of readmission for elective admissions when compared to the England average. This was unchanged since our previous inspection. A breakdown for the top three specialties is below.

Elective Admissions - *Macclesfield District General Hospital*

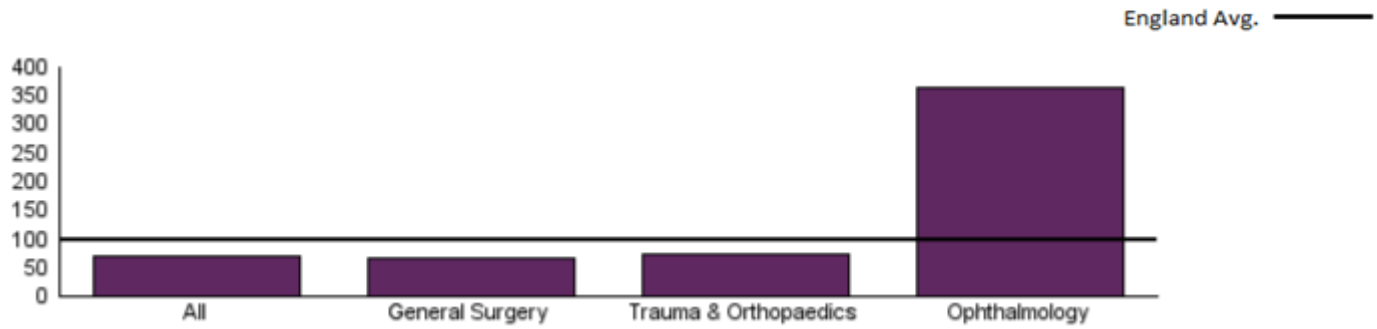


Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity

Non-Elective Admissions - *Macclesfield District General Hospital*

For non-elective admissions, General Surgery and Trauma & Orthopaedics patients at Macclesfield District General Hospital still had a lower expected risk of readmission for non-elective admissions when compared to the England average following our previous inspection published in 2015; however Ophthalmology patients had a higher than expected risk of readmission for non-elective admissions when compared to the England average.

Non-Elective Admissions - *Macclesfield District General Hospital*



Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity

(Source: Hospital Episode Statistics)

Hip Fracture Audit

In the 2017 Hip Fracture Audit, the risk-adjusted 30-day mortality rate was 7% which was within the expected range. The 2016 figure was 9.2%.

The proportion of patients having surgery on the day of or day after admission was 76.7%, which was worse than the national standard of 85%. The 2016 figure was 75.7%.

These results were also identified as an issue during our previous inspection. Senior staff said this remained a challenge due to increasing comorbidities amongst elderly patients which delayed surgery. We saw evidence of this during our inspection where a patient was delayed due to clinical concerns which had to be treated before surgery could take place.

To help manage delays, managers reviewed these patients each month to identify trends and take action if required. So far no links had been found between delays and mortality. Managers had also sourced an ortho-geriatrician to help manage elderly patients with comorbidities

The perioperative medical assessment rate was 88.2%, which failed to meet the national standard of 100%. The 2016 figure was 88.7%.

The proportion of patients not developing pressure ulcers was 98.3%, which falls in the middle 50% of trusts. The 2016 figure was 96.2%.

The length of stay was 28.4 days, which falls in the top 25% of trusts in England. The 2016 figure was 22.3 days.

(Source: National Hip Fracture Database 2016)

Bowel Cancer Audit

In the 2016 Bowel Cancer Audit, 86.4% of patients undergoing a major resection had a post-operative length of stay greater than five days. This was worse than the national aggregate. The 2015 figure was 74.4%. This had worsened since our previous inspection.

Senior managers had begun a review of patients with a greater than expected length of stay. So far, results indicated that delays discharging medically fit patients were the cause. Once the review was complete managers planned to visit other NHS trusts to observe and adopt good practice to improve the length of stay for patients.

The risk-adjusted 90-day post-operative mortality rate was 5% which was within the expected range. The 2015 figure was 2.9%.

The risk-adjusted 2-year post-operative mortality rate was 16.8% which was within the expected range. The 2016 figure was 27.7%.

The risk-adjusted 30-day unplanned readmission rate was 10.5% which was within the expected range. No figure was provided for the previous year.

The risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection was 47.8% which was within the expected range. The 2016 figure was 45.5%.

(Source: National Bowel Cancer Audit)

National Vascular Registry

The trust did not participate in the 2016 National Vascular Registry (NVR) audit.

(Source: National Vascular Registry)

Oesophago-Gastric Cancer National Audit

In the 2016 Oesophago-Gastric Cancer National Audit, the age and sex adjusted proportion of patients diagnosed after an emergency admission was 7.1%, this was better than the national aggregate.

The proportion of patients treated with curative intent in the Strategic Clinical Network was 38.9%, which is similar to the national aggregate.

This metric is defined at strategic clinical network level; the network can represent several cancer units and specialist centres; the result can therefore be used a marker for the effectiveness of care at network level; better co-operation between hospitals within a network would be expected to produce better results.

(Source: National Oesophago-Gastric Cancer Audit 2016)

National Emergency Laparotomy Audit

In the 2016 National Emergency Laparotomy Audit, the East Cheshire Trust achieved an amber rating for the crude proportion of cases with pre-operative documentation of risk of death. This was based on 92 cases.

The trust achieved a green rating for the crude proportion of cases with access to theatres within clinically appropriate time frames. This was based on 53 cases.

The trust achieved a green rating for the crude proportion of high-risk cases with a consultant surgeon and anaesthetist present in the theatre. This was based on 59 cases.

The trust achieved a green rating for the crude proportion of highest-risk cases admitted to critical care post-operatively. This was based on 40 cases.

The risk-adjusted 30-day mortality for the trust was within expectations, based on 92 cases.

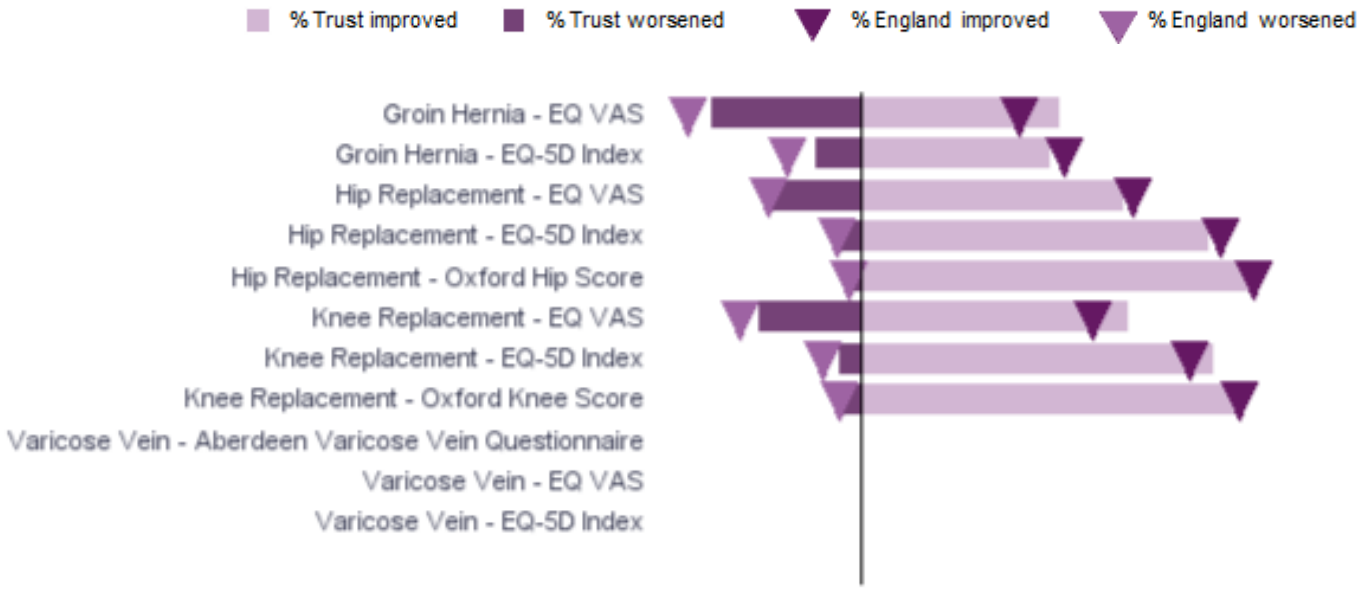
(Source: National Emergency Laparotomy Audit)

Patient Reported Outcome Measures

In the Patient Reported Outcomes Measures survey, patients are asked whether they feel better or worse after receiving the following operations:

- Groin Hernias
- Varicose Veins
- Hip Replacements
- Knee replacements

Proportions of patients who reported an improvement after each procedure can be seen on the right of the graph, whereas proportions of patients reporting that they feel worse can be viewed on the left.



In 2016/17 performance on groin hernias was better than the England average in terms of the EQ VAS score but mixed in terms of the EQ-SD index.

For hip replacements, performance was about the same as the England average.

For knee replacements was slightly better than the England average.

The trust provided no varicose vein procedures to the audit.

(Source: NHS Digital)

Other local audits were completed to help maintain standards. These included audits to ensure risk assessments and observations were recorded appropriately in records. Performance targets were used which helped focus areas for improvement including completing 90% of observations on time. On ward 1 we saw that this standard was maintained between April and August 2017

Care for patients with sepsis was regularly reviewed to ensure standards were maintained and outcomes were good. In particular, the percentage of patients screened appropriately was recorded as a measure of good practice.

Competent staff

Staff were competent in their role however the service did not always ensure that this was recorded and monitored. For example, on ward ten, individual staff self-assessed their abilities using a score system, and managers then added their assessment. Actions were required depending upon the score. However two files held forms which were blank and two others were not completed in line with requirements. For example, staff did not consistently score their ability or list actions to address low scores.

On the day unit nurses we spoke to were not familiar with competency files. They had never been asked to complete documents. However, the trust provided information to indicate that in areas of specific skill for example cannulation this was a core clinical competence. Core clinical competencies were dovetailed into the appraisals and revalidation process for trained staff. Training figures for cannulation showed that all staff on ward two were up to date. In terms of assurance clinical, statutory mandatory training and appraisals were monitored through Planned Care Safety and Quality Standards Surgical Management Team meetings and performance.

In theatres staff received comprehensive training in a range of competencies which were recorded in files. We saw evidence of training relevant to their roles. For example, scrub nurses received training in gowning and gloving, skin preparation, draping and specimen collection, as well as training to handle new equipment.

For new starters in theatres, training in core competencies was provided. This included learning about clinical governance, communication, safe use of equipment, positioning patients and team work.

Student theatre handbooks were also provided which covered facilities, dress codes and theatre

practice. Learning was reviewed at 'checkpoints' throughout learning phases.

Theatre nurses described feeling supported, particularly with the nurse revalidation process which they said worked well.

Medical students received two week inductions which they said was helpful. This was followed by two weeks shadowing another staff member. Formal teaching took place twice each week for medical students which was compulsory.

Appraisal rates

Staff received annual appraisals. These were completed by nurses for other team members in a tier system. For example, band seven staff completed them for band six staff who in turn undertook band five staff appraisals.

Between April 2016 and March 2017, 91% of staff within surgery at the trust had received an appraisal compared to a trust target of 90%. This had improved since our previous inspection where only 30% of theatre staff had completed an annual appraisal. A breakdown by staffing group can be found below.

Staff Group	Number receiving an appraisal 2016/17	Number requiring an appraisal 2016/17	Appraisal completion rate	Target	Met Target (Yes/No)
Additional Clinical Services	86	94	91%	90%	Yes
Allied Health Professionals	4	5	80%	90%	No
Administrative and Clerical	18	20	90%	90%	Yes
Nursing and Midwifery	96	106	91%	90%	Yes
Estates and Ancillary	2	2	100%	90%	Yes
Healthcare Scientists	1	1	100%	90%	Yes
Prof Scientific and Technic	16	16	100%	90%	Yes
Grand Total	223	244	91%	90%	Yes

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

Multidisciplinary working

Staff on wards and in theatres worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide care.

On wards; dieticians, social workers, occupational and physiotherapists and nurses completed daily patient reviews. Medical staff completed their own reviews. Theatre staff including anaesthetists, surgeons and nurses demonstrated good team work when caring for patients throughout their surgery which we observed during our inspection.

In theatres a range of medical and nursing staff worked together to care for patients. This included anaesthetists, surgeons, recovery nurses, scrub nurses and operating department practitioners.

Team briefs took place each morning in theatre areas involving surgeons, anaesthetists, operating department practitioners, scrub nurses, health care assistants

Staff caring for patients suffering traumatic orthopaedic injuries shared details with on call surgeons, which was updated daily and enabled staff of all disciplines to access the correct personnel without delay.

Ward and theatre staff worked to update each other about patients under their care. This helped anticipate potential issues and allowed staff to redistribute patients on theatre lists or take action to address issues prior to commencing surgery. Junior doctors reported good working relationships with senior doctors as well as with the wider team (including physiotherapists, occupational therapists and dieticians).

We saw staff liaising with porters who came to transfer patients to different areas of the hospital.

Pharmacists were present on wards we visited providing support to staff and caring for patients.

Seven-day services

Some services were provided seven days a week but others were only available during weekdays.

Patients on wards were cared for 24 hours a day, seven days a week. Surgery was undertaken six days a week with a seventh day provided on an ad-hoc basis if required (for example to reduce waiting lists).

Physiotherapists and dieticians were available during office hours from Monday to Friday.

Housekeepers worked on some wards but not all. They helped make sure ward areas remained tidy and clutter free, that linen stocks were replenished and that new stock was ordered and stored correctly.

Pharmacists worked Monday to Friday between 9am and 5pm and from 10am at weekends.

Chaplaincy services were available 24 hours a day with scheduled services for the Roman Catholic faith both at weekends and midweek.

Health promotion

Patients were comprehensively assessed so that their clinical needs and general health status (including smoking and alcohol habits) could be considered.

Information leaflets provided information about lifestyle changes to help make sure surgery was as successful as possible. These included information about stopping smoking and taking regular exercise.

Assessments incorporated national priorities to improve the population's health such as care for those living with dementia. Other priorities such as smoking cessation and alcohol dependency were noted during pre-operative assessments.

We saw enhanced recovery protocols used for surgical patients. These helped staff focus on early mobilisation, eating and drinking after surgery with minimal intervention such as drains or catheters. The protocols were based on evidence and helped people recover quicker following surgery.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked capacity to make decisions about their care.

Staff received training and up to date policies, procedures and pathways supported them when assessing and recording consent, mental capacity and Deprivation of Liberty safeguards.

Managers conducted random audits each month to ensure staff were familiar with these policies and processes. Results for November 2017 showed that all of the nine staff audited were confident regarding the policies and processes. In December 2017 seven out of nine were familiar, with two staff relatively new taken through the process again for seeking advice if unsure.

For minor procedures such as inserting cannulas, staff used the principle of implied consent after verbally obtaining consent.

For surgery staff used one of four different consent forms which were available to cover various scenarios including consenting children or those lacking mental capacity. Our review of patients' records confirmed that staff selected the right forms, based on a patient's circumstances ensuring they obtained consent pre-operatively after discussing potential risks and alternatives to surgery in line with legislation and guidance.

The trust was unable to provide the appropriate data and we are awaiting updated information. Once this has been received in the correct format we will be able to populate the analysis to complete this section.

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

Is the service caring?

Compassionate care

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

Patients told us that 'nothing was too much trouble', 'the care and efficiency of staff is wonderful' and that staff 'did all they could to help me and get me on my feet again'.

We saw staff care for patients with reassuring gestures and a calm friendly manner. Staff identified needs through their contact with patients and took steps to make sure they were as comfortable as possible.

Friends and Family test performance

Patients completed a questionnaire called the Friends and Family Test which rated how likely they would be to recommend the service to friends or family members.

Data on the percentage of patients recommending the service as a place to receive treatment is shown in the table below:

Trust Name: EAST CHESHIRE NHS TRUST

Core Service: Surgery

Ward name	Total Resp	Avg. Response Rate	Percentage of patients recommending the service as a place to receive treatment												
			Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Annual
SDCU	499	36%	96%	98%	95%	95%	97%	97%	90%	93%	91%	90%	92%	93%	92%
Ward 2	390	29%	90%	95%	100%	93%	100%	93%		93%	98%	100%	100%	100%	95%
Ward 10	380	32%	100%	97%	100%	100%	97%	100%	100%	94%	83%	100%	95%	93%	97%
Ward 1	313	26%	100%	94%	100%	100%	97%	100%	91%	100%	100%	100%	97%	96%	98%
Ward 1 (A)	221	22%		100%	100%		100%	100%	100%	100%	100%		100%	100%	99%

Key	Highest score to Lowest score		
	100%	50%	0%

Note - The formatting above is conditional formatting which colours cells on a grading from highest to lowest, to aid in seeing quickly where scores are high or low. Colours do not imply the passing or failing of any national standard.

Note: sorted by total response

(Source: NHS England Friends and Family Test)

Staff drew curtains around patients when talking to them which helped provide privacy and maintain dignity. However, on wards we saw noticeboards containing patient identifiable information which could be seen by passers-by including members of the public. This reduced privacy for patients.

Emotional support

Staff provided emotional support to patients to minimise their distress. We saw staff approach patients, refer to them by name and introduce themselves before commencing care. They identified needs and took steps to reassure them and make them feel more comfortable.

Patients supported what we saw describing the support they were given as ‘excellent’ and saying that staff were ‘very attentive’.

Understanding and involvement of patients and those close to them

Staff involved patients and those close to them in decisions about their care and treatment.

We saw staff explain procedures such as inserting needles, telling them why this was required and how it would help them. Staff took extra time to reassure a patient during a difficult needle insertion, providing step by step details with a calm, supportive approach.

We spoke to ten patients during our inspection. Most said they received information about the risks and benefits before surgery and described it as ‘a good level of information’. This included details about who to contact if they had any concerns after going home.

They said staff explained information in a way they could understand, with written information provided to refer back to it if needed.

Despite this, two patients felt they were not listened to by medical staff. One said ‘they walk off without listening to me’ and another said ‘I keep asking to see a doctor but they haven’t been back to see me…no one is listening’; ‘no explanation was given about my plan for medical treatment and I would like to know’ and ‘I don’t feel listened to’.

Is the service responsive?

Service delivery to meet the needs of local people

The service planned and provided services in a way that met the needs of local people. Managers described the local population as predominantly white British and information we reviewed during our inspection confirmed this. Staff said the population was ageing rapidly which was supported by trust figures showing the local area had the fastest ageing population in the North West.

Staff also told us about local patients with learning disabilities and explained that services were delivered specifically to meet their needs. For example, lists included fewer patients to provide extra time to support them and multiple procedures were completed together to limit the number of visits to hospital.

Staff described working with staff at a local centre caring for epileptic patients to help plan the most appropriate care and ensure needs were met when they were discharged.

Chaplaincy services were provided for patients with posters used to display service times. However, the posters only made reference to Roman Catholic or Church of England services, with nothing listed for other faiths such as Muslim, Hindu or Buddhist. Despite this we did see comprehensive information for staff providing information about a range of faiths which helped identify patients’ needs.

Leaflets were provided for patients being discharged explaining what to expect following surgery.

A frailty team worked with patients providing holistic assessments and care plans based on a multi-disciplinary approach from specialists including geriatrician and GPs.

Service plans were in place for bariatric patients.

Pager systems were in use for those attending per-operative clinics. This allowed patients to go elsewhere within the hospital rather than waiting outside the unit for their appointment.

Meeting people’s individual needs

The service took account of individual needs including those with living with dementia, physical or learning disabilities or communication difficulties.

Dementia screening formed part of the pre-operative assessment. Red stickers on files indicated those patients living with this condition. Link nurses were available via email should staff have queries about care for these patients.

Boxes containing local memorabilia, local history and colouring books (which nurses had sourced themselves) were available for elderly patients and those living with dementia. Twiddlemuffs were also available for patients to take away with them. These are double thickness hand muffs with different items attached inside and out. They help provide stimulation activity for restless hands in patients suffering from dementia.

Red trays used on wards helped to visually identify patients requiring assistance with feeding so that staff could provide assistance.

Staff used 'communication boxes' which contained items including magnifying glasses, liquid levellers and pictorial statements that patients with communication difficulties could use to make requests or express emotions.

Items to help blind or poorly sighted people. These included small dome shaped plastic stickers which patients could stick to tables to help them locate items such as hot drinks or food.

Access and flow

At the time of our inspection, all non-urgent elective surgery had been cancelled until February 2018 in line with NHS England guidance. This meant the service was only caring for patients who required urgent or emergency surgery.

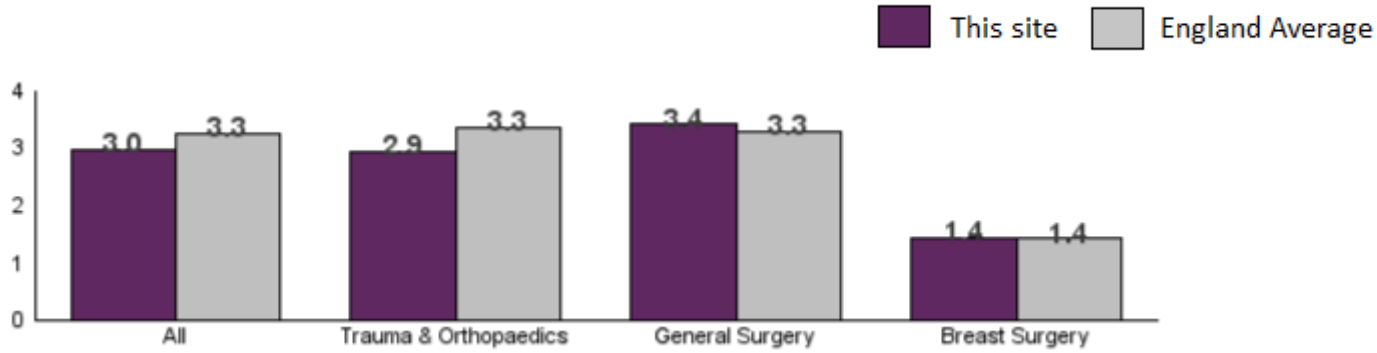
During our previous inspection we found that patients were not always able to access the service when they needed it and this remained the case during this inspection. Waiting times for treatment and arrangements to admit, treat and discharge patients were not always in line with good practice.

Average length of stay

Macclesfield District General Hospital - elective patients

From August 2016 to July 2017 the average length of stay for all elective patients at Macclesfield District General Hospital was 3.0 days, which is similar to the England average of 3.3 days. Figures for the top three specialties are in the table below.

Elective Average Length of Stay - Macclesfield District General Hospital



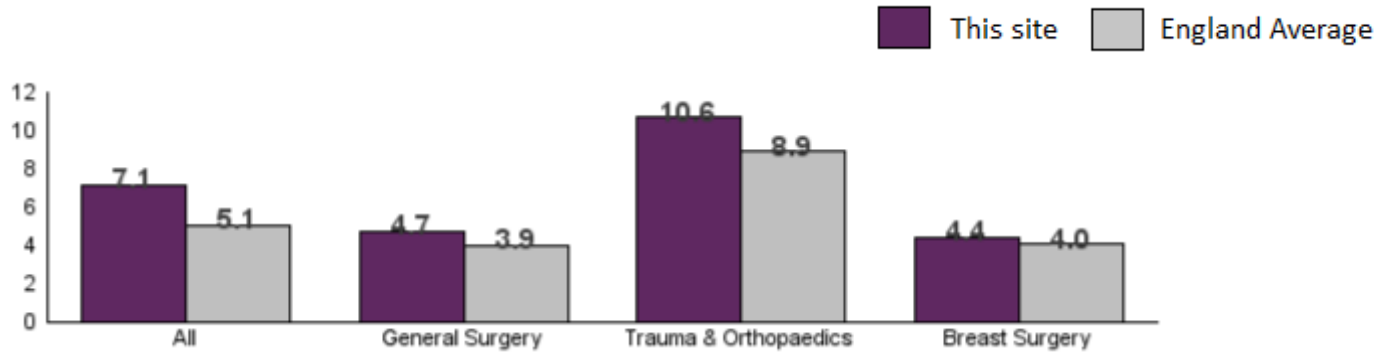
Note: Top three specialties for specific trust based on count of activity.

Macclesfield District General Hospital - non-elective patients

The average length of stay for all non-elective patients at Macclesfield District General Hospital

was 7.1 days, higher than the England average of 5.1 days. A breakdown for the top three specialties is below.

Non-Elective Average Length of Stay - Macclesfield District General Hospital

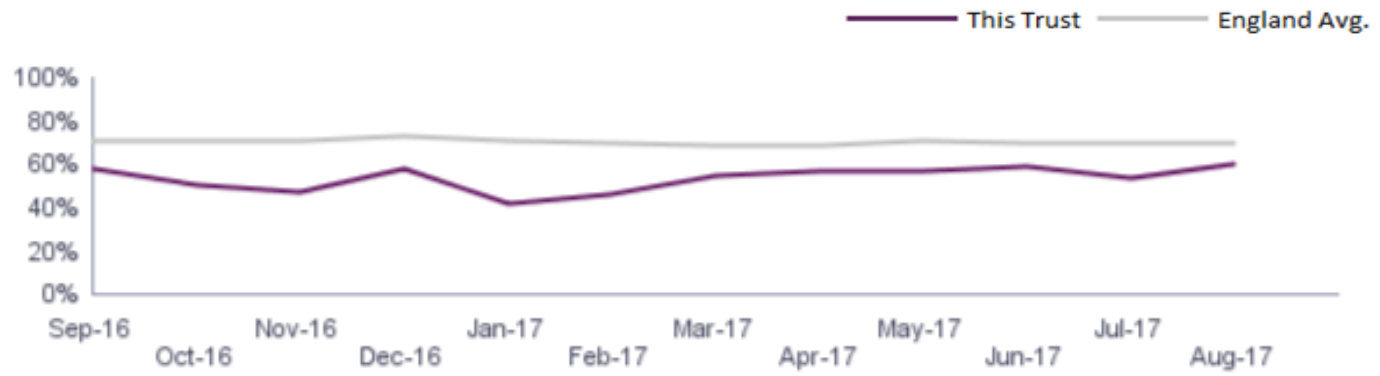


Note: Top three specialties for specific trust based on count of activity.

(Source: Hospital Episode Statistics)

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

From September 2016 to August 2017 the trust's referral to treatment time (RTT) for admitted pathways for surgery was below the average for England with a slow improvement from January 2017.



(Source: NHS England)

Referral to treatment (percentage within 18 weeks) – by specialty

A breakdown of referral to treatment rates for surgery broken down by specialty Shows three of the specialties were above (better than) the England average and four of specialties were below (worse than) the England average.

Specialties better than the England average

Speciality grouping	Result	England average
Plastic surgery	90.1%	82.6%
Oral surgery	83.8%	65.8%
General surgery	78.3%	72.7%

Specialties worse than the England average

Speciality grouping	Result	England average
Urology	75.3%	77.3%
Ophthalmology	37.5%	74.3%
ENT	54.3%	65.0%
Trauma and Orthopaedics	39.2%	62.2%

Senior managers expressed concern about referral times and described actions to try to improve them. These included running extra theatre lists and holding weekly meetings to check theatre spaces were being used effectively. Additional staff had also been employed. The managers explained that these actions had helped improve services but that increasing winter activity was now impacting negatively on the referral times. However, referral to treatment times in January 2018 showed improvement for the entire speciality groups which were identified worse than the England average.

Managers monitored the timeliness of surgery and reviewed findings each month at safety quality standard meetings. Results included how many patients were brought to theatre on time, how much theatre time was used performing surgery, how many theatre lists were cancelled, and how many operations were undertaken against the number planned. Results were displayed on noticeboards for staff to review.

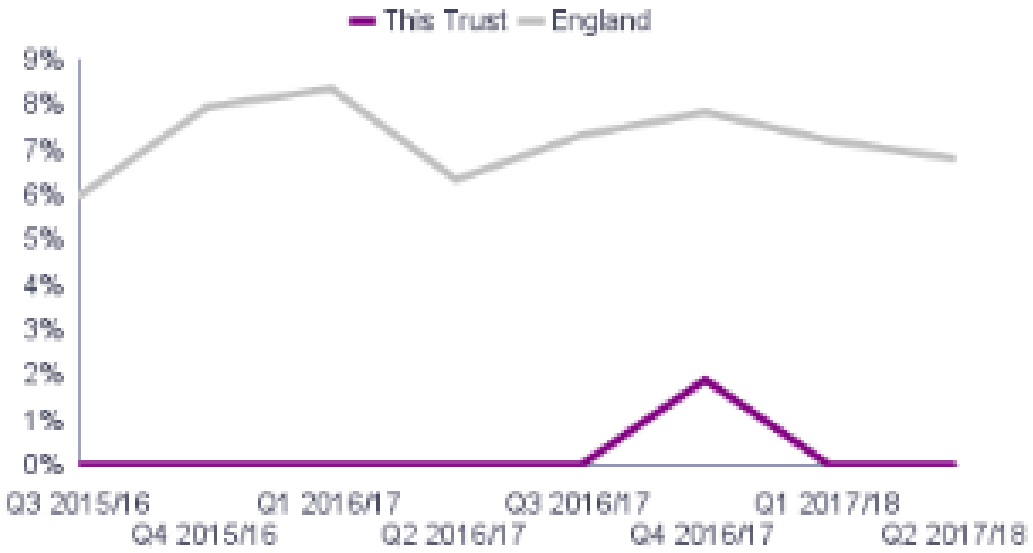
Between April and December 2017, 66% of patients were not brought to theatres on time. This was reflected in surgery start times which were delayed more often than on time (1133 late starts between April and December 2017 versus 400 on time).

Cancelled operations

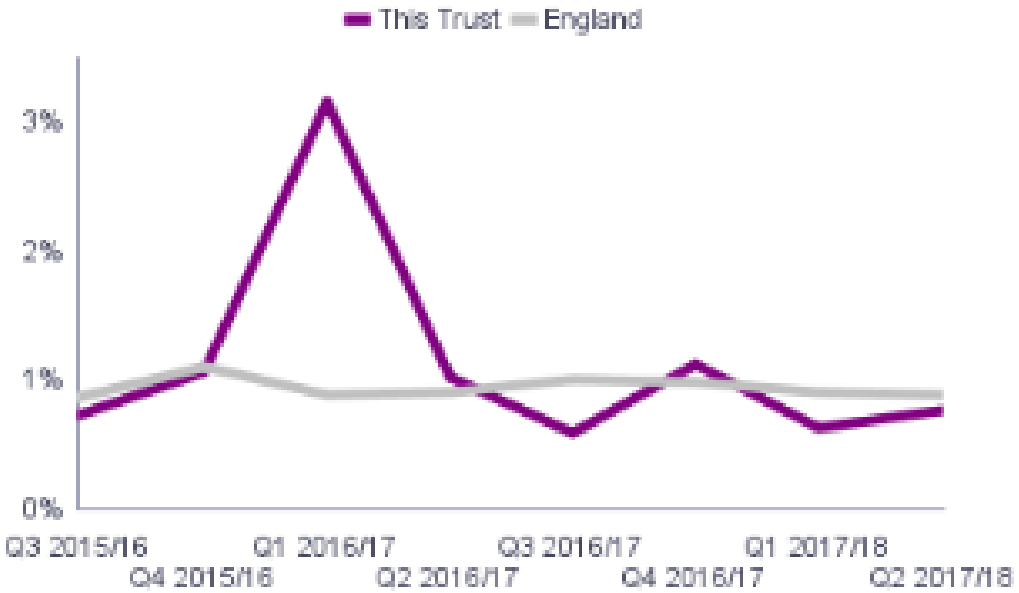
A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient has not been treated within 28 days of a last-minute cancellation then this is recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice.

One of the surgeries which were cancelled was not treated within 28 days, in Q4 of 2016/17.

Percentage of patients whose operation was cancelled and were not treated within 28 days - East Cheshire NHS Trust



Cancelled Operations as a percentage of elective admissions - East Cheshire NHS Trust



Over the two years, the figures for cancelled operations as a percentage of elective admissions at the trust fluctuated, with a spike in quarter 1 2016/17.

(Source: NHS England)

Figures we reviewed during our inspection showed since April 2017 surgeons cancelled 109 theatre lists to take annual or study leave after operations had already been scheduled. Cancellations on the day of surgery occurred 124 times between April and November 2017. Fifty-two of these were because there was no available bed for the patient to go to following surgery. This had been identified as an issue during our previous inspection. Twenty-nine were due to patients being unfit for surgery on the day.

Senior managers were reviewing other actions to ensure patients received timely treatment. Business cases were in progress to employ more nurses, implement virtual appointments (remote appointments using computer screens rather than patients attending in person), and introducing a local anaesthetic treatment room to free theatre space for other surgery.

At the time of our inspection the hospital was under extreme pressure. Whilst elective surgery was cancelled the hospital was still receiving high numbers of medical patients which were filling beds assigned for surgical patients.

To increase capacity, a treatment unit usually used for local anaesthetic procedures had been turned into an escalation ward with seven beds. Set criteria helped ensure only those who were well enough were selected to stay. This included self-caring, mobile patients who were expected to go home within a few days. All beds were visible from the nurses' station.

Noticeboards on wards gave an overview of patients and in particular, their discharge status which was identified through the use of coloured magnets. Green meant a patient was being discharged that day, black meant the discharge had been delayed and red meant the patient was not yet fit for discharge. Presenting information in a concise way helped staff obtain an overview of the ward at a glance and helped focus activity on discharging those who were medically fit.

To help manage the discharge process more effectively the trust had a 'wrap around' team. They went home with patients being discharged to settle them in and ensure they were warm and had adequate food and refreshments. Groceries could also be sourced by the team if needed. This helped bridge gaps in care until social care providers could take over.

The service monitored delays discharging patients so that they could be actioned promptly. Patients who had been fit to leave hospital for seven days or more were categorised based on the reason for delay, and reviewed weekly by managers and clinical staff including a social worker, and members of the integrated discharge team.

Patients still in hospital after thirty days received a letter from the trust to highlight this and ask that they liaise with staff to organise a suitable destination.

Additionally, the trust was piloting a responsive pharmacy discharge team across the hospital with the aim to reduce discharge times by speeding up the medicine dispensing process. Electronic discharge forms were completed as part of the process which helped speed up the preparation and dispensing process.

Learning from complaints and concerns

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

From October 2016 to November 2017, there were 37 complaints about surgical care. Figures showed 34 of these were closed within either 25 or 45 days, in accordance with the internal trust policy.

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

Managers we spoke with said that complaints were closed earlier. However, they did not provide any other figures to support this.

Complaints were reviewed and discussed at monthly safety quality standards meetings so that learning could be shared and then disseminated to teams in further staff meetings or daily huddles. Actions to prevent recurrence were also discussed which included reminders for staff to provide accurate information and record details correctly in records.

To proactively manage complaints, staff from the trust's patient advice and liaison service visited patients on wards to ask about their care and address any issues arising. Patients placed into extra beds in bays were prioritised. We also saw posters displayed throughout the hospital and on the website explaining the complaints process.

Is the service well-led?

Leadership

Staff in the service worked as part of the planned care division. Operational and clinical managers for specialties were overseen by the general manager for surgery who reported to the trust's medical and associate directors.

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

Leaders had worked for the trust for a number of years gaining experience in their roles. Nursing staff said leaders supported them well, and felt able to approach them easily.

Leaders described periods when they supported staff by coming down to help them when services reached capacity. Managers confirmed this had been done daily over the winter period to help ease pressures. This was an improvement following our previous inspection where staff told us leaders were not always visible.

In our inspection report published in 2015 we noted that theatre areas did not have a manager. Following this inspection we saw that a manager was now in post.

Vision and strategy

The trust had a vision for what it wanted to achieve. This was to ensure patients received the best care in the right place and to provide high quality affordable integrated services. Priorities for achieving this were grouped into four areas: patients, people (staff), partnerships and resources which helped to remain focused as plans to achieve this progressed.

In particular the trust aimed to maintain patient satisfaction, reduce vacancies and deliver agreed financial targets. We saw evidence of activity which focused on these topics during our inspection. For example, the patient advice and liaison teams actively visited patients to check they were satisfied with care, rolling vacancies were advertised and bespoke medical jobs were created to draw people to employment and finance managers met monthly with managers to review needs and budgets.

Theatres also had a five year plan for refurbishment which was in progress at the time of our inspection. This involved upgrading areas of each theatre area. Regular meetings took place to discuss the plan and ensure progress was maintained.

Culture

Managers promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

Senior managers and staff described the culture as ‘open door’ and felt able to approach members of the trust board or managers at any time. They also described the culture as ‘friendly’, which was reflected in quality assurance checks completed by local commissioners who spoke with staff who reported feeling ‘comfortable about raising concerns’. This gave managers assurance about the culture of the service.

Other staff explained that the hospital was small compared to some local trusts which promoted a feeling that everyone knew each other.

Many of the staff we spoke to had worked at the trust for a number of years and gave examples of giving up other work to remain in the trust because they liked the culture.

We observed team working between staff on wards and in theatres and this supported what staff had told us. Staff demonstrated a friendly, happy and caring approach to their work, patients and colleagues.

Governance

The trust used a systematic approach to continually improving the quality of its services and safeguarding high standards of care.

Monthly and bi-monthly meetings were held providing staff with an opportunity to hear about challenges and changes to services, new risks identified, and lessons learned from incidents or complaints. Data packs held information about incidents, complaints and audit results which helped attendees identify good practice and areas requiring improvement. However, attendance at the meetings was low. For example in October 2017 only 19 out of 53 staff attended.

Meetings were minuted and placed onto a shared drive for other staff to review with a copy also placed onto the staff noticeboard in ward areas which helped reduce the impact of low attendance.

Specific staff acted as leads in areas including sepsis and safeguarding. Steering groups were used to monitor and evaluate performance, for example in sepsis.

Management of risk, issues and performance

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

A risk management policy helped managers decide what details to record on local and trust risk registers. This helped ensure that appropriate risks were recorded on the correct register and that the trust board were aware of the most serious risks.

Senior managers were aware of risks which included reduced staffing, not meeting referral targets, equipment replacement and refurbishment needs balanced with financial constraints. The concerns correlated and were recorded to help make sure all senior staff were cited on the risks and actions in place to mitigate them.

Risks were discussed monthly during safety quality standards meetings which were attended by senior nurses and service managers.

Information management

The trust collected, analysed, managed and used information to support activities. It used secure systems but these were not always effective and as a result staff found information difficult to locate. For example, Information was available for staff on the trust 'infonet' system. However several staff we spoke to told us the search function did not work which caused difficulties locating information. We witnessed staff attempt to locate particular guidance without success.

Other systems worked well. Data was provided for managers to analyse and report on each month. This gave a large range of information about topics including infection control, mandatory training levels, incidents and complaints. The reports were then presented and discussed at monthly safety, quality standards meetings.

Engagement

The service engaged well with patients, staff and the public to plan and manage services.

Members of the trust board (including non-executive directors) conducted scheduled visits to different areas of the service each month to meet staff and patients.

A senior manager within the trust acted as a 'freedom to speak up' guardian in line with national requirements. This helped ensure staff could raise concerns with appropriate support in a way that felt safe.

Engagement with patients took place with questionnaires and visits from the patient advice and liaison service who took action to improve services as a result. Senior nurses conducted monthly spot checks asking three patients whether they had received the care that mattered to them, how they felt this had been provided and whether they felt they had been treated with dignity and compassion. Action was taken based on feedback received, including the installation of wireless internet networks to improve hospital stays.

Staff worked with local residents with a learning disability who posed for photographs to help explain processes such as taking blood or breast screening. These formed a pictorial booklet which was then shared with other patients coming for care or treatment.

Learning, continuous improvement and innovation

The trust was committed to improving services by learning from when things go well and when they go wrong. They shared findings in newsletters and regular meetings to ensure everyone could learn and adopt new practice to prevent incidents recurring.

Staff on ward ten were trialling mattress motion sensors to help minimise the risk of patients falling when getting out of bed. The sensors produced an alarm which prompted staff to come and assist the patient before they injured themselves.

To help people get back on their feet after surgery the trust promoted the idea of getting up, dressed and mobile every day. To raise awareness, they hosted pyjama paralysis campaigns which explained the reasons why getting dressed and being mobile aided recovery.

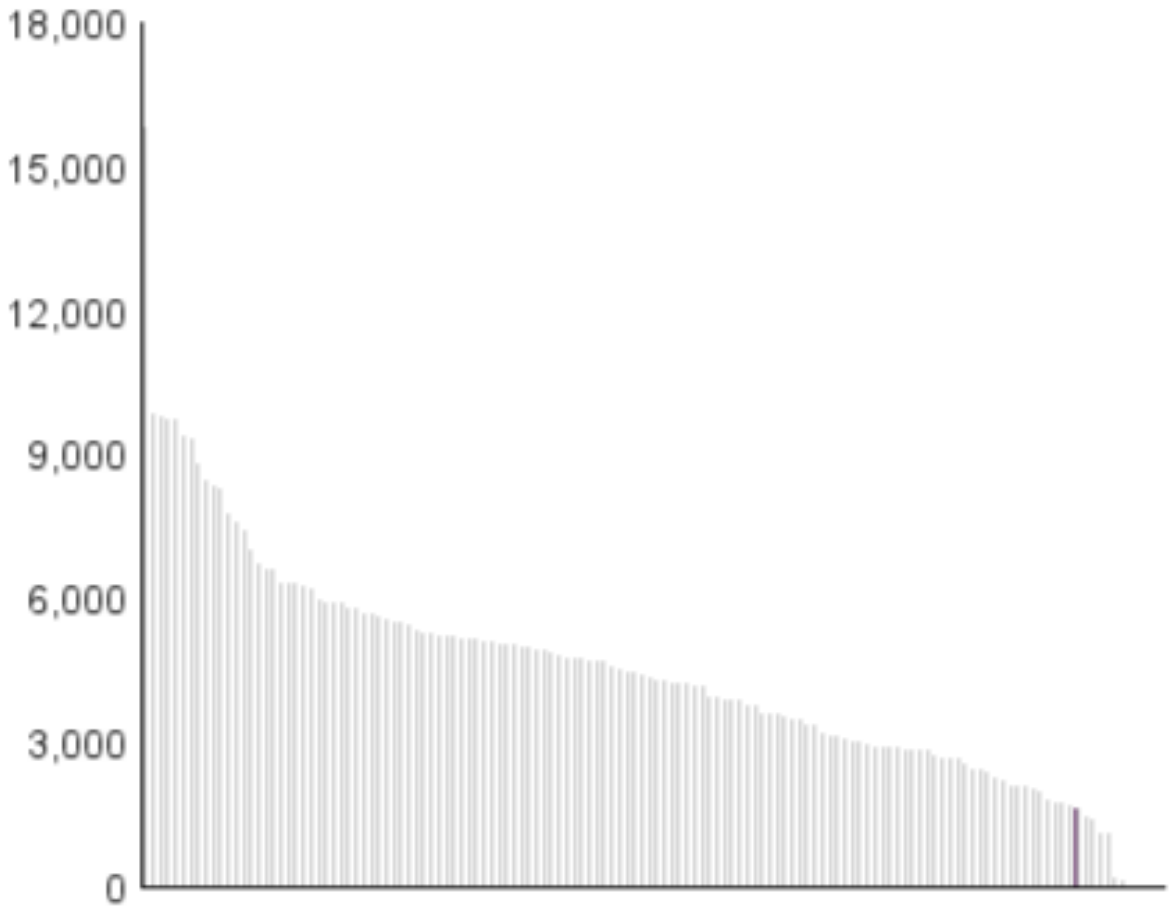
Maternity

Facts and data about this service

From July 2016 to June 2017 there were 1,597 deliveries at the trust.

A comparison from the number of births at the trust and the national totals over the most recent 12 months is shown below.

Number of babies delivered at East Cheshire NHS Trust – Comparison with other trusts in England.



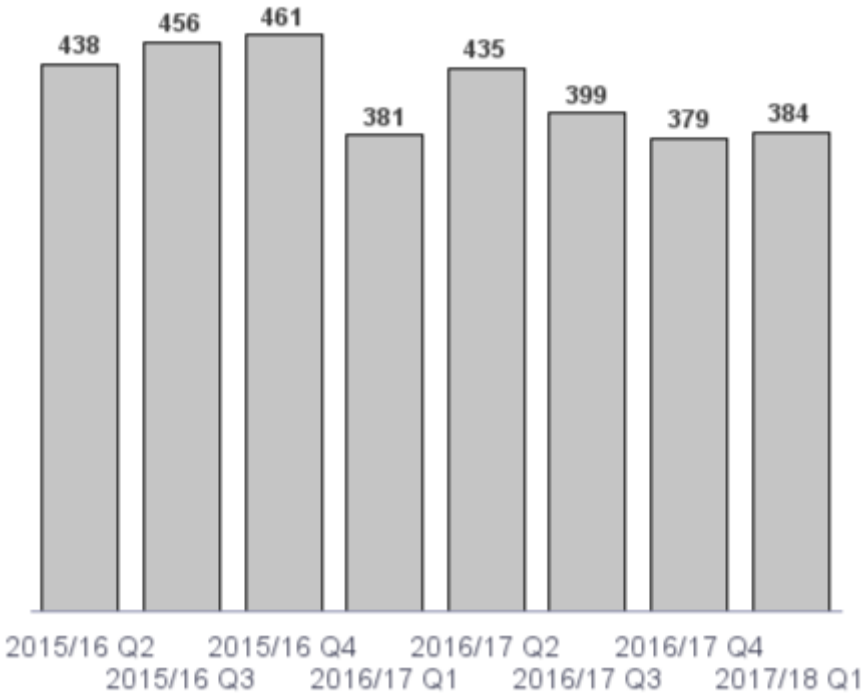
A profile of all deliveries from July 2016 to June 2017 can be viewed below.

Table 1: Profile of all deliveries (July 2016 to June 2017)			
	East Cheshire NHS Trust		England
	Deliveries (n)	Deliveries (%)	Deliveries (%)
Single or multiple births			
Single	1,573	98.5%	98.5%
Multiple	24	1.5%	1.5%
Mother's age			
Under 20	37	2.3%	3.2%
20-34	1,158	72.5%	75.0%
35-39	319	20.0%	17.8%
40+	83	5.2%	3.9%
Total number of deliveries			
Total	1,597		608,950

(Source: Hospital Episodes Statistics (HES) – Provided by CQC Outliers team)

Trends by quarter for the last two years can be seen in the graph below.

Number of deliveries at East Cheshire NHS Trust by quarter.



SOURCE: HES - Deliveries (July 2016 - June 2017)

Is the service safe?

Mandatory training

Mandatory training completion

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

A practice development midwife monitored the training needs of the service. Training included face to face and e learning modules. The trust target was 75% compliance. If staff did not complete training, a reminder was sent to managers of midwifery and medical staff, to ensure they booked on the next available course and complete training by March 2018.

The training programme was multidisciplinary and included obstetricians, midwives, anaesthetists, maternity care assistants, health care assistants and student midwives.

At the time of the inspection the service showed 90% training compliance. The table below shows the training levels:

Title of Training Module	Staff Compliance Rate
Newborn Life Support	90%
Emergency drills shoulder dystocia (when the baby's shoulder is stuck after delivery of the head), cord prolapse (the umbilical cord is visible before the baby), and breech birth (when baby is bottom first instead of head),	90%
Emergency drill through simulation - haemorrhage (excessive bleeding) and eclampsia (disorder of pregnancy that can lead to fits),	90%
Blood transfusion	90%
Intermittent auscultation and CTG interpretation	90%
Antenatal and newborn screening	90%
Early warning scores to recognise the severely ill pregnant woman including sepsis	90%
Safeguarding children Level 3	90%
Practical fire evacuation	90%
Maternal resuscitation AED training and anaphylaxis	76% (trust reported that resuscitation officer off sick in November and December)
Newborn feeding	90%
Perineal trauma	90%
Prevent training	100 staff (started July 2017)
Infection control	90%
Mentorship for midwives / nurses	92%

Senior staff told us that topical subjects were highlighted for extra focus such as sepsis in 2017 This included training and simulations for all staff. There was a sepsis policy that was due for review in December 2017, although the date had been extended to March 2018.

Simulations were carried out for obstetric and neonatal emergencies to enhance training and monitor competencies.

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 told us that compliance with safeguarding level three training was 80% for midwives and 79% for medical staff as below.

	No of staff	Compliant	Not compliant	
Midwifery Bank	16	10	6	62.5%
Ante Natal Clinic	12	12	0	100.00%
Midwifery Teams and Ward	85	69	16	81.18%
Obs and Gynae Specialty	14	11	3	78.57%

Total Midwives	113	91	22	80.5%
Total Doctors	14	11	3	78.57%

The trust had safeguarding policies and procedures in place and there was a safeguarding midwife that could provide guidance and support to staff as well as facilitate training modules and provide safeguarding supervision. There was a vulnerable patient's midwife who worked closely with women identified as requiring extra support. There was no dedicated midwife for teenage pregnancy, although; if considered vulnerable then could be referred as needed.

Safeguarding training included female genital mutilation and child sex exploitation.
We observed updates of information for safeguarding including child sex exploitation displayed in staff offices.

Patient records were organised so that any woman with a concern was easily identified by staff. The safeguarding midwife and vulnerable patient's midwife worked closely with community teams. Records we reviewed included comprehensive evidence of multi-disciplinary input such as social workers and other health professionals.

We observed that when booking a woman for antenatal services, she was seen individually, prior to inviting the partner into the room, to check if the woman felt safe.

We were told that, any women, who booked in for maternity services who had identified a GP within the trust region, the staff could access records to identify any vulnerable circumstances such as safeguarding. For women, with a GP, outside the area the service was required to request access to GP records.

At the time of inspection, a draft copy of an abduction policy was provided that included processes to follow. There was previous version to view, although we observed that when an alarm sounded, during the inspection, staff responded promptly.

Cleanliness, infection control and hygiene The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.

All ward and obstetric theatre areas inspected were visibly clean and cleaning rotas were in place. Staff were observed adhering to 'arms bare below the elbows' guidance and washing hands prior to patient contact.

There were wall mounted hand washing solutions at clinical sinks with handwashing instructions. Some taps were operated by non-touch sensors. Hand gels and personal protective equipment such as gloves and aprons, were adequately stocked in all areas.

Monthly hand hygiene audits carried out between October 2017 and January 2018, showed 100% compliance for the antenatal clinic and ward areas.

Staff were aware of, and adhered to, current infection prevention and control guidance. We observed staff using hand washing techniques and personal protective equipment whilst delivering care.

Equipment included 'I am clean' stickers to identify when suitable to use.

Monthly environmental audits were carried out including flushing to help prevent legionella infections. Between October and December 2017, there was a compliance of 91% to 98% with actions clearly identified.

Monthly cleaning audits for the labour ward between November 2017 and January 2018 showed 98% compliance with areas to address highlighted.

Staff followed the correct dress code and gowning procedures in theatre areas. However, we observed that theatre footwear that would be shared with partners were not all clean. This was addressed on-site.

The privacy curtains in labour ward were all disposable and dated as changed in January 2018, however on the ante / postnatal ward, the curtains, in the bays, were cloth with no indication when last changed. If an infection risk was identified, we were told that curtains would then be changed.

All sharps bins seen were not over filled and used appropriately. We observed that all clinical waste was disposed of appropriately including pregnancy remains.

There were processes in place for women to receive vaccinations with midwives administering antenatally, if required.

In the 12 months prior to inspection, there were three readmissions identified as infections including puerperal sepsis.

Environment and equipment

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

The maternity unit included a labour ward with five individual rooms and a ward for both antenatal and postnatal women. The labour ward included a midwifery-led area (two rooms, one with a pool) and three other rooms for consultant-led cover (one with a pool). The rooms were interchangeable as each included a resuscitaire and other equipment if required. The neonatal unit was within the maternity unit and was close to the delivery area and ward for parents to visit.

The wards and theatres were well maintained, free from clutter and suitable for treating obstetric patients with a side room being utilised to store equipment when not in use.

Clocks in labour rooms were synchronised with theatres in order to record times accurately.

Completion of daily checks was monitored by the shift co-ordinator. These were recorded in the office and also in a file with more detailed checklists. These were all completed appropriately.

The theatre nominated for obstetrics was in the main theatre complex and opposite the maternity unit. Staff from the maternity unit were part of the obstetric theatre team with two staff members allocated either for 'scrub' duties' or to assist with the baby once delivered.

A bay with six beds was being used by medical services at the trust although there were sufficient beds for the number of obstetric patients. The women assessed as higher risk were cared for in the bay close to the midwives station; the lower risk women were cared for in a quieter area of the ward. One of the beds in the low risk bay was temporarily not in use due to a fault with the call bell; it was awaiting repair from the maintenance department.

Entry to the maternity unit was by a controlled access system in order to monitor staff, patients and visitors. Cameras showed individuals awaiting entry with an accompanying intercom system.

Following the last inspection, processes were in place to maintain equipment with stickers to indicate that equipment had been serviced, electrically tested or calibrated in the last 12 months. Equipment included three cardiotocography machines and an ultrasound machine available, as well as infusion pumps; all had evidence of a maintenance check.

Cardiotocography is a means of recording the fetal heartbeat and the uterine contractions during pregnancy. The machine used to perform the monitoring is called a cardiotocograph.

Records showed that staff carried out regular checks on key pieces of equipment, for example; resuscitation equipment had a daily check of items on top of the trolley with a more detailed check weekly when a coded tamper proof tag was broken. There was one resuscitation trolley that was accessed by the labour ward and the ante / postnatal ward in the event of an emergency.

There was also a trolley with other neonatal emergency items that was being stored in a secure clinical room close to the trolley. The ward were awaiting a panel for this trolley to ensure all items were secured with the intention of moving next to the main trolley once in place.

On the ante / postnatal ward piped oxygen and suction was not available at every bed, although portable oxygen and suction were available in the event of an emergency. Post – operative patients were cared for in beds where piped oxygen and suction was available. There was no piped oxygen or suction in the triage bay (five beds). It was available in all side rooms, four out of six beds in the acute bay and two out of six in the bay where low risk women were cared for.

Temperatures of clinical, environmental and milk fridges were monitored. However, the ranges were not recorded. The clinical fridge on the ante / post-natal ward was set at a maximum of 14 degrees which was not in line with trust policy of acceptable temperatures of between two and eight degrees Celsius. This was addressed on-site.

Following the last inspection, all the clinical rooms we inspected had secure entry, with key-pad access, for the storage of hazardous materials or equipment. We found that equipment and materials were generally stored appropriately. However, the sluice rooms were not locked and contained hazardous cleaning fluids. We addressed this on site and they were promptly removed.

In the hospital antenatal clinic, we observed a corridor that was accessed by key pad entrance at one end, however the other end was open where clinical notes were being stored.

The community antenatal clinic we visited was within a community hospital. There were some information posters displayed, however we observed some paint flaking off on the walls, there was no date when the cloth privacy curtains had last been changed and the wall-mounted lamp was

labelled as due testing in February 2017, although we did not see this used. We addressed this, on return to the hospital.

In the community hospital clinic we visited, resuscitation equipment was available from the outpatient department or urgent care area. At the time of inspection, urgent care was closed, however we were told that a process was in place in the event of an emergency.

If a homebirth was expected, the community midwife needed to collect equipment from the unit such as medicines and medical gases. At night, we were told that midwives would either pair together or equipment would be delivered from the unit. Midwives parked in areas that were well-lit

In the maternity unit, the labour ward included two pools. Following the last inspection, each of the two pools had a net in case of a need for emergency evacuation. If a pool was being during a homebirth, these were usually inflatable. In the event of an emergency, we were told that the pool would be popped to access the woman.

Monitoring equipment, such as blood pressure machines were positioned in designated areas. This meant it was easy to locate in the event of an emergency.

All babies had two identification bands and a 'tagging' alarm. This meant that an alarm would sound if a baby left the unit with a tag in place. We observed that when an alarm sounded, midwifery staff reacted quickly. We were told that hospital security service was alerted when an alarm sounded and also the accident and emergency department were also informed by the hospital switchboard staff. There was no abduction policy for the service. However, there was a policy being developed and a draft available. Identification and tags were monitored as part of midwifery checks of the baby.

Assessing and responding to patient risk

Risk assessments were carried out for women.

We observed the completion of paper risk assessments at the time of booking, to assess the level of risk for the woman during the pregnancy, such as previous history, risk of venous thromboembolism, any allergies, and personalised growth plan as part of 'gap and grow'. The service participated in the perinatal institutes growth assessment project (gap and grow) which monitored the growth of babies in utero, with particular attention to smaller babies.

The level of risk identified determined any needs for referral to an obstetrician. These risk assessments were repeated at time of admission.

From the maternity dashboard, 96% of women were booked by 12 weeks of the pregnancy. This meant that women could be monitored from an early stage in their pregnancy.

We were told that there was always one to one care in labour and delivery. Midwives used cardiotocography to monitor women. This included 'fresh eyes' where another midwife checks the monitoring for accuracy and supports the midwife providing the one to one care. This was carried out hourly as per the trust policy.

If an antenatal patient arrived in the accident and emergency (A & E) department at night, when other entrances were locked, they were directed or escorted to the maternity unit and the unit informed. There was also a call bell in A & E that was linked to the unit. This could be used to request immediate support from the midwifery team. Specific monitoring equipment was stored in the maternity unit: this could be taken to A & E if needed. Birth packs were stored in A & E in the event of an unplanned delivery.

Any woman that required induction of labour were cared and treated in the labour ward. This meant they could be monitored closely. In the event of a patient requiring more intensive care, an outreach team visited the unit to assess need for transferring to the high dependency unit that was close to the unit.

If a patient required greater support than what was available at this trust, senior staff told us that agreements were in place with other larger trusts, for example a triple pregnancy or insulin dependent diabetes.

During the inspection, elective caesarean section operations were planned. Immediately prior to the commencement of one of these operations we observed the anaesthetist confirming with the labour ward that there were no events to prevent the operation proceeding.

We observed an obstetric theatre team undertaking the World Health Organization maternity five steps to safety surgery checklist during a caesarean section operation. The checklist was applied appropriately by all the team involved with a very clear pause and excellent debrief at the end. An audit for the completion of the safer surgical checklist in January 2018 showed that out of a total of 568 maternity operations, during 2017, three checks were not completed with a compliance of 99%.

Staff used the modified early obstetric warning score system when monitoring women. MEOWS is a system to allow early recognition of physical deterioration by close monitoring of vital signs of women receiving maternity care.

An audit of MEOWS carried out in June 2017, showed that on admission, antenatally; there was 80% compliance of recording a triggered response. It also showed that there was an overall compliance of 95% in recording a full set of observations prior to transfer to the postnatal ward or prior to discharge home. An electronic system was being considered to monitor patients centrally.

In December 2017 an audit of the neonatal early warning score (NEWS) was carried out. NEWS is a system to allow early recognition of physical deterioration, in neonates, by close monitoring of vital signs. The audit found that there was 100% compliance of recording NEWS at two hours of age, however, only 71% had been completed within one hour of birth. An action plan was in place to address this.

An audit of the sepsis six bundle was completed in March 2017 to assess if it was being applied appropriately. The audit recommendations included adopting the UK sepsis trust maternal sepsis bundle. From the action plan, the service was awaiting a trust guideline in February 2018.

In the event of a patient requiring a blood transfusion, the blood bank was close by in the theatre complex.

We observed a booking of a woman for maternity services, in a community antenatal clinic, that included screening using a sample of blood. We observed the midwife take the sample, however, the identity of the woman had not been re-confirmed prior to the sampling. In addition, we observed a doctor, in the labour ward, hand writing a label on a blood sample bottle, in the labour ward office rather than at the patient bedside. We addressed this with senior managers whilst on inspection. They agreed that both instances did not follow nationally agreed protocols.

The tables below show the percentage of staff that had completed training in maternal resuscitation and newborn life support

Yearly Maternal Resuscitation Anaphylaxis and AED
Competency Assessment for Basic Life Support and AED included

December 2016	80%
March 2017	82%
August 2017	79%
December 2017	76%

Yearly Newborn Life Support

December 2016	80%
March 2017	90%
August 2017	84%
December 2017	90%

4 Yearly Newborn Life Support
Competency Assessment based on the NLS standards

December 2017	87%

Midwifery and nurse staffing

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

There were processes in place to ensure sufficient numbers of trained midwifery and support staff in ward areas and theatres, to provide safe care and treatment.

A noticeboard displayed the expected and actual numbers of midwifery and nursing staffing levels for the maternity unit. Staff were allocated to either the labour ward or antenatal and postnatal ward, by the unit co-ordinator depending on needs of the wards.

Safety huddles took place three or four times a day that included monitoring staffing requirements and by use of acuity tool. A staffing red flag system was also in place as per NICE guideline NG4. We observed handovers on the labour ward and the ante / postnatal ward. These took place in offices, when staff began a shift, and included clear concise information about women. Staff were allocated women from their team if possible.

The unit co-ordinator was supernumerary to the midwives allocated to women.

The midwives worked in teams of four of five with a team leader. These teams worked both in the hospital and in the community on a rotational basis. This meant that women saw the same team of midwives throughout their antenatal, delivery and postnatal periods for continuity of care as recommended by Better Births guidance. The team leader was the named midwife for the woman with the other team members supporting and also delivering care and treatment. We observed that it was not always possible for a midwife or the team leader from a women's own team to

deliver the care but staff were allocated to their team if possible.

There was an on-call system where two midwives could be requested to support the unit if necessary. During 2017, there were a total of 28 occasions when an on call midwife was required for the maternity unit and eight occasions to support a homebirth.

In the event of a second caesarean section, as an emergency, another team were required either in the main theatres or day case theatres close to the maternity unit. Midwifery staff operated an on-call system where two midwives for homebirths could be requested to work in the unit if required.

The triage area was staffed by the labour ward midwives. Women were advised, at booking and included in the patient information booklet, that if any concerns to contact the service dependent on how advanced the pregnancy was. For women less than 26 weeks pregnant, they were asked to contact their team midwife, if possible but could also contact the maternity unit or antenatal day unit. For women more than 26 weeks pregnant, they were asked to contact the maternity unit or antenatal day unit.

There was also a managers rota where each band seven worked a shift 12pm until 8pm to support staff early evening.

The service monitored staffing levels in safer staffing reports. From the board papers (November 2017) the August 2017 report included that there was a midwifery fill rate of 92% during the day although this was mitigated with use of bank midwives. For healthcare assistants the fill rate in the day was 84.4% and 62.9% at night, although the two on-call midwives for homebirths could be called to support the unit if required.

In September 2017, the safer staffing report was 94% for midwives and 91.6% for care assistants during the day. At night staffing was 96% for midwives and 90% for care assistants.

From September 2016 to August 2017, the trust reported a vacancy rate of 7.9% for maternity, this was worse than the trust target of 7.01%.

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

At the time of the inspection, there were no vacancies.

From September 2016 to August 2017, the trust reported a turnover rate of 2.2% for maternity, this was better than the trust target of 15.60%.

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

From September 2016 to August 2017, the trust reported a sickness rate of 5.6% for maternity, this was worse than the trust target of 4.63%.

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

Any shortfalls in staffing were supplemented by the midwifery bank; these were staff that regularly worked in the unit.

Between October and December 2017, trust data showed that a total of 178 shifts, both day and night, were covered by bank midwifery staff.

Midwife to birth ratio

As of June 2017, the trust had a ratio of one midwife to every 26.3 mothers. This is similar to the national average.

(Source: Electronic Staff Records – EST Data Warehouse)

From the trust dashboard, the average ratio of midwife to birth was one to 28, although in September the ratio was one to thirty three.

Medical staffing

From September 2016 to August 2017, the trust reported a vacancy rate of 21.5% for maternity, this was worse than the trust target of 7.01%.

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

From September 2016 to August 2016, the trust reported a turnover rate of 12.7% for maternity, this was better than the trust target of 15.60%.

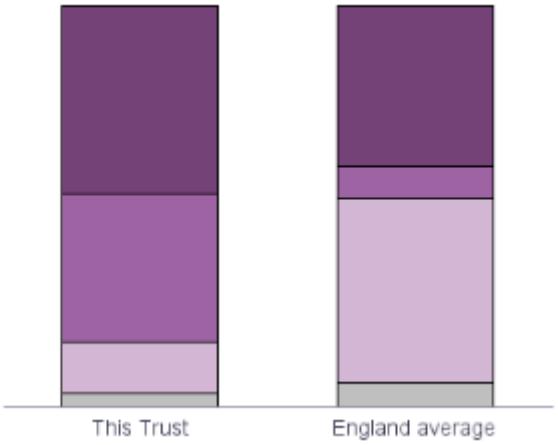
(Source: Routine Provider Information Return (RPIR) P18 Turnover)

From September 2016 to August 2017, the trust reported a sickness rate of 0.6% for maternity, this was better than the trust target of 4.63%.

Between October and December 2017, trust data showed that there were 48 shifts covered by locum doctors for the maternity service.

In August 2017, the proportion of consultant staff reported to be working at the trust was higher than the England average and the proportion of junior (foundation year 1-2) staff was about the same as the England average.

Staffing skill mix for the 28.4 whole time equivalent staff working in Urgent and Emergency Care at East Cheshire NHS Trust.



	This Trust	England average
Consultant	47%	40%
Middle career^	37%	8%
Registrar group~	13%	46%
Junior*	4%	6%

^ 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)

Doctors we spoke with felt there were sufficient numbers of obstetric medical staff for the demands of the service with seven consultant obstetricians employed for the service. There were greater numbers of staff grade doctors to compensate for other vacancies.

From the maternity dashboard, there was on average 46.3 hours consultant cover on the labour ward which was consistently above the target of 40 hours.

There was an anaesthetist on call, who also supported critical care, in case of an emergency although there was a second on-call anaesthetist available if needed.

We observed a medical handover. Doctors of all grades attended and we found it to be well-structured, clear and comprehensive. All patients were reviewed thoroughly and appropriately.

Out of hours there were processes in place for consultant and anaesthetic cover. Consultant cover was by 'hot weeks' and on-call.

Records

Staff kept appropriate records of patients' care and treatment. Records were generally clear, up-to-date and available to all staff providing care.

Midwifery care records were a combination of electronic and paper records. Medical staff recorded care in paper clinical records.

Patient's clinical records were stored securely in offices accessed by authorised staff. We looked at the care records for 10 patients; theses were structured, legible, and up to date, however, not all forms were signed.

Boards with patient details were located in staff offices that were secured with keypad entry. These also identified any vulnerable patients by a discreet key system.

Risk assessments were completed for patients as part of their maternity bundle of care.

Patient records showed that assessments were carried out before, during and post-delivery and that these were documented appropriately.

Standardised documentation was kept at the end of patients beds. Observations were well recorded and the observation times were dependent on the level of care needed by the patient.

In the community, staff accessed electronic systems using tablet devices that were encrypted.

We observed that paper communication books, for each team, were stored in the maternity unit, to record any relevant information. We were told that this was transferring to an electronic system.

The discharge process included an electronic checklist to ensure that all checks were completed prior to the woman leaving the unit. Copies of paperwork were forwarded to G.P's and health visitors as well as for the parents and midwives. Red books were given to parents to record the babies' health and development.

We observed that the computer screen could be viewed from the corridor. We addressed this on-site and the blinds were positioned appropriately to protect the information.

Medicines

Staff prescribed, gave, recorded and stored medicines well. Patients received the right medication at the right dose at the right time.

Medicines, including intravenous fluids, were appropriately stored and access was restricted to authorised staff. Controlled drugs were managed appropriately and accurate records were maintained.

Paper prescription records were in place, which included details of any allergies. Patients had individual medicine cabinets at the bedside (prescription only medicines.) that staff accessed by keypads. This meant that patients requiring analgesia were responded to promptly when requested.

Medicines reconciliation was completed in a timely way by a regular member of the pharmacy team.

Following the last inspection, medical gases were now stored in a secure room with trolleys for transportation. If gases were required for a home delivery, staff had brackets to secure cylinders safely in vehicles with stickers to alert other road users.

Discharge medications were manged well, including midwifery led discharge with medication in the prescription only medicine boxes labelled appropriately for discharge.

Following a homebirth, we were told that any medication was either destroyed or removed by the midwife attending.

Incidents

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 November 2016 to October 2017, the trust reported no incidents which were classified as never events for maternity.

(Source: Strategic Executive Information System (STEIS))

In accordance with the Serious Incident Framework 2015, the trust reported one serious incident in maternity which met the reporting criteria set by NHS England from November 2016 to October 2017, a maternity incident involving a baby only.

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.

Between October 2016 and October 2017, there were a total of 173 incidents reported for the maternity service. Of these, there was one stillbirth, one incident of domestic abuse and 12 incidents classified as moderate harm. The majority of incidents were classified as either no harm or low harm.

The service investigated incidents using a root cause analysis approach. We reviewed examples of investigation reports; these included any lessons learned and action plans. External reviewers were also requested for serious incidents to provide an independent opinion.

Following an investigation of a stillbirth in November 2016, lessons learned were identified and an action plan produced. The service had identified an increase in the number of stillbirths. An internal review of each case was carried out. This was presented to the Trust Board. There were no trends identified other than the lessons learned. However, the investigation, following a stillbirth in September 2017 appeared to have identified similar issues to the incident in November 2016. This meant we were not assured that all learning had been disseminated to all staff.

Staff we spoke with understood the term duty of candour. (The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person). Root cause analysis investigation reports showed that families were involved in the process at each stage.

Senior managers told us that they invited patients to the unit to discuss any incidents face to face. We were also told that all births between 22 and 24 weeks, who did not survive were reported to Mothers and Babies Reducing Risks Through Audits and Confidential Enquiries UK.

Mortality was discussed monthly at the audit meetings and quarterly at perinatal morbidity and mortality meetings. These were attended by midwives and doctors (obstetricians and paediatricians). Cases were presented with any lessons learned or actions included.

Safety thermometer

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

The safety thermometer is used to record the prevalence of patient harms and to provide 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 is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

In the antenatal clinic and the maternity unit, safety information was displayed monthly in a poster. This included information about time since the last serious infection identified, perineal trauma (tears), severe haemorrhage following birth, as well as patient feedback results from the NHS Friends and Family Test.

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness.

This included guidance from the National Institute for Health and Care Excellence (NICE), Royal College of Obstetricians and Gynaecologists (RCOG) and MBBRACE-UK.

A guideline group monitored any updates and met monthly to discuss current guidelines that needed updating and were allocated to appropriate staff to complete then feed back to the group. The group included the head of midwifery, practice development midwife, an obstetrician, a paediatrician, neonatal practitioner, antenatal manager, governance manager, service manager.

The service participated in the perinatal institutes growth assessment project (gap and grow) which monitored the growth of babies in utero, with particular attention to smaller babies.

An audit of 'gap and grow' was carried out in May 2017 and repeated in July 2017. Results showed, in the later audit, that there was compliance of 90% of plotting the charts correctly compared to only 37% in the previous audit. Action plans were put in place and were all completed at time of inspection.

Nutrition and hydration

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

We observed staff manage the nutrition and hydration needs of patients well antenatally, during labour and postnatally.

Women we spoke with told us that they enjoyed the food provided. The unit had a trolley where hot drinks and snacks were available.

The service participated in the baby friendly initiative set up by UNICEF and the World Health Organisation. The initiative recommends exclusive breastfeeding up to six months of age, with continued breastfeeding along with appropriate complementary foods up to two years of age or beyond. The service had achieved baby friendly status level three in 2014; and was now waiting re accreditation.

Breast pumps were available for women to express milk and stored in a locked milk fridge (in a key pad entry milk kitchen) that was shared with the neonatal unit. There was a dedicated breast feeding room located in the antenatal clinic for visiting women to the hospital.

Initiation of feeding was monitored on the maternity dashboard to show that 76% of women were breast feeding from birth. This number reduced in the community to 54% when care was handed over to health visitors.

A breast feeding charity attended the ward to support women and midwives.

Pain relief

Staff recorded pain scores and managed pain well.

Pain scores were recorded as part of the Modified Early Obstetric Warning Score. We observed midwifery staff checking the comfort levels of patients and saw analgesia administered as needed.

Alternative forms of pain-relief were available including use of the pools and yoga for relaxation.

All patients we spoke with told us that staff gave them pain relief medication when needed. Staff told us that following a termination of pregnancy, a patient would be assessed and offered analgesia as necessary.

Epidural waits were monitored on the maternity dashboard. Between January and December 2017, there was one patient that had waited which was below the trust target of four in a year.

Patient outcomes

The service monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them. They were active members of the regional strategic network where best practice was shared.

The service completed a maternity dashboard that recorded a number of outcomes. For third or fourth degree tears, between January and December 207, the average number of all deliveries was 2.2% which was blow the trust target of 5.4%.

For the same time period, there were six episodes of post-partum haemorrhages of more than 2000mls. The trust target of one per month was exceeded in October 2017 with three episodes, however, below the trust target of 12 per year.

Between January and December 2017, there were a total of 78 term babies transferred to the neonatal unit. These ranged from three to eleven per month. For the same time period, there were four women admitted to the critical care unit. The trust target was no more than one a month.

Obstetricians and midwives completed annual internal audits to monitor the service. These included an audit of records following fetal blood sampling in February 2017. High quality documentation was found with one area of improvement that had been actioned and completed.

An antenatal care audit of records was carried out in May 2017. There were areas identified that were not compliant with NICE CG62 (antenatal care for uncomplicated pregnancies). All areas identified for improvement had been completed at the time of inspection.

An audit regarding access of antenatal screening processes for women who may be disadvantaged such as women under 19 years old and women whose first language was not English showed that improvements were required for information to be given in an appropriate language. The action plan was currently on-going.

In May 2017 an audit of amniocentesis competencies was carried out. It was found that numbers had reduced and were below the 30 procedures recommended by the Royal College of Obstetricians and Gynaecologists. The action plan included continued monitoring of practitioner / procedure ratios with a yearly audit.

In July 2017, following an increase in the number of caesarean sections performed, an audit was carried out. It was found that 32 out of 34 cases were carried out appropriately; an action plan was in place to address improvements.

In November 2017, following an increase in the numbers of induction of labour, an audit was carried out. It was found that this increase was since the introduction of growth assessment protocols. The action plan included multidisciplinary work with sonographers to carry out audits to ensure only performed if clinically needed and also carry out quality assurance checks of growth scans.

An audit of appropriate use of the pool during labour and delivery, in September 2017, showed that there was 100% compliance with the services guideline.

National Neonatal Audit Programme

In the 2016 National Neonatal Audit East Cheshire NHS performance was as follows:

Question: Do all babies of less than 32 weeks gestation have their temperature taken within an hour of birth?

Answer: No. For 2,723 babies out of 2,807 born the temperature was taken within an hour of birth. This is a performance of 97%.

Question: Are all mothers who deliver babies from 24 to 34 weeks gestation inclusive given any dose of antenatal steroids?

Answer: No. 6,803 out of 7,813 eligible mothers were given antenatal steroids. This is a percentage of 87%.

Question: What proportion of babies < 33 weeks gestation at birth were receiving any of their own mother's milk at discharge to home from a neonatal unit?

Answer: 29%

(Source: National Neonatal Audit Programme, Royal College of Physicians and Child Health)

Standardised Caesarean section rates and modes of delivery

From July 2016 to June 2017 the total number of caesarean sections of all types was similar to expected.

Standardised caesarean section rates					
Type of caesarean	England	East Cheshire NHS Trust			
	Caesarean rate	Caesareans (n)	Caesarean rate	Standardised Ratio	RAG
Elective caesareans	12.1%	220	13.8%	108.5 (z=0.6)	Similar to expected
Emergency caesareans	15.4%	237	14.8%	95.2 (z=-0.4)	Similar to expected
Total caesareans	27.5%	457	28.6%	101.2 (z=0.1)	Similar to expected

Note: Standardisation is carried out to adjust for the age profile of women delivering at the trust and for the proportion of privately funded deliveries.

Source: Hospital Episode Statistics July 2016 to June 2017

Note: Delivery methods are derived from the primary procedure code within a delivery episode.

In relation to other modes of delivery from July 2016 to June 2017, the table below shows the proportions of deliveries recorded by method in comparison to the England average:

Proportions of deliveries by recorded delivery method			
Delivery method	East Cheshire NHS Trust		England
	Deliveries (n)	Deliveries (%)	Deliveries (%)
Total caesarean sections[1]	457	28.6%	27.5%
Instrumental deliveries[2]	218	13.7%	12.5%
Non-interventional deliveries[3]	919	57.5%	59.7%
Other/unrecorded method of delivery	3	0.2%	0.3%
Total deliveries	1,597	100%	100% (n=608,950)

[1]Includes elective and emergency caesareans
[2]Includes forceps and ventouse (vacuum) deliveries
[3]Includes breech and normal (non assisted) deliveries

The total of caesarean sections was above the average for England. The figure of instrumental deliveries was above the average for England. The figure of non-interventional deliveries was below the average for England.

Maternity delivery methods and Caesarean sections for November 2017

The service averaged about three homebirths per month; with a target of four or more.
Maternity active outlier alerts

As of November 2017 the trust reported two active maternity outliers. One is a case of septicaemia and is due to be followed-up. The other is a case of skin and subcutaneous tissue infections and is active.

When this was discussed on inspection with the senior management team, they explained that there was no longer an issue and they considered them closed.

(Source: Hospital Evidence Statistics (HES) – provided by CQC Outliers team)

Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE Audit)

The trust took part in the 2017 MBRRACE audit and their stabilised and risk-adjusted extended perinatal mortality rate (per 1,000 births) was 3.3. This is similar to the national average. The rate was 4.1 the previous year.

(Source: MBRRACE UK)

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and provided support.

From April 2016 to March 2017, 94.8% of staff within maternity at the trust had received an appraisal compared to a trust target of 90%.

A split by staff group can be seen in the table below:

Staff Group	Number of staff receiving an appraisal 2016/17	Number of staff requiring an appraisal 2016/17	Appraisal completion rate	Met Target (Yes/No)
Additional Clinical Services	18	20	90.0%	Yes
Administrative and Clerical	7	8	87.5%	No
Nursing and Midwifery	67	69	97.1%	Yes
Total	92	97	94.8%	Yes

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

From the trust board papers, in September 2017, the compliance rate was 93.6%.

Maternity staff completed 'skills and drills' training that included management of homebirth emergencies.

Midwives, including preceptorship staff, completed competency training in subjects that included perineal suturing, medical devices training, cannulation and administration of medical gases.

Skills and drills training between September and December 2017 focussed on evacuation from the pool using the net with correct position of the delivery bed for transfer and also shoulder dystocia including the importance of the Royal College of Obstetricians and Gynaecologists (RCOG) reporting form.

For examination of the newborn, the trust told us that 13 midwives were fully trained and two were in training.

Midwives who supported in theatres completed competencies every three years. Compliance, at the time of inspection was 84%.

Maternity support workers completed competencies that were reviewed annually to support theatre staff during a caesarean section.

We observed that the trust website referred to supervisors of midwives. We addressed this on-site and promptly this was changed and replaced with Professional Midwifery Advocate (PMAs) who currently support midwives.

Multidisciplinary working

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

There was effective internal multidisciplinary team working that included pharmacists, sonographers, maintenance staff and housekeeping as well as doctors, midwives and support workers.

Mental health support was available from a neighbouring trust that was based in the grounds of the hospital. There were also plans to employ a perinatal mental health midwife for the maternity service.

There was effective external team working. Specialist midwives liaised with social workers and family nurse partnership colleagues when necessary.

Records reviewed showed that information was shared with G.P's, and health visitors as well as midwives in the community.

Seven-day services

Maternity services were available seven days a week. Medical and anaesthetic cover was provided outside of normal working hours and midwifery staff told us that they felt well supported during these periods.

Laboratory, imaging and pharmacy, were available if needed following an on-call system at weekends.

Health promotion

We observed booking appointments where advice about health was offered. Midwives discussed areas such as supplementing diet with vitamins, alcohol in pregnancy and smoking. Smoking cessation support was available if required. Testing for carbon monoxide levels were included in the booking process.

In addition the service had a 'get fit for birth' programme. This was for women identified with a body mass index of greater than 30 or 35. Depending on the assessment, women were offered support including aqua natal classes, continuity and specialist advice including a consultant anaesthetist appointment.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff understood their roles and responsibilities under the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

The Mental Capacity Act and Deprivation of Liberty safeguards was included in safeguarding training.

If patients lacked capacity to make their own decisions staff made decisions about care and treatment in the best interests of women and involved their representatives and other healthcare professionals appropriately.

We observed staff obtaining verbal consent from women prior to providing care and treatment.

Written consent prior to surgery was obtained in a comprehensive and detailed form.

Staff we spoke with understood their responsibilities in consent from younger women with regards to Gillick and Fraser competence. (Gillick competence is a term originating in England and is used in medical law to decide whether a child (under 16 years of age) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge. The 'Fraser guidelines' specifically relate only to contraception and sexual health.

There was a trust interpreter and translation service to assist with consent for patients whose first language was not English.

Staff received training as part of safeguarding. Staff had the knowledge and awareness of the Mental Capacity Act and Deprivation of Liberty safeguards.

Is the service caring?

Compassionate care

Staff cared for women with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

Women described care as excellent from staff. This included both midwifery and medical staff.

All staff introduced themselves and communicated well to ensure women fully understood.

Women were encouraged to ask questions and were given time to ensure they understood what was being said to them.

Staff involved women and those close to them in decisions about their care and treatment.

Women were encouraged to provide feedback, about the service. Feedback boxes were available on the wards.

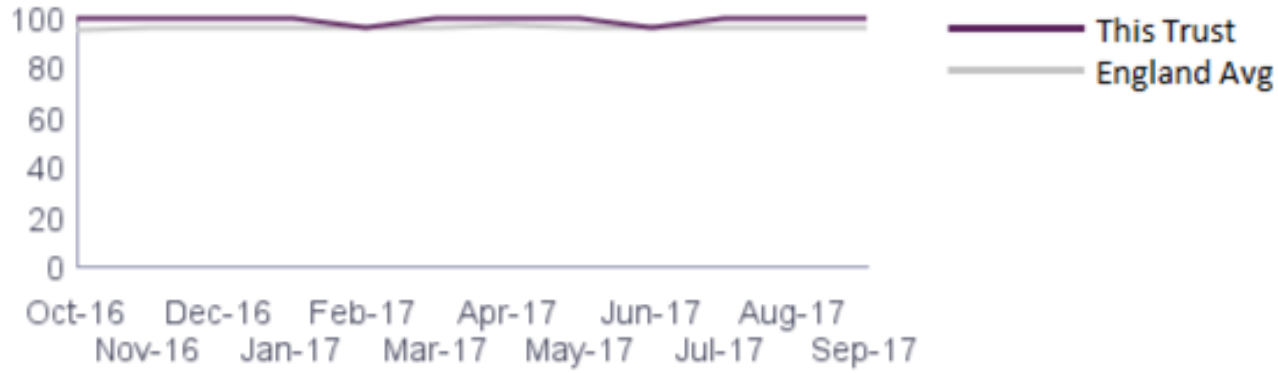
We observed staff interacting positively with women and those close to them. Staff spoke to women sensitively and appropriately depending on individual need.

In theatre we observed staff protecting patient dignity during a caesarean section.

We observed that, in the bereavement room, the glass was clear and it was possible to look into the room. This was addressed on-site and a coating was applied to the glass that made it opaque.

Friends and Family test performance

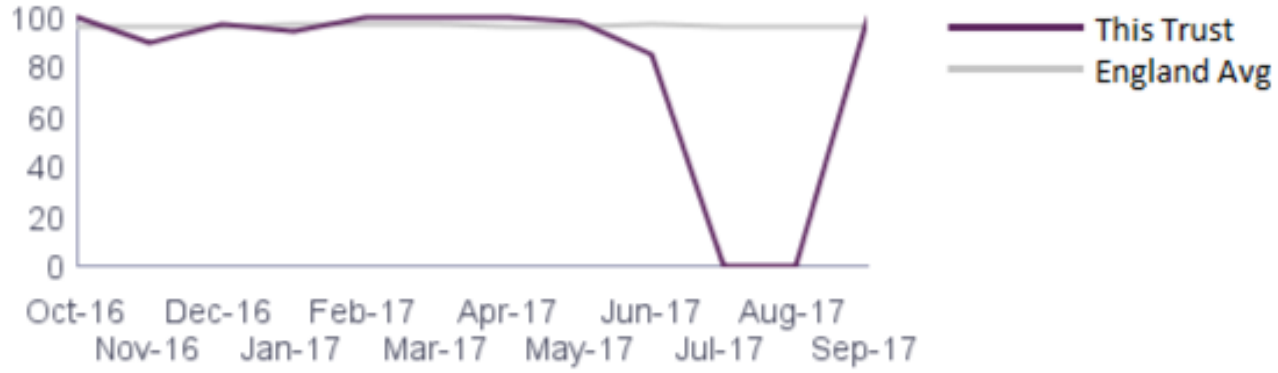
Friends and family test performance (antenatal), East Cheshire NHS Trust



From October 2016 to September 2017 the trust's maternity Friends and Family Test (antenatal) performance (% recommended) was generally similar to the England average.

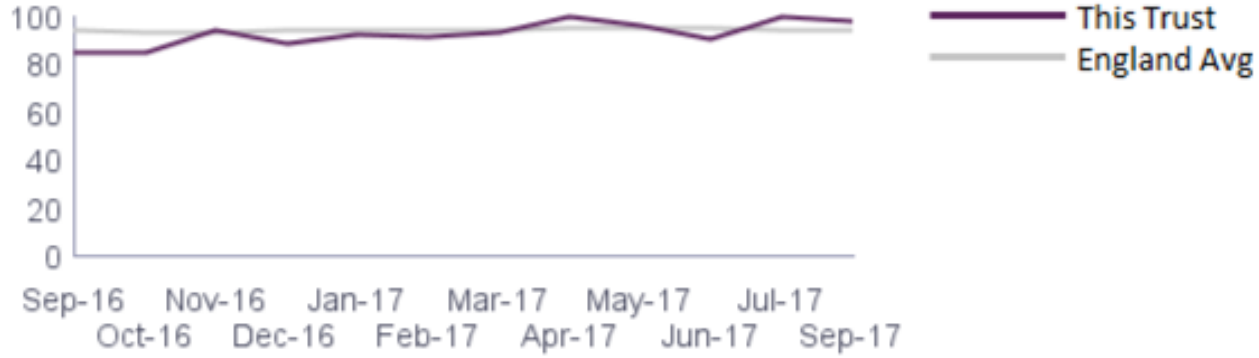
The trust's performance in this area remained within 95% and 100% throughout the year.

Friends and family test performance (birth), East Cheshire NHS Trust



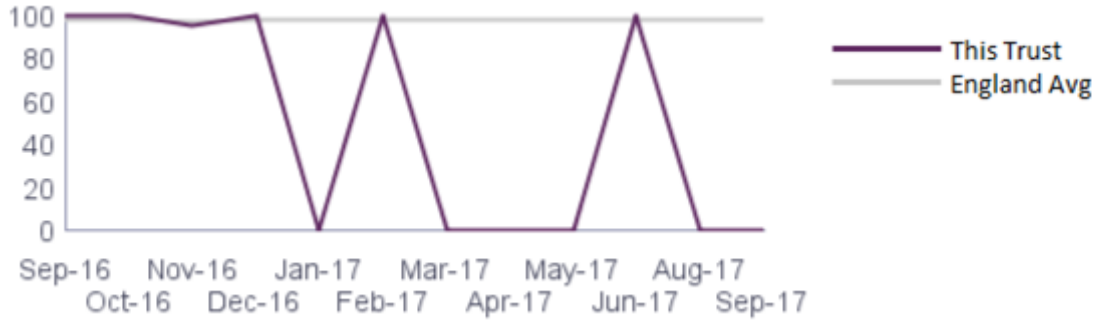
From September 2016 to September 2017 the trust's maternity Friends and Family Test (postnatal community) performance (% recommended) was generally similar to the England average. In July and August 2017 no information was provided. For these months the graph reads 0%.

Friends and family test performance (postnatal ward), East Cheshire NHS Trust



From September 2016 to September 2017 the trust's maternity Friends and Family Test (postnatal ward) performance (% recommended) was generally similar to the England average.

Friends and family test performance (postnatal community), East Cheshire NHS Trust



From September 2016 to September 2017 the trust's maternity Friends and Family Test (postnatal community) performance (% recommended) was generally similar to the England average.

For a number of months no information was provided. For these months the graph reads 0%.

(Source: NHS England Friends and Family Test)

CQC maternity survey 2017

The trust was among the best preforming trusts for seven out of 15 applicable questions in the CQC maternity survey 2017.

Area	Question	RAG	Score
Labour and birth	At the very start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?	About the same	9.16
	During your labour, were you able to move around and choose the position that made you most comfortable?	Best performing trusts	9.12
	If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?	Best performing trusts	10.00
	Did you have skin to skin contact (baby naked, directly on your chest or tummy) with your baby shortly after the birth?	About the same	9.62
Staff during labour and birth	Did the staff treating and examining you introduce themselves?	About the same	9.35
	Were you and/or your partner or a companion left alone by midwives or doctors at a time when it worried you?	About the same	8.37
	If you raised a concern during labour and birth, did you feel that it was taken seriously?	About the same	8.99
	Thinking about your care during labour and birth, were you spoken to in a way you could understand?	About the same	9.66
	Thinking about your care during labour and birth, were you involved enough in decisions about your care?	Best performing trusts	9.16
	Thinking about your care during labour and birth, were you treated with respect and dignity?	About the same	9.63
	Did you have confidence and trust in the staff caring for you during your labour and birth?	Best performing trusts	9.42
Care in hospital after the birth	Looking back, do you feel that the length of your stay in hospital after the birth was appropriate?	Best performing trusts	8.60
	Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed?	Best performing trusts	8.67
	Thinking about your stay in hospital, how clean was the hospital room or ward you were in?	Best performing trusts	9.49
	Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding?	About the same	9.09

(Source: CQC Maternity Survey 2017)

Emotional support

Staff provided emotional support to patients to minimise their distress.

We observed staff providing reassurance and comfort to women. Staff provided support as required.

During booking appointments we observed a midwife discussing mental health needs with advice of seeking support if needed. There were no counsellors in the unit, however, two of the midwives offered a listening service to support women and those close to them such as in the event of bereavement; where midwives could support families for up to 28 days if requested. The service was also planning to recruit a perinatal mental health midwife to support women if needed.

Staff shared an example of a woman diagnosed with a mental health condition and being treated in a mental health ward, for the neighbouring trust, in the grounds of the hospital. The woman needed to attend the maternity unit for care. There was a multidisciplinary approach to the care, including facilitation by the safeguarding lead with an agreed plan resulting in a positive experience for the woman.

Understanding and involvement of patients and those close to them

Staff involved women and those close to them in decisions about their care and treatment.

We observed staff interacting positively with women and those close to them. Staff spoke to families sensitively and appropriately, dependent on individual need. Staff respected women's choices and delivered their care with an individualised person – centred approach. Women's care records were individualised to take into account their personal wishes.

Women and those close to them told us that they received information in a manner that they understood. Family members were encouraged to attend with women.

Is the service responsive?

Service delivery to meet the needs of local people

The service planned and provided services in a way that met the needs of local women.

Some women chose to attend antenatal clinics and have post-natal care in one area and plan for delivery in a different hospital or vice versa.

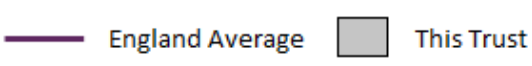
Women could be seen in ante-natal clinics close to their homes rather than visiting the hospital each time.

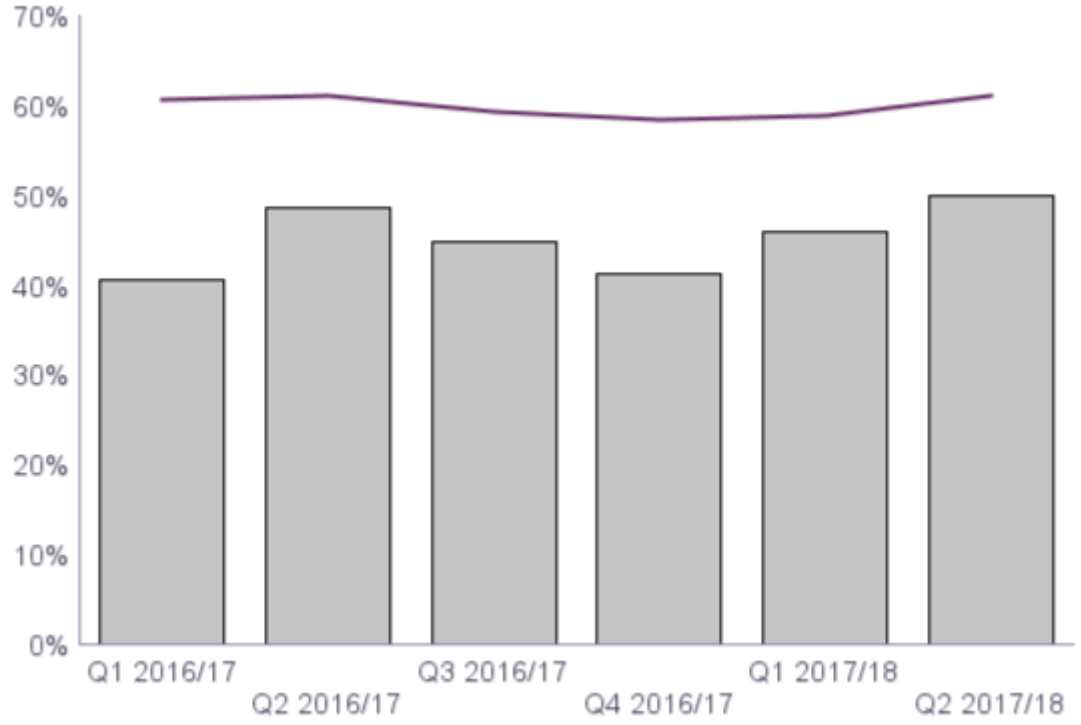
For this trust, there was a core of staff that were employed in the antenatal clinic and on the wards. The maternity service was also planned in teams of four or five midwives that worked rotationally in the hospital and community area in order to provide continuity for the women as well as the clinics being situated in their local area.

Women who were diagnosed with diabetes in pregnancy or who required insulin injections to regulate blood sugars in pregnancy could not currently be accommodated by the service. There was currently no diabetes specialist midwife at the trust, although, a midwife had been identified and was commencing training.

From Q1 to September 2017 the bed occupancy levels for maternity were generally lower than the England average by approximately 10% to 20%.

The chart below shows the occupancy levels compared to the England average over the period.





(Source: NHS England)

Meeting people's individual needs

The service took account of patients' individual needs.

There were good systems to meet the needs of women whose circumstances made them vulnerable.

Women identified as vulnerable were assigned to the vulnerable patients midwife for extra support. There were other specialist midwives in the unit including risk, safeguarding and practice development.

A dedicated maternity care assistant was allocated as a 'single point of contact' (implemented June 2016) for pregnant women between 9.30am and 2.30pm. This took calls from women and could book antenatal and scan appointments and provide phone support.

There was a day case unit and early pregnancy assessment unit attached to the antenatal clinic, at the hospital for women up to 14 weeks pregnant. There was a triage unit attached to labour ward for more advanced pregnancies.

In the antenatal clinic there were two scan rooms that were separated. This meant that, in the event of bad news there was a private area.

The service had designated consultants to support women in pregnancy, such as a cardiologist and a gastroenterologist.

All women undergoing an induction of labour were cared for in the labour ward rather than in busy postnatal areas.

Bariatric equipment was available if needed such as larger blood pressure cuffs.

Parent craft sessions included evening sessions to allow office-hour workers to attend.

Staff aimed to position women sensitively in the unit. Side rooms were offered to patients for a variety of reasons including multiple births, a learning disability, mental health need or if the baby was being nursed in the neonatal unit.

On entry to the unit, signage requested that any person visiting the unit who had a hearing impairment, should press the buzzer three times.

For women who had attended for termination of a pregnancy due to fetal anomalies, there was a bereavement room located away from the main unit. The en-suite room included a reclining chair for the partner although the bed was a hospital bed, the room looked bare and there was no signage to indicate if a woman was in the room. We were told that following a termination of pregnancy a post mortem was offered to the family and that they were offered choices about the pregnancy remains.

There were memory boxes available as well as donated clothing. A photography charity could take photos, hand and foot prints could be taken and a bereavement charity provided leaflets as appropriate. There was a 'cuddle cot' available. This meant that families could stay together as long as required. There was a trust chaplaincy service available if requested.

A remembrance service was held annually in 'loss week' for any parents that wished to attend in the town Parish church. There was a trust chapel that could be accessed if required.

The community antenatal clinic we visited did not include any signage to indicate whether the room was in use or not.

Posters in the hospital antenatal clinic displayed details of how to contact the trusts interpreter and translation service to provide face to face and telephone interpreting. There was also information for women with a visual impairment.

All areas were accessible for women with reduced mobility needs including walk-in showers in ward areas.

In April 2017, a birth choice clinic was set up for women who may have had a traumatic birth, such as an admission to critical care.

There were patient information leaflets available in the clinics and ward areas, although these were in English only, such as advice on healthy eating and vitamin supplements in pregnancy. For patients whose first language was not English, leaflets could be requested. We were given an example of a patient, who was identified with a learning disability; a bespoke booklet was made that included photographs and was in an easy –read format.

For caesarean sections, partners were encouraged to stay with the patient except during the time in recovery in theatre. The theatre recovery was shared with other surgery at the trust and therefore partners were required to leave. We observed a caesarean section where the partner was required to wait approximately 30 minutes before he was reunited with the woman. This is not in line with the National Service Framework and Maternity Matters.

The midwifery-led area looked similar to other consultant – led labour rooms with monitoring equipment in all areas.

In the antenatal clinic, there was a dedicated area for other children of pregnant women to play, however, there were no toys available. We were told that this was due to infection control risks.

Access and flow

Women could access the service when they needed it. There had been no episodes when the unit needed to close in 2017.

Between January and December 2017, the trust told us that there were a total of 49 readmissions to the maternity unit within 30 days of a previous admission. The most common reason was for hyperemesis (excessive vomiting in pregnancy and then a delivery episode as the next most common cause)

For the same time period, there were 60 episodes of delayed induction of labour, although the trust reported that these were reviewed and reported four hourly meaning that more than one episode may relate to the same woman.

Antenatal appointments were available at multiple locations dependent on the choice of the woman.

Learning from complaints and concerns

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

Information about complaints procedures was available in the unit; there were leaflets about the patient advice and liaison service (PALS).

From 1 August 2016 to 31 July 2017 there were two complaints about maternity. Both complaints were responded to within 45 days, which was in accordance with the trust's internal policy.

(Source: Provider Information Return P55)

Senior managers told us that they invited patients with a complaint to the unit to discuss face to face. The trust told us that in the three months prior to inspection, there had been two complaints.

Is the service well-led?

Leadership

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

There were clearly defined and visible leadership roles across the maternity service. The senior management team included the clinical director and the head of midwifery. Maternity services were part of planned care services at the trust with an operations manager overseeing both maternity and surgical services.

The head of midwifery was supported by a dedicated maternity matron and team of ward and clinic managers that were all very visible, accessible and approachable in the maternity unit.

Medical and midwifery staff understood reporting structures and told us they were well supported by their managers.

Vision and strategy

Senior managers told us that they followed trust values and also worked within the Neonatal Strategic Networks for the region that were available to support women to make safe informed choices throughout the pregnancy, birth and in the postnatal period.

We were provided with the trust's five year vision for the service that included a national maternity review and better births action plan. This included recommendations and actions with clear timescales for completion.

Senior managers told us that there were no non – executive directors dedicated to maternity services although the trust director of nursing supported the service.

Culture

Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

There was an open and transparent culture that encouraged reporting of incidents in order to learn from them and improve quality for people in the local community.

There was a positive attitude and culture where staff valued each other. Staff reported good team working and a sense of pride providing continuity of care using the team approach.

All staff were passionate about the service they provided.

The length of service of staff we spoke with varied, but all staff demonstrated a strong commitment to the hospital.

Some staff we spoke with told us that they travelled considerable distances so that they could work in this service.

Midwives worked rotationally in the hospital unit and also in the community. There was no lone working policy, however, there was a draft. Midwives were in contact with their team leaders to check that they were safe if in the community. We were told that the unit were considering purchasing personal pocket alarms for staff.

Governance

A clinical governance process was in place within the maternity service that allowed risks to be escalated to divisional and trust board level.

The women's and children's senior management team meetings were held monthly. These were attended by midwifery managers, specialist midwives, team leaders, neonatal managers and human resources. Areas discussed included training, staffing, environment and expected visits from external stakeholders.

A risk midwife had responsibilities for monitoring governance arrangements including facilitating or reporting incident investigations as well as maintaining the risk register for the service and co-ordinating the audit programme.

Clinical governance committee meetings took place monthly and the risk management sub-group took place bi-monthly.

The service collected data to monitor and improve performance. Maternity dashboards captured compliance with a number of indicators.

Management of risk, issues and performance

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

There was a maternity risk register that identified risks across the service that was reviewed monthly by the maternity and women's service clinical governance committee. These were attended by managers, specialist midwives, allied health professionals and medical staff (senior obstetricians / anaesthetists). The standardised agenda reported on items such as the risk register, incidents, complaints, friends and family results, guidelines, dashboards, staffing and training. We reviewed the risk register that showed that risks had been appropriately identified with controls in place to mitigate risks.

Senior managers told us that risks were discussed in the trust safety quality and standards committee meetings and other issues were discussed with the trust senior management team. The maternity senior managers were in regular contact with the trust senior managers.

There was a trust-wide major incident plan and staff were in regular contact with managers regarding locations and any need to change plans due to unforeseen circumstances.

Information management

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

Paper records for patients were securely stored in locked offices. Community staff recorded information in encrypted electronic tablets.

Engagement

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

In July 2016, midwives attended a local carnival and attended the annual Birth Bump & Baby open day to promote midwifery services.

Staff could choose either to work long – days or shorter shifts.

The practice development midwife liaised with schools of nursing regarding student midwives allocated to the trust. We were told the trust had received excellent feedback from the Nursing and Midwifery Council, in November 2017, about student placements.

At the time of inspection, newly qualified staff had been recruited. These midwives were shadowing more experienced midwives with induction plans and mentor plans in place. Although they had not trained there, other colleagues had recommended the unit to them.

Staff attended meetings including monthly maternity forums with attendees including doctors and midwives representing all grades and areas. Standardised agenda items included updates on any issues, incidents, complaints, friends and family results, staffing and dashboard.

The midwives attended meetings for their own geographical teams bimonthly with a standard agenda. Items discussed included feedback from the maternity senior management team, training, sickness and other relevant updates.

The service produced a monthly maternity newsletter that was disseminated to all staff.

The unit had improved the staff room facilities for break times as part of the Royal College of Midwives ‘caring for you’ programme.

The housekeeper, for the unit, had recently received an award; this was presented on the unit by the trust chief executive. We were told that senior managers carried out walk-arounds quite regularly.

Computer screensavers included updates for staff and trust-wide newsletters were available to view.

The service participated in the NHS Friends and Family Test and information about how women and those close to them could provide feedback when displayed in the unit.

We observed that the trust website included information and minutes of meetings from 2014 for the Maternity Services Liaison Committee. We addressed this on-site and this was promptly updated to the current Maternity Voices Committee with the latest minutes from the meetings to view. The meetings were attended by health professionals from the hospital and community as well as members of the public using the service.

Learning, continuous improvement and innovation

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

As a small unit, senior managers told us that the number of births has now plateaued and any drop was comparable in the region. They told us that they were now using social media to promote services, although many women were choosing to have subsequent births at the hospital. There were also new-build plans in the area that could impact on the number of women delivering at the trust.

Services for children and young people

Facts and data about this service

Children's services at Macclesfield District General Hospital comprise two main wards:

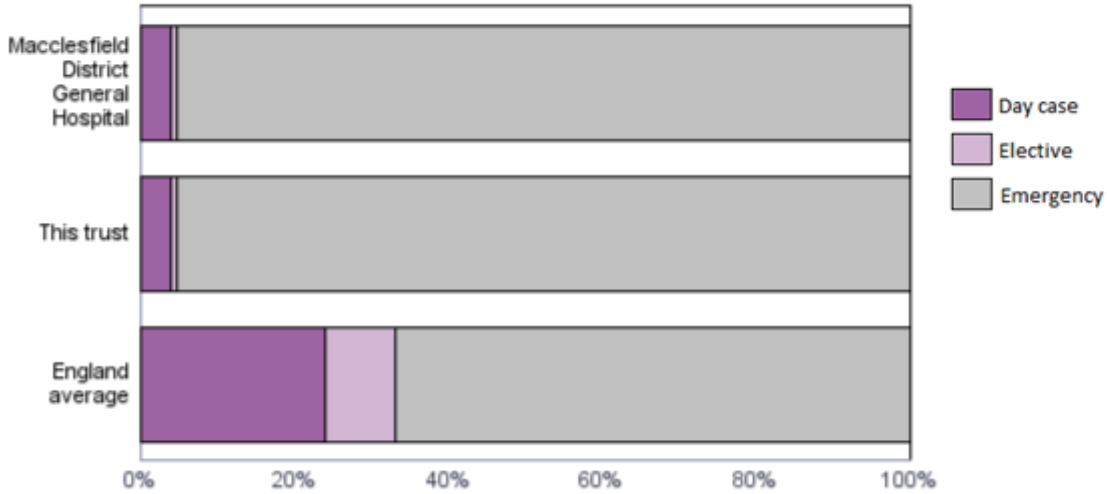
- Children's ward (incorporating a paediatric observation unit) - Includes 10 cots, six beds and five paediatric observation beds.
- Neonatal Unit (comprising nursery) – Includes eight cots and incubators.

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

The trust had 3,050 spells from September 2016 to August 2017.

Emergency spells accounted for 95% (2,910 spells), 4% (117 spells) were day case spells, and the remaining 1% (23 spells) were elective.

Percentage of spells in children's services by type of appointment and site, from September 2016 to August 2017, East Cheshire NHS Trust.



Total number of children's spells by Site, East Cheshire NHS Trust.

Site name	Total spells
Macclesfield District General Hospital	3,050
Trust total	3,050
England total	1,100,414

(Source: Hospital Episode statistics)

Is the service safe?

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

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

Mandatory Training

Mandatory training had been improved since the previous CQC inspection through the development of a paediatric essentials course, which operated over 10 sessions throughout the calendar year. Compliance on the children's ward was 87.1% and 78.1% on the special care baby unit.

Mandatory training was recorded on the electronic staff record and the matron kept an up to date spread sheet showing the compliance of each individual staff member to the various annual updates.

Mandatory training was primarily delivered face to face with simulation sessions. Staff commented that the mandatory training system was good and they told us they were given sufficient time to complete their training. The nurses we spoke confirmed they were up to date with their mandatory training requirements

Safeguarding

The trust had an organisational policy and procedures on safeguarding children and young people, which were available on the trust intranet. The policy detailed individual responsibilities and the process to follow for reporting and escalation of concerns about child welfare or maltreatment. There was a named safeguarding lead nurse contactable by dedicated telephone number. There was also a liaison health visitor who was part of the safeguarding team, named safeguarding lead doctor and designated doctor contactable via the main hospital switchboard. Additionally the lead nurse was supported by a safeguarding nurse specialist.

Safeguarding children training formed part of the trust's mandatory training programme and operated as a face to face course. Clinical staff working with children and young people completed safeguarding 'level three' training which was multidisciplinary in nature. Doctors in training also completed level three safeguarding training and attended the grand round each week where safeguarding concerns were discussed. The lead nurse for safeguarding confirmed the compliance to level 3 safeguarding updates was 82.1%.

All of the staff we spoke with had a very good understanding of safeguarding and were aware of the various policies and their own responsibilities. They were also able to define the triggers that would alert them to call for a safeguarding assessment and all staff members including the student nurses were clear about who they would contact if they needed to escalate safeguarding concerns.

Safeguarding information, including contact numbers and details of the trust lead were highly visible throughout the clinical areas and staff were confident in being able to access safeguarding. Staff we spoke with were able to recall examples of when they had raised concerns.

The lead nurse attended the ward monthly meetings where she offered safeguarding supervision.

Safeguarding supervision was in place. Doctors were compliant with the 2014 RCPCH standards for safeguarding and undertook regular documented reviews of their own (and/or team) safeguarding/child protection practice. Quarterly safeguarding supervision was available for nursing staff including the cohort of specialist nurses'. All new starters had an appointment with the safeguarding team members to discuss safeguarding policies.

Medical and nursing staff routinely discussed safeguarding concerns at daily handover meetings, and when we attended a medical handover we noted that any safeguarding issues were fully discussed. The staff we spoke with were knowledgeable about identification of female genital mutilation (FGM) and there was a protocol in place for escalation. Nurses in charge received

additional FGM awareness training which was incorporate within the safeguarding level 3 training module. Staff told us they felt comfortable to report and escalate concerns.

Young people over the age of sixteen could be admitted to adult wards and good practice outlined by the Royal College of Nursing suggests that all trusts should have a senior registered children's nurse whose role it is to be visible and credible in the promotion of services for children and young people. We were told that the senior children's nurse (the matron) had no jurisdiction over young people elsewhere in the trust and therefore this posed a risk. We spoke with the lead nurse and the nurse specialist and they told us that risk to children over the age of 16 was mitigated by the use of a specially designed and comprehensive proforma which allowed staff in adult wards to identify any young person for who they had a safeguarding concern. The "keeping children and young people safe" was a trigger for liaison with the safeguarding children's team and had been formulated to highlight potential safeguarding concerns to adult nurses caring for young people over the age of 16 who might be cared for in departments of the hospital outside of the children's ward. The trigger liaison proforma included prompts on a range of safeguarding concerns including among others female genital mutilation, domestic abuse, trafficking, sexual exploitation and unaccompanied asylum seekers.

Children who were not brought to the outpatient department were carefully managed through a "did not attend" protocol which triggered contact with the GP should a child fail to attend on a second occasion. One of the consultant paediatricians we spoke with in the outpatient department told us that children who were not brought were closely monitored for safeguarding issues.

Cleanliness, infection control and hygiene

In the CQC Children and Young People's Survey 2016 the trust scored 8.6 out of ten for the question 'How clean do you think the hospital room or ward was that your child was in?' This was about the same as other trusts.

(Source: CQC Children and Young People's Survey 2016, RCPCH)

Cleanliness, infection control and hygiene had improved since our previous inspection. At the last inspection in 2014, we identified concerns in relation to infection control; these included the decontamination arrangements for toys in the inpatient and outpatient areas and cots on the special care baby unit. We found actions had been taken to address the issues identified and effective systems and processes were now in place.

The trust had standard operating procedures for infection prevention and control. We reviewed these and found they were up to date and accessible by staff on the hospital intranet.

All of the children's and young people's clinical areas were visibly clean and clutter free. Hand sanitisers were available throughout the wards and at the point of entry and handwashing sinks were placed at strategic point within the clinical areas including the entry to the special care unit. There were clear, child friendly handwashing instructions at handwashing basins as well as signage to inform visitors to use hand sanitisers and all staff were vigilant in asking or reminding visitors including other staff to wash their hands.

There was easy access to personal protective equipment such as aprons and gloves throughout the wards and at the entrance to side rooms. We witnessed staff using personal protective equipment effectively.

Throughout our inspection all staff we spoke to or saw adhered to ‘bare below the elbow’ and adhered to infection control procedures, such as hand washing and using hand sanitisers when entering and exiting the unit and bed spaces. Staff told us they felt confident to challenge staff to ensure they were ‘bare below the elbows’ and used personal protective equipment.

Infection, prevention and control was part of mandatory training. The special care baby unit and the ward had a dedicated infection, prevention and control link nurse. Clinical staff knew who their link nurse was and reported a good flow of communication form.

Infection, prevention and control compliance was audited monthly . Noticeboards throughout the clinical areas communicated to staff and visitors the results of monthly audits such as hand hygiene, infections, central venous catheter (CVC) and peripheral venous catheter (PVC) infections. Noticeboards on wards consistently showed 100% hand hygiene compliance for the month immediately before our inspection.

There was a daily briefing with updates on audit results via the handover and infection, prevention and control risks were part of the formal handover process between the nurses in charge of the shifts. The handover sheets included a range of checklist pertinent to daily cleaning which was completed by the nurse in charge at the point of handover.

There was a dedicated domestic for the special care baby unit and the children’s ward. They felt very much part of the team. We saw they worked to standardised cleaning schedules which detailed the types of cleaning tasks that needed to be completed. Nurses also followed a dedicated cleaning schedule and we inspected the log and saw that it was fully up to date. The service used ‘I am clean’ stickers to identify equipment that had been cleaned and was ready for use.
The ward had a dedicated play cleaning policy and we observed one of the play specialists cleaning toys in the playroom using antibacterial wipes on large toys in the outdoor play area and full washing of smaller toys within the dirty utility room. Play services staff told us that playrooms were cleaned every morning and toys that had been used would be put to one side for subsequent cleaning before being re used. We inspected the toy cleaning rota and saw that it was fully up to date.

Patients and relatives we spoke with were highly satisfied with the level of cleanliness on the ward and special care baby unit.

Isolation procedures were in place for patients with infections and cubicles were marked clearly with a red poster to alert staff and visitors of an infectious patient with instructions of the precautions to take prior to entering the cubicle. We observed staff adhering to these protocols and doors remained closed.

We saw leaflets were available for patients and visitors about infection control and isolation. These provided details about the purpose of isolation and what was required.

Waste management and removal, including those for contaminated and hazardous waste, was in line with national standards.

Environment and equipment

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

The environment on the children's ward, the outpatient department and the special care baby unit was bright, clean and child friendly. Walls displayed colourful children's characters and each area was welcoming. We saw that the waiting areas within the service areas were free of clutter.

The clinical areas had secure entry with CCTV and buzzers to monitor who entered, however this did not monitor who exited the ward.

Emergency trolleys were available on every ward and were secured with plastic snap locks so it was clear if someone had accessed the resuscitation equipment. Trolleys were checked daily and weekly with staff signing a log to confirm the checks had been made. Consumables and equipment were appropriately stored and labelled and the paediatric cardiac arrest box was secure and dated. We checked consumables, such as fluids and found that they were sealed and in date.

We saw evidence that equipment was regularly serviced and calibrated. We checked items of equipment such as defibrillators and blood pressure monitors and found they had been safety tested.

Needle sharps bins were available throughout wards and within the medication preparation area. The bins we inspected were correctly labelled and none were filled above the maximum fill line.

Sensory equipment and projectors were available in playrooms and the treatment rooms for use with children with learning disabilities and treatment phobias.

The play room was spacious enough to accommodate patients in wheelchairs and the outdoor play area was fully equipped with large recreational toys.

There were fridges for breast milk storage and an expressed breast milk fridge in each nursery.

Assessing and responding to patient risk

In the CQC Children and Young People's Survey 2016, the trust scored 7.1 out of ten for the question 'Were the different members of staff caring for and treating your child aware of their medical history?' This was about the same as other trusts.

In the CQC Children and Young People's Survey 2016 the trust scored 9.5 out of ten for the question 'Were you given enough information about how your child should use the medicine(s) (e.g. when to take it, or whether it should be taken with food)?' This was about the same as other trusts.

CQC Children and Young People's Survey 2016 questions, safe domain, East Cheshire NHS Trust

Question	Age group	Trust score	RAG	KLOE
How clean do you think the hospital room or ward was that your child was in?	0-15 adults	8.66	About the same as other trusts	S1
Were the different members of staff caring for and treating your child aware of their medical history?	0-15 adults	7.10	About the same as other trusts	S3

Were you given enough information about how your child should use the medicine(s) (e.g. when to take it, or whether it should be taken with food)?	0-15 adults	9.50	About the same as other trusts	S4

(Source: CQC Children and Young People's Survey 2016, RCPCH)

The service had systems in place to assess and respond to risk.

Children and young people were monitored for signs of deterioration using a paediatric early warning score system (PEWS). A sepsis tool was also used to help staff escalate appropriately when signs of sepsis had been detected. A PEWS and sepsis flowchart was also on the wall by each bed. Observations protocols and charts were accessible on the trust intranet.

Nursing staff we spoke to were aware of escalation protocols if a patient scored higher than expected. Escalations for higher scoring children were made using the situation, background, assessment, recommendation (SBAR) method and was part of every medical and nursing handover and reinforced through the use of the specially designed yellow handover sheets. SBAR is a structured method for communicating critical information that requires immediate attention and action. Escalation was made first to the nurse in charge then to medical staff and a consultant paediatrician was contacted directly if required.

We attended a morning medical handover on the children's ward unit and observed that the design of the handover sheets facilitated the use of SBARD and that this technique was used to convey information about sick children. Handover sheets were updated twice daily. We saw that there was detailed discussion regarding the management of each child and baby patient's where psychological concerns were raised as well. There were twice daily nursing and medical handovers.

We inspected the medical records of children whom had been to theatre and saw that the WHO surgical safety checklist, which was designed for use in the operating theatre environment to improve the safety of surgery, had been fully completed and adhered to.

Deteriorating children in need of intensive care were transferred via a transport service that had been commissioned by specialist commissioners in the North West to transfer critically ill children from the hospital to any of the paediatric intensive care units within the North West and North Wales area.

The special care baby unit was part of the Cheshire and Merseyside Neonatal Network and neonates in need of level 3 care were transferred via a cot bureau and transport service for the North West Neonatal Operational Delivery Network and North Wales. The staff we spoke with told us that the services worked well and were very effective and timely.

Children requiring child and adolescent mental health support services (CAMHS) were admitted to the children's ward from the emergency department and were seen by a member of the CAMHS team during office hours Monday to Friday. Staff told us that they were fully supported by the CAMHS team including out of hours by request. Where necessary, for example, for a child with challenging behaviours, agency mental health nurses were employed while the child remained as an inpatient until a specialist bed became available. Concerns about the limited access to CAMHS had been recorded on the risk register

Staff we spoke with told us that all band 5 nurse had paediatric life support training and band 6 nurses had advanced life support training. However, there was a shortage of band 6 nurses for night duty which failed to comply with RCN standards.

A screening tool for the assessment of malnutrition was not routinely undertaken within the children's ward. The matron of the unit told us that consideration of introducing this was being considered for 2018. However, children with known nutritional deficits were routinely assessed. We saw that the children's ward used red trays as a safety alert for children with specific dietary requirements including allergies.

We saw that there was a current trust-wide abscondment policy which included 'lockdown' procedures in the case of children and young people going missing in the hospital estate.

Nurse staffing

The service had enough staff, most of the time, 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. However, the ward did not comply with the 2013 RCN standards for nurse staffing of a general children's ward at night.

The ward used the RCN Staffing guidance 2013 to determine staffing levels and the paediatric early warning scores (PEWS) to assess acuity of individual children. The ward did not use a specific acuity tool for paediatric settings.

The trust met the 2013 RCN standards for nurse staffing of a general children's ward during the day. We reviewed the staffing data for the three months prior to our inspection. We saw that staffing levels had been achieved on most occasions; where this had not been the case mitigation was put in place such as the senior sister and matron stepping down into core staffing numbers in addition to community nurses covering outstanding shifts at short notice to support safe staffing levels. Bank and agency staff had also been utilised, where necessary, to maintain required dependency ratios. In November 2017, the unit was closed to admissions on four occasions because of staff shortages to maintain patient safety.

However, the ward did not comply with the 2013 RCN standards for nurse staffing of a general children's ward at night. This was because the provision of band 6 nurses at night with advanced paediatric life support (APLS) training was not sufficient to meet the standard. We examined the nurse off duty roster for October and December 2017 and saw that there were 28 occasions in October when there was not a band 6 nurse on duty and 26 occasions in December. However, risk was partially mitigated by access to consultants who lived within three miles of the trust and the availability of night time registrars with APLS training. This was not recorded on the risk register.

The ward staffing complement included band 7 and 6 ward sisters/charge nurses, band 5 staff nurses, a ward receptionist, three hospital play specialist, a housekeeper, and a domestic.

The neonatal unit used guidance from the British Association of Perinatal Medicine (BAPM) regarding staffing levels and were compliant with recommendations. The unit employed an advanced neonatal nurse practitioner who participated in the middle grade medical rota on

Mondays and Wednesdays and was available as an extra resource to nurses on the other days of the week.

Staff on the wards said they did not use many agency staff and were mostly happy with the staffing numbers on the wards.

From September 2016 to August 2017, Macclesfield District General Hospital reported a vacancy rate of 4.9% in children's services; this was better than the trust target of 7%. Overall vacancy rates at the hospital for nursing staff were 12.6%.

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

From September 2016 to August 2017, Macclesfield District General Hospital reported a turnover rate of 6% for nursing staff in children's services, this is better than the trust target of 15.6%. Overall turnover rates at the hospital were 7.2% for nursing staff.

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

Between September 2016 and August 2017, Macclesfield District General Hospital reported a sickness rate of 4% in children's services, this was better than the trust target of 4.6%. Overall sickness rates for the whole trust for nursing staff were 4.9%.

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

The trust reported a bank and agency rate of 6.8% for nursing staff within children's services from September 2016 to August 2017.

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

Medical staffing

At the time of the inspection, the children's service employed six consultant paediatricians and was in the process of recruiting a seventh consultant. The lead consultant paediatrician confirmed that the unit was not compliant to the Royal College of Paediatrics and Child Health (RCPCH) "facing the future" standards which recommends 10 full time consultants being in post.

However, consultants we spoke with told us that risks to patients were mitigated by concentrating consultant activity on clinical work. Eight shifts per week were also covered by agency or bank locum doctors at middle grade level. Most of these were recruited from the existing cohort of doctors employed within the unit.

Doctors we spoke with felt there were adequate numbers of doctors on the wards during the day and at night. There was 24-hour consultant cover for the paediatric and neonatal wards, seven days a week.

An audit had been undertaken by the medical team in April and May 2017 against compliance with the Royal College of Paediatrics and Child Health facing the future standards. This identified that 80% of children had a review by a registrar within 4 hours of admission in accordance with the guidance. Children were seen by a consultant within 14 hours in 60% of cases. Of those not seen within 14 hours, all were seen the morning following the day after admission. Actions had been implemented and we saw evidence, during the inspection, that the standard of children being seen by a consultant within 14 hours of admission was met.

However, the service had not developed a consultant of the week as recommended by the

RCPCH.

Returners from long term sick leave were required to undertake a return to work programme and we saw that there was a sickness policy in place.

From September 2016 to August 2017, Macclesfield District General Hospital reported a vacancy rate of 2.7% in children's services, this was better than the trust target of 7.0%. Overall vacancy rates at the hospital for medical and dental staff were 9.4%.

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

From September 2016 to August 2017, Macclesfield District General Hospital reported a turnover rate of 16.7% in children's services, this was worse than the trust target of 15.6%. Overall turnover rates at the trust were 6.6% for medical staff.

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

From September 2016 to August 2017, Macclesfield District General Hospital reported a sickness rate of 1.3% in children's services for medical staff, this was better than the trust target of 4.63%, overall sickness rates at the trust for medical staff were 1.6%.

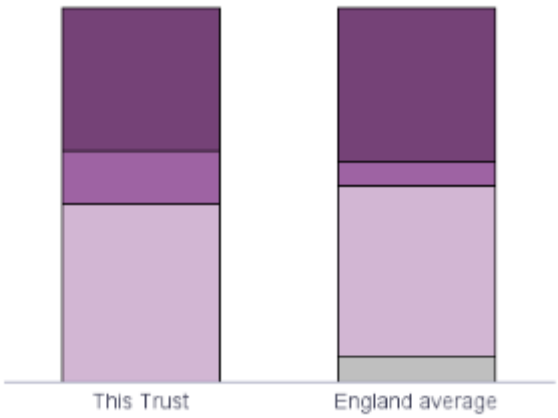
(Source: Routine Provider Information Return (RPIR) P19 Sickness)

The trust reported an agency and locum rate of 9% for medical staff within children's services from December 2016 to August 2017.

(Source: Routine Provider Information Return (RPIR) P21 Medical Locums)

In August 2017, the proportion of consultant staff reported to be working at the trust was lower than the England average and the proportion of junior (foundation year 1-2) staff was 0%.

Staffing skill mix for the 21 whole time equivalent staff working in children's services at East Cheshire NHS Trust



	This Trust	England average
Consultant	38%	41%
Middle career^	14%	7%
Registrar Group~	47%	45%
Junior*	0%	7%

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

(Source: NHS Digital Workforce Statistics)

Records

Record keeping had been identified as requiring improvement at the last inspection and the staff had been working to improve this.

The unit used multidisciplinary records for the children. We saw that care plans were based on pre-printed proformas which were individualised as required for each child. We saw that care plans were evaluated via entries to the evaluation sheet which was part of the care plan.

We examined four sets of care records. We saw records were mostly completed, although we found a few gaps in one record. We identified that parts of the care plan had not been completed. We were told that the current system of care planning was to be changed and replaced with multidisciplinary care pathways orientated around differing diseases of children.

The unit doctors undertook a weekly audit of medical records and the nursing staff undertook a monthly audit. During the medical handover which we attended, we saw that the consultants specifically addressed the importance of accurate and complete record keeping to junior staff.

There was a flag on the system to identify any children with safeguarding needs. Staff were aware of this.

We saw that medical records were securely stored at all times in a new lockable cabinet. The medical record cabinet was always locked, if unattended by a member of staff.

Medicines

Medicines were managed and stored safely and securely on the children's ward. The treatment room was secured with a coded lock and all medicines were kept in locked cupboards in the room. Medicines in use were stored in a secure trolley and the date opened was recorded on each container, where appropriate. All medicines inspected were within their expiration date.

Pharmacy support was provided to replenish and manage stock and staff reported no issues with supply. Patients own medicines were administered, where possible.

Controlled drugs were checked daily by ward staff and quarterly as part of the pharmacy audit system. Controlled drug stationary was secure and stock and records were accurate.

Medicines and vaccines requiring refrigeration were stored in locked fridges, which were monitored daily. Records demonstrated the fridges remained within manufacturers guideline of 2-8^{o}C. Staff recorded the minimum and maximum temperatures in accordance with hospital policy.

In order to prevent delays, the ward held stocks of commonly used medicines, such as antibiotics and analgesics, which were pre-labelled and could be used for patients being discharged out of pharmacy normal working hours.

A clinical pharmacist visited the ward Monday to Friday to complete medicines reconciliation, review prescription charts and provide prescribing advice.

The prescription charts we viewed showed evidence of pharmacist review, actioned by prescribers. The prescription charts were clearly presented and patient details including allergy

status and weight were completed. Pharmacist and technician support meant that on weekdays medicines were dispensed on the wards, so prescription charts did not leave the ward. Additionally, the trust had introduced a discharge team across the hospital to prepare take home prescriptions promptly and prevent delays.

Medicines and equipment required in an emergency were readily available and regularly checked and replenished as needed.

Incidents

The trust used an electronic incident reporting system to report incidents. Staff across all disciplines, were aware of how to report incidents and could show us how to access the online system. Staff told us they were encouraged to report incidents and were able to identify types of situations that should trigger incident reporting completion, including 'near miss' situations.

The matron of the service reviewed all incidents. Nurses met monthly to discuss reported incidents and to formulate action plans as necessary. Although nurses attended meetings each month where incidents were discussed, because of winter pressures planned December meetings were substituted for a safety newsletter. This newsletter was accessible on the trust intranet and was printed out and pinned up in prominent places.

Incidents were discussed at quarterly clinical governance meetings. We saw these were analysed in the governance reports.

Although children's services had not implemented formal multidisciplinary morbidity and mortality meetings, incidents were discussed within the weekly multidisciplinary grand round and at the monthly safety and quality standards meetings.

Staff told us they received feedback when they reported incidents. Staff we spoke with were able to recall the most recent serious incident and the learning and recommendations that came from the investigation .

The service received information about alerts from the central alert system. These were recorded in the paediatric governance pack and a lead person and deadline date for implementation was clear.

The Duty of Candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. We saw that the application of Duty of Candour was good and reminders of the importance of candour was shown and highlighted on every computer screen saver throughout the unit.

Staff across all disciplines we spoke with had a good knowledge of the duty of candour and confirmed that it was part of their mandatory annual updating. We saw that consideration of the Duty of candour was recorded for appropriate individual incidents within the governance report.

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 November 2016 to October 2017, the trust reported no incidents classified as never events

In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents

(SIs) in children's services which met the reporting criteria set by NHS England from November 2016 to October 2017.

(Source: Strategic Executive Information System (STEIS))

Safety Thermometer

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

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

Data from the Patient Safety Thermometer showed that the trust reported no new pressure ulcers, no falls with harm and no new catheter urinary tract infections from November 2016 to November 2017 for children's services.

Quality indicator noticeboards on wards were used to demonstrate to staff and visitors the results of monthly audits such as hand hygiene, infections, central venous catheter (CVC) and peripheral venous catheter (PVC) infections.

(Source: NHS Digital)

Is the service effective?

Evidence-based care and treatment

We saw that the policies and procedures appropriately referenced current good practice and national guidelines from organisations such as the National Institute for Health and Care Excellence (NICE) and Royal Colleges. They contained appropriate guidance for screening, referrals, escalation, specific interventions and further sources of advice and information.

The trust's care pathways for children and young people services were delivered in line with referenced national clinical guidance.

We saw that there were protocols, policies and guidance for clinical and other patient interventions and care available on the trust intranet. Staff could also access paper copies of policies. We inspected 10 of these polices including asthma, meningitis and urinary tract infections and identified one was due for review. A lead for guidelines due for review and a timeframe were clearly documented in the children's service governance pack.

There were effective processes for the identification and implementation of new clinical guidelines and new practice development notifications were cascaded to staff via email. The matrons also shared information and displayed this on a range of information boards throughout the special care baby unit and the children's ward. Policies and guidelines were included in the children's governance pack and were reviewed at the governance meeting.

Staff we spoke with including nurses and junior doctors told us policies and guidelines were easy to access on the trust database. We saw that understanding of and adherence to policy guidelines was embedded in multidisciplinary working and was cited in the medical handover we attended.

There were regular quantitative and qualitative audits including weekly audits of hygiene and infection control, patient feedback, cancellations and attendances amongst many others. The results of these regular audits were shared at ward meetings. The unit participated in a range of other audits such as a monthly record audit and an annual PEWs audit.

The children's ward also conducted an annual audit of compliance to the National Patient safety Agency alert which was designed to ensure that pregnancy assessment has been considered prior to surgical intervention of all female patients of childbearing potential.

In the outpatient department an annual audit of children who were not brought had been conducted.

Within the special care baby unit a range of ongoing audits had been completed including the management of new-born babies born to mothers with meconium stained liquor. Other audits such as admission temperature were audited via the Badgernet online neonatal system which is a single record of care for all babies within neonatal services across the UK. Other local audits included Intravenous infusions, bronchiolitis, prolonged jaundice and neonatal jaundice.

The service participated in a number of national clinical audits, including the national paediatric diabetes audit, asthma, growth hormone and the National Confidential Enquiry into Patient Outcome and Death.

Nutrition and hydration

The neonatal unit was part of the maternity unit accredited UNICF level 3 award where the focus was on ensuring that the baby friendly standards were implemented for all pregnant women and new mothers. UNICEF stage 3 for maternity services means that hospitals have supported mothers and babies with their infant feeding choices and encouraged the development of close and loving relationships between parents and baby. We saw that supporting breast feeding was a priority for the nurses working on the neonatal unit. One of the new mothers we spoke with told us that she had received a great deal of support to breast feed her baby.

A screening tool for the assessment of malnutrition in paediatrics was not routinely undertaken within the children's ward. The matron of the unit told us that consideration of introducing this was being considered for 2018. Children with known nutritional deficits were, however, routinely assessed.

Provision of food within the children's ward was good with a large variety of choice on the children's menu including Halal and vegan alternatives.

There were protected meal times on the ward and we saw that sandwiches, fruit and yoghurt and a selection of drinks were available throughout the day for the children. There was a finger food menu which was available at tea time.

The services of a paediatric dietitian were available to ward staff.

Pain relief

There were effective processes in place to ensure patients' pain relief needs were met and pain was well managed in the children and young people service.

The service utilised a range of pain assessment tools. These included a smiley faces assessment chart and FLACC which is the Face, Legs, Activity, Cry, Consolability scale which is a measurement used to assess pain for children between the ages of two months and seven years or individuals that are unable to communicate their pain.

The current PEWs early warning score sheet were being updated to include pain assessment.

Patient outcomes

Children's services contributed to relevant local and national patient outcome and performance audits, including benchmarking activities and peer review with other local NHS hospital trusts.

Data from national audits showed mixed results for the paediatric diabetes audit 2015/16 with two indicators improving and one deteriorating from previous results.

There was a higher percentage of under ones readmitted following an elective admission and the same percentage of patients aged one to 17 readmitted following an elective admission compared to the England average.

The trust performed better than the England average for the percentage of patients who had multiple readmissions for asthma and had satisfactory results for the National Neonatal Audit Programme.

Paediatric diabetes audit 2015/16

HbA1c levels are an indicator of how well an individual's blood glucose levels are controlled over time. The NICE Quality Standard QS6 states "People with diabetes agree with their healthcare professional a documented personalised HbA1c target, usually between 48 mmol/mol and 58 mmol/mol (6.5% and 7.5%)".

The data below shows that performance in the 2015/16 diabetes audit at Macclesfield District General Hospital was mixed.

The proportion of patients receiving all key care processes annually was 34% which was within the expected range, compared to a national aggregate of 35.5%, the previous year's score was 25%.

The average HbA1c value (adjusted by case-mix) at the trust was 72.1 which was worse than expected, compared to a national aggregate of 68.3, the previous year's score was within the expected range.

The median HbA1c value recorded amongst the 2015/16 sample was 64.0, which was a clinically significant improvement on the previous year's median which was 67.0.

(Source: National Paediatric Diabetes Audit 2015/16)

Emergency readmission rates within two days of discharge

The data shows that from September 2016 to August 2017 there was a higher percentage of under ones readmitted following an elective admission and the same percentage of patients aged 1-17 readmitted following an elective admission compared to the England average.

Emergency readmissions within two days of discharge following emergency admission among the under 1 age group, by treatment specialty
(September 2016 to August 2017)

Specialty	East Cheshire NHS Trust			England
	Readmission rate	Discharges (n)	Readmissions (n)	Readmission rate
Paediatrics	3.5%	992	35	3.3%
No other speciality at this trust had six or more readmissions.				

Emergency readmissions within two days of discharge following emergency admission among the 1-17 age group, by treatment specialty
(September 2016 to August 2017)

Specialty	East Cheshire NHS Trust			England
	Readmission rate	Discharges (n)	Readmissions (n)	Readmission rate
Paediatrics	3.1%	1,914	59	2.7%
No other speciality at this trust had six or more readmissions.				

There were no emergency readmissions after elective admission at East Cheshire NHS Trust from September 2016 to August 2017.

(Source: Hospital Episode Statistics, provided by CQC Outliers team)

Rate of multiple emergency admissions within 12 months among children and young people for asthma, epilepsy and diabetes

From September 2016 to August 2017the trust performed better than the England average for the percentage of patients who had multiple readmissions for asthma for both under ones and children aged 1-17.

The trust performed worse than the England average for the percentage of patients who had multiple readmissions for epilepsy for children aged 1-17.

Rate of multiple (two or more) emergency admissions within 12 months among children and young people for asthma, epilepsy and diabetes (for children aged under 1 year and 1 to 17 years).

(October 2016 to September 2017)

	East Cheshire NHS Trust			England
Long term condition	Multiple admission rate	At least one admission (n)	Two or more admissions (n)	Multiple admission rate
Asthma				
Under 1	0.0%	*	0	18.3%
1 to 17	12.7%	63	8	16.4%
Diabetes				
Under 1	-	-	-	30.8%
1 to 17	*	22	*	13.0%
Epilepsy				
Under 1	-	-	-	31.1%
1 to 17	50.0%	14	7	27.9%

(Source: Hospital Episode Statistics, provided by CQC Outliers team)

National Neonatal Audit Programme

In the 2016 National Neonatal Audit, Macclesfield District General Hospital's performance was as follows:

Do all babies < 1501g or a gestational age of < 32 weeks at birth undergo the first Retinopathy of Prematurity (ROP) screening in accordance with the current guideline recommendations?

There were four babies born with a birth weight < 1501g or with a gestational age at birth < 32 weeks who were assigned to Macclesfield District General Hospital for ROP screening. 100% of these babies were screened on time in accordance with the NNAP extended screening window*; this was above the national average, where 98% of eligible babies had their screening performed within the NNAP extended screening window.

Is there a documented consultation with parents by a senior member of the neonatal team within 24 hours of admission?

There were 134 first episodes of care that were eligible for inclusion in this audit measure at Macclesfield District General Hospital. Episodes of care lasting less than 12 hours have been excluded from analysis. The first consultation following admission occurred within 24 hours for 81% of the eligible episodes; this was below the national average, where 90% of eligible episodes had the first consultation within 24 hours of admission.

Are rates of normal survival at two years comparable in similar babies from similar neonatal units?

There were eight babies born at < 30 weeks born between July 2013 and June 2014 who have been assigned to Macclesfield District General Hospital for two year health assessment based on their final neonatal discharge. Data was entered for 101% of the babies assigned to Macclesfield District General Hospital, whilst nationally data was available for 61% of babies born at < 30 weeks born between July and June 2014.

What is the proportion of babies born <32 weeks who develop Bronchopulmonary Dysplasia?

There were 15 babies born < 32 weeks in Macclesfield District General Hospital who were included in the analysis for Bronchopulmonary Dysplasia. Of these babies 1 were identified as having Significant BPD.

(Source: National Neonatal Audit Programme, Royal College of Physicians and Child Health)

Competent staff

The service made sure staff were competent for their roles.

We saw that appraisals were 100% completed at the time of inspection and staff we spoke with were able to confirm that they had received an annual appraisal.

The trust supported continued professional development of its staff, including formal qualifications, practical training, conference attendance, secondments, team days, mentoring and shadowing opportunities on other paediatric wards. There were opportunities for leadership and management training for senior nurses and clinicians. Nurses told us they were actively encouraged to apply for development opportunities.

Students and newly qualified nursing staff reported a supportive and encouraging learning environment in children and young people services with good supervision. Student nurses told us they enjoyed their placements at the hospital.

The nurses we spoke with told us there the trust was helpful in supporting their career development and although there were financial restrictions they were able to request funding for specialised courses.

The junior doctors we spoke with told us that training was good within the service and that it was a good place to work. They perceived the consultants as being both approachable and supportive and in providing good supervision and good access to practical teaching and learning opportunities. At the medical handover we attended, we saw that the consultants used every opportunity to engage with and provide tuition to junior staff.

Consultant paediatricians and nurses told us the trust was supportive of revalidation.

We saw that there was a comprehensive induction pack available for all new staff and where competencies including equipment use were signed off within six weeks of commencing duties.

Information and minutes of meetings pertinent to core medical training (CMT) which aims to provide the core medical skills needed for junior doctors was sent out via email to all members of the CMT group. We saw the minutes of these meetings and the ensuring action plans.

At the previous inspection, there had been concerns with training for nursing staff in the use of continuous positive airway pressure therapy. Continuous positive airway pressure therapy (CPAP) is used to help children with respiratory difficulties. The staff were now all competent in the use of this equipment and on each day rostered staff with CPAP training were identified on the roster sheet. CPAP monthly training updates had been implemented and full records were kept. We inspected the CPAP training record and saw that it was fully completed and up to date.

Staff we spoke with on the children's ward told us that all band 5 nurse had paediatric life support training and band 6 nurses advanced paediatric life support training. However, there was a shortage of band 6 nurses for night duty which failed to comply with RCN standards.

Band 6 nurses on the neonatal unit were trained in neonatal life support.

Surgical staff confirmed that they complied with the Royal College of Surgeons Standards for non-specialist emergency surgical care of children.

Appraisal rates

From April 2016 to March 2017, 92% of staff within children's services at the trust had received an appraisal compared to a trust target of 90%.

A split by staff group can be seen in the table below, the target was met for all staff groups except for 'Prof Scientific and Technic' staff.

Staff Group	Number receiving an appraisal 2016/17	Number requiring an appraisal 2016/17	Appraisal completion rate	Target	Met Target (Yes/No)
Additional Clinical Services	2	2	100%	90%	Yes
Allied Health Professionals	1	1	100%	90%	Yes
Administrative and Clerical	16	16	100%	90%	Yes
Nursing and Midwifery	95	103	92%	90%	Yes
Estates and Ancillary	117	127	92%	90%	Yes
Healthcare Scientists	19	21	90%	90%	Yes
Prof Scientific and Technic	4	5	80%	90%	No
Total	254	275	92%	90%	Yes

(Source: Trust Provider Information Return P46)

Multidisciplinary working

There was an effective multidisciplinary team (MDT) working environment within children and young people services. Multidisciplinary grand rounds were held weekly and facilitated good dialogue between members of the multidisciplinary team. We were told that the trust nurse specialist for learning disability joined the grand round.

We found evidence of good multidisciplinary relationships supporting patients' health and wellbeing. We observed multidisciplinary input in caring for and interacting with patients on the wards and other clinical areas such as paediatric surgery.

The nursing staff regularly met with the nursing staff of the emergency department. Nursing staff from the children's ward participated in simulation training with the emergency care staff.

Staff from children's services met regularly with the speech and language therapist, the paediatric dietitians, physiotherapists, the paediatric community nurses and the two psychotherapists who provided services to the ward.

There were three play specialists as part of the children's ward team who provided play at the bedside or within the playroom. Play therapists worked closely with the multidisciplinary team to incorporate play into daily routines and development plans for long term patients.

We saw that members of the multidisciplinary team were involved in transition of children to adult services including clinical nurse specialists. The ward had adopted the "Ready, Steady Go" protocol for transition. Ready Steady Go is a transition programme developed to help young people and their families through the transition from children's to adults' services. Although not all parts of the service had completed their transition to adult service plans, there were appropriate processes in place to support patients' transition between services, for example, from the special care baby unit to the paediatric inpatient ward, and from paediatrics to some adult services.

There was effective multidisciplinary working with children and adolescent mental health service (CAMHS) team. Staff told us that they were fully supported by the CAMHS team during office

hours Monday to Friday and out of hours by request. Meetings between CAMHS staff and medical staff based on the children's ward were undertaken every eight weeks.

In the CQC Children and Young People's Survey 2016 the trust scored 8.37 out of ten for the question 'Did the members of staff caring for your child work well together?' This was about the same as other trusts.

(Source: CQC Children and Young People's Survey 2016, RCPCH)

Seven-day services

The hospital delivered a full inpatient service for children and young people over seven days with on-site consultant paediatrician availability seven days per week.

The operating theatre was available 24 hours per day seven days a week for emergency cases for children over 8 years of age.

Paediatric therapies, such as physiotherapy and play therapy, provided a week day 9-5pm service. Therapies covered all paediatric wards including the special care baby unit, but there was no overnight cover and no weekend on call cover for paediatric therapies.

The pharmacy was open Monday to Friday and 10.30-14.30 on Saturday and Sunday. There was access to 24 hour pharmacist on call and an emergency drug cupboard .

There was seven day access to x-ray facilities.

Child and Adolescent Mental Health Services (CAMHS) were available during office hours Monday to Friday for telephone consultation and individual visits to children on the ward. When needed, access to the CAMHS was available out of hours and at weekends. The risks associated with the limited service was recorded on the risk register.

Health Promotion

There was a comprehensive range of information and support available for patients and their families and carers. We saw that there was a wide range of good quality patient literature with informative content available via patient literature stands.

There were also leaflets on managing different health conditions for example for children living with epilepsy or asthma. There were leaflets on managing different conditions and all of the information we saw was easy to read and written in plain English.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Mandatory training in Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) awareness was provided to staff working in the trust.

The clinical staff we spoke with were knowledgeable about Fraser and Gillick competencies to help assess whether a child has the maturity to make their own decisions without consent of a parent or guardian and understand the implications of those decisions.

We saw that the staff had developed a poster which told Gillick competent children that they could speak to a doctor or nurse without their parent's presence. Staff we spoke with were fully knowledgeable about Gillick competence.

Other CQC Survey Data

The trust performed about the same as other trusts for all applicable questions relating to effectiveness in the CQC Children and Young People's Survey 2016.

CQC Children's Survey questions, effective domain, East Cheshire NHS Trust

Question	Age group	Trust score	RAG	KLOE
Did you feel that staff looking after your child knew how to care for their individual or special needs?	0-15 adults	7.70	About the same as other trusts	E3
Did staff play with your child at all while they were in hospital?	0-7 adults	7.83	About the same as other trusts	E4
Did different staff give you conflicting information?	0-7 adults	8.58	About the same as other trusts	E4
Did the members of staff caring for your child work well together?	0-15 adults	8.37	About the same as other trusts	E4
During any operations or procedures, did staff play with your child or do anything to distract them?	0-15 adults	8.14	About the same as other trusts	E4
Did hospital staff play with you or do any activities with you while you were in hospital?	8-11 CYP	No Score	No Score	E4

(Source: CQC Children and Young People's Survey 2016, RCPCH)

Is the service caring?

Compassionate care

Throughout our inspection, we saw all clinical staff interacting with patients and their family members and carers in in a caring, polite and friendly manner. All of the people we spoke with during the inspection were very happy with the care and treatment provided by the trust.
The children's ward and outpatients participated in the NHS Friends and Family Test (FFT), the results of which were consistently very good across children and young people service areas. For the children's ward, data from October 2016 to September 2017 showed 98% of respondents would recommend the ward to friends and family. We saw that all staff placed significant emphasis on the friends and family test and we saw posters around the clinical areas including the outpatient department highlighting the test.

We sampled FFT feedback and found that it was very complimentary and positive about the care received and the staff who delivered it. Comments made by parents included "I love how the staff always address my daughter before me and ask how she is feeling rather than asking me how she feels " and "superb nurses, doctors and other staff –excellent care given to my baby."

The special care baby unit had not implemented the friends and family test and instead issued a detailed satisfaction survey questionnaire to parents and carers. The neonatal unit parental survey was conducted in 2017 and consisted of 15 questions, for example, “were procedures explained to you.” We examined the data analysis from the questionnaire and saw that family members were extremely positive about the whole experience of having a baby being cared for in the special care baby unit. An action plan was produced following the analysis of the data addressed areas where improvements could be made.

Although the special care baby unit did not have a dedicated breast feeding room, we saw that when mothers were breast feeding that privacy was fully assured through the use of portable screens.

We spoke with mothers who had babies being cared for on the special care baby unit. They were highly complementary about all the care staff and felt very safe within the special care baby unit.

Parents on the children’s ward told us that the staff were very kind and supportive. Throughout the inspection, we saw all clinical staff interacting with the children and their family carers with an appropriate caring, polite and friendly approach.

The children’s ward had initiated a “you said –we did” notice board which clearly showed how the ward had responded to comments made by parents.

Although the ward did not have a dedicated cubicle or area for adolescent patients, the play specialists had created an area within the large playroom which was fully equipped for adolescent recreational activities and privacy was ensured by the use of a screen.

Play specialists accompanied children to the anaesthetic room where they remained with the child until the anaesthetic had been administered. As appropriate, they used guided imagery to help certain children. After the administration of the anaesthetic, they accompanied the parent back to the ward.

The trust performed about the same as other trusts for most questions. The trust performed worse than other trusts for one question in the CQC Children and Young People’s Survey 2016 relating to compassionate care, ‘Overall, how well do you think you were looked after in hospital?’, where the trust scored 7.96 out of 10.

CQC Children and Young People’s Survey 2016 questions, compassionate care, East Cheshire NHS Trust

Question	Age group	Trust score	RAG	KLOE
Did new members of staff treating your child introduce themselves?	0-7 adults	8.66	About the same as other trusts	C1
Did you have confidence and trust in the members of staff treating your child?	0-15 adults	8.62	About the same as other trusts	C1
Were members of staff available when your child needed attention?	0-15 adults	7.43	About the same as other trusts	C1
Do you feel that the people looking after your child were friendly?	0-7 adults	9.30	About the same as other trusts	C1

Do you feel that your child was well looked after by the hospital staff?	0-7 adults	9.11	About the same as other trusts	C1
Do you feel that you (the parent/carer) were well looked after by hospital staff?	0-15 adults	8.00	About the same as other trusts	C1
Was it quiet enough for you to sleep when needed in the hospital?	8-15 CYP	7.10	About the same as other trusts	C1
If you had any worries, did a member of staff talk with you about them?	8-15 CYP	No Score	No Score	C1
Do you feel that the people looking after you were friendly?	8-15 CYP	8.79	About the same as other trusts	C1
Overall, how well do you think you were looked after in hospital?	8-15 CYP	7.96	Worse than other trusts	C1

(Source: CQC Children and Young People's Survey 2016, RCPCH)

Emotional support

Staff provided emotional support to patients and their parents and carers to minimise their distress.

There was a dedicated play therapy team which worked very closely with doctors, nurses and therapists to incorporate play into clinical interventions and therapies. For example, portable sensory distraction equipment consisting of fibre optic light displays had been purchased and we saw this in use with a child on the children's ward.

The play staff had been trained in the use of guided imagery, which is a relaxation technique that uses sensory visualisation to help children cope with anxiety and stress during hospital procedures. The play specialists use this technique with children admitted to the observation bay and when taking children to the anaesthetic room prior to surgery.

The play team had access to a number of Starlight distraction boxes which are yellow portable toolkits filled with a variety of toys, games and puzzles providing hospital staff with different ways of distracting a child whilst medical procedures are undertaken. The play team had no dedicated budget for toys but received significant charitable funding, and there were many high quality, age appropriate toys across the ward and in children's outpatients. Parents told us they found the play therapists kind and supportive.

We saw that there was significant emphasis on psychological care on the children's ward. This was facilitated through an initiative entitled "PUG" –how are you feeling ?" which used differing pug dog faces to represent various mental health emotions. The play team had also developed a hopes and dreams notice board where children could write about their experiences of being in hospital. Similarly, the safeguarding team had developed a poster entailed "keeping children safe" which had been designed to encourage children with issues or concerns to speak to a staff member in confidence.

There was a hospital chapel which provided a peaceful space for contemplation and reflection.

The trust performed better than other trusts for one question (treatment with dignity and respect with an average score of 9.6 out of 10) and about the same as other trusts for the remaining four questions relating to emotional support in the CQC Children and Young People's Survey 2016.

CQC Children and Young People's Survey 2016 questions, emotional support, East Cheshire NHS Trust

Question	Age group	Trust score	RAG	KLOE
Was your child given enough privacy when receiving care and treatment?	0-7 adults	9.32	About the same as other trusts	C3
If your child felt pain while they were at the hospital, do you think staff did everything they could to help them?	0-15 adults	7.79	About the same as other trusts	C3
Were you treated with dignity and respect by the people looking after your child?	0-7 adults	9.60	Better than other trusts	C3
Were you given enough privacy when you were receiving care and treatment?	8-15 CYP	8.22	About the same as other trusts	C3

If you felt pain while you were at the hospital, do you think staff did everything they could to help you?	8-15 CYP	7.89	About the same as other trusts	C3

(Source: CQC Children and Young People's Survey 2016, RCPCH)

Understanding and involvement of patients and those close to them

All of the carers we spoke with throughout children's services during the inspection told us that they were delighted with the care and treatment provided by the staff and that everything had been explained to them in language that they could understand.

We observed doctors, nurses and therapists working in partnership with parents and families. Staff in children and young people's services demonstrated a patient-centred approach which encouraged family members to take an active role in their child's healthcare.

The parents we spoke with told us nurses were very supportive, explained treatments and what was going to happen. Doctors kept them informed of progress, clinical interventions and referrals to other services. Parent consistently reported the positive attitude of clinical staff.

Clinical nurse specialists were able to give tailored teaching and support to families and families could also access remote support and guidance by telephone.

The trust performed worse than other trusts for one question relating to understanding and involvement of patients and those close to them in the CQC Children and Young People's Survey 2016. The trust scored about the same as other trusts for the remaining 17 questions.

The question scoring worse than other trusts was 'Did staff involve you in decisions about your child's care and treatment?' where the trust scored an average of 7.23 out of 10.

CQC Children and Young People's Survey 2016 questions, understanding and involvement of patients, East Cheshire NHS Trust

Question	Age group	Trust score	RAG	KLOE
Did members of staff treating your child give you information about their care and treatment in a way that you could understand?	0-15 adults	8.71	About the same as other trusts	C2
Did members of staff treating your child communicate with them in a way that your child could understand?	0-7 adults	7.67	About the same as other trusts	C2
Did a member of staff agree a plan for your child's care with you?	0-15 adults	8.63	About the same as other trusts	C2
Did staff involve you in decisions about your child's care and treatment?	0-15 adults	7.23	Worse than other trusts	C2
Were you given enough information to be involved in decisions about your child's care and treatment?	0-15 adults	7.99	About the same as other trusts	C2
Did hospital staff keep you informed about what was happening whilst your child was in hospital?	0-15 adults	7.60	About the same as other trusts	C2
Were you able to ask staff any questions you had about your child's care?	0-15 adults	8.46	About the same as other trusts	C2
Before your child had any operations or procedures did a member of staff explain to you what would be done?	0-15 adults	8.24	About the same as other trusts	C2
Before the operations or procedures, did a member of staff answer your questions in a way you could understand?	0-15 adults	8.94	About the same as other trusts	C2

Afterwards, did staff explain to you how the operations or procedures had gone?	0-15 adults	7.30	About the same as other trusts	C2
When you left hospital, did you know what was going to happen next with your child's care?	0-15 adults	7.35	About the same as other trusts	C2
Do you feel that the people looking after your child listened to you?	0-7 adults	8.58	About the same as other trusts	C2
Did hospital staff talk with you about how they were going to care for you?	8-15 CYP	9.22	About the same as other trusts	C2
When the hospital staff spoke with you, did you understand what they said?	8-15 CYP	8.11	About the same as other trusts	C2
Did you feel able to ask staff questions?	8-15 CYP	9.47	About the same as other trusts	C2
Did the hospital staff answer your questions?	8-15 CYP	9.37	About the same as other trusts	C2
Were you involved in decisions about your care and treatment?	8-15 CYP	5.49	About the same as other trusts	C2
If you wanted, were you able to talk to a doctor or nurse without your parent or carer being there?	12-15 CYP	No Score	No Score	C2
Before the operations or procedures, did hospital staff explain to you what would be done?	8-15 CYP	No Score	No Score	C2
Afterwards, did staff explain to you how the operations or procedures had gone?	8-15 CYP	No Score	No Score	C2
When you left hospital, did you know what was going to happen next with your care?	8-15 CYP	6.59	About the same as other trusts	C2

(Source: CQC Children and Young People's Survey 2016, RCPCH)

Is the service responsive?

Service delivery to meet the needs of local people

The service provided a 24 hours, seven days a week children's and neonatal service. The service did not operate on children under the age of eight years; they were transferred to another hospital.

The children's ward had initiated an open access scheme where children with long term conditions could access care without going through a formal GP referral.

There was large dedicated playroom, which contained toys and recreational material for all ages and a book trolley. The playroom was only used for play purposes and not used for any clinical interventions.

We saw that the neonatal unit was tranquilly decorated and very quiet and well organised. Following the previous CQC inspection, the special care baby unit had been refurbished and had developed a new parents kitchen and sitting room, both well decorated and peaceful. We saw that there was a well-equipped parents room with magazines, television and comfortable seating.

A secure parents kitchen adjacent to the parents room allowed for the making of tea and coffee. Resident parents were provided with breakfast, lunch and dinner.

On the children's ward, although parents did not have individual room accommodation, the facilities for their welfare including the kitchen sitting room and the shower room accommodation was good. Parents said they were happy to stay with their children by the bedside on 'put you up' beds.

The children's ward did not have a dedicated cubicle or area for adolescent patients. The play specialists had created a screened off adolescent recreational area, entitled the teenage hangout hub, with age appropriate activities available such as DVD's and table football.

We spoke with all three play specialists during the inspection and saw that play provision was very good with access to a range of distraction toys and games. The provision of play was very good within the children's ward with play specialist availability Monday to Friday. The play team provided well stocked cupboards for staff to use at the weekends when no play specialist was available.

Adjacent to the main playroom was a large well-equipped outdoor play area where children could engage in safe play weather permitting. The play environment was enhanced with many donated toys.

The children's ward was host to a small community nursing team, which operated the observation and assessment unit and visited children in their homes after discharge from the ward. At the time of our visit the team were also providing school nurse cover within a local special school because of illness. This was compromising their ability to provide optimum services to discharged children. During busy period, the care of children within the ward took priority over the care of discharged children in the home. Three junior doctors we spoke with had some concerns about the availability of the community nurses.

The trust performed better than other trusts for one question, worse than other trusts for one question and about the same as other trusts for the remaining 11 applicable questions relating to responsiveness in the CQC Children and Young People's Survey 2016.

The trust performed better than other trusts for the question 'For most of their stay in hospital what type of ward did your child stay on?" scoring an average of 9.96 out of 10. This question relates to whether a child is treated on an adult ward due to bed shortages.

The trust performed worse than other trusts for the question 'Did a member of staff give you advice on how to look after yourself after you went home?' scoring an average of 6.52 out of 10.

CQC Children and Young People's Survey 2016 questions, responsive domain, East Cheshire NHS Trust

Question	Age group	Trust score	RAG	KLOE
For most of their stay in hospital what type of ward did your child stay on?	0-15 adults	9.96	Better than other trusts	R1
Did the ward where your child stayed have appropriate equipment or adaptations for your child's physical or medical needs?	0-15 adults	8.13	About the same as other trusts	R1
Did you have access to hot drinks facilities in the hospital?	0-15 adults	8.52	About the same as other trusts	R1

Were you able to prepare food in the hospital if you wanted to?	0-15 adults	3.38	About the same as other trusts	R1
How would you rate the facilities for parents or carers staying overnight?	0-15 adults	6.95	About the same as other trusts	R1
Was the ward suitable for someone of your age?	12-15 CYP	No Score	No Score	R1
Were there enough things for your child to do in the hospital?	0-7 adults	7.99	About the same as other trusts	R2
Did your child like the hospital food provided?	0-7 adults	6.10	About the same as other trusts	R2
Did a staff member give you advice about caring for your child after you went home?	0-15 adults	8.04	About the same as other trusts	R2
Did a member of staff tell you who to talk to if you were worried about your child when you got home?	0-7 adults	8.60	About the same as other trusts	R2
Were you given any written information (such as leaflets) about your child's condition or treatment to take home with you?	0-15 adults	7.18	About the same as other trusts	R2
Were there enough things for you to do in the hospital?	8-15 CYP	5.87	About the same as other trusts	R2
Did you like the hospital food?	8-15 CYP	No Score	No Score	R2
Did a member of staff tell you who to talk to if you were worried about anything when you got home?	8-15 CYP	6.91	About the same as other trusts	R2
Did a member of staff give you advice on how to look after yourself after you went home?	8-15 CYP	6.52	Worse than other trusts	R2
Did the hospital give you a choice of admission dates?	0-7 adults	No Score	No Score	R3
Did the hospital change your child's admission date at all?	0-7 adults	No Score	No Score	R3

(Source: CQC Children and Young People's Survey 2016, RCPCH)

Meeting people's individual needs

The service took account of patients' and their families' needs.

The children's ward was especially responsive to children and young people with learning disabilities and others on the autism spectrum. The hospital had introduced a learning disability 'passport' system and children were also identified within the medical record. There was specific equipment for staff to use to help engage and care for children and young people with learning disabilities, for example multisensory toys and a projector within the treatment room.

We saw that there was significant emphasis on communication with autistic children throughout the children's ward. The children's ward had a communication box which had been specially developed to help staff communicate with children using among others, Maketon and basic sign

language. Members of the play team were Maketon users. Makaton is a language programme using signs and symbols to help people to communicate. We saw that the box also had considerable information and emphasis on ethnicity.

There were a number of posters highlighting and identifying individual nurses and play specialists as champions for children with learning disabilities or autism were prominently displayed around the ward area. The trust had also introduced a complex care team who were available to assist the staff within children's services when they needed advice on providing care to a particular child with learning disabilities, especially when exhibiting challenging behaviour.

We saw that the National Autistic Society had accredited the children's ward and we saw details from their accreditation notes that the ward staff had taken important steps to audit their progress in providing optimum care for children with autism improving signage around the ward and the introduction of "all about me sheets" which provided key information about a child on the ward with autism.

The ward staff had developed special recreational bags for children with mental health issues. These bags contained a stress ball, fidget spinner and ear plugs to minimise noise from younger children. For children with food aversions the play team worked with the speech and language therapist to develop therapeutic food play.

The special care baby unit had a purpose made booklet to give the parents an insight into the care of their baby and to answer some of the questions that they might have. The children's ward and the special care baby unit had a large range of information leaflets for carers. We saw that it was possible for these to be made available in other languages such as Polish.

Staff had sufficient access to appropriate translation and advocacy services to support patients with language and communication challenges. Nurses told us that translation services could be booked for direct face-to-face and remote telephone interactions. They told us the service was accessible and timely. The staff we spoke with understood when it was appropriate to use family member to translate and when to use a professional interpreter, for example when given specific clinical information and when obtaining consent.

Although there were no Child and Adolescent Mental Health Services staff based within the trust, the consultants and senior nursing staff we spoke with told us that the relationship between service staff and Child and Adolescent Mental Health Services was good and they were available during office hours Monday to Friday for telephone consultation and individual visits to children on the ward.

There was access to clinical nurse specialists including an allergy nurse, an asthma nurse, an epilepsy nurse and a diabetes nurse.

Hard to reach groups of children were accessed through strong working links with the cohort of paediatric community nurses who were employed by the trust as an adjunct to the staffing complement of the children's ward, This was undertaken on a case by case basis as the numbers of such children were very low.

However, the examination of looked after children was not being undertaken to meet the 20 day standard and this was attributable to deficiencies in the training of doctors and their availability. This was being undertaken by one single registrar and two part time community paediatricians.

Access and flow

Between the 1 September 2016 and 31 August 2017, the trust had 3650 admissions to children's services, 512 children admitted to other services including surgery and maternity services and they saw 9257 children in outpatients. Children are defined as 17 years and under.

Children were admitted via the emergency department or via their GP to the paediatric ward. Children were also admitted as elective day cases for surgery.

The trust had consistently achieved over the 92% standard for the percentage of patients who were waiting less than 18 weeks from point of referral to treatment for patients who were on an admitted or a non-admitted pathway. This ranged from 98.2% to 100% for April 2016 to March 2017.

The trust did not have dedicated paediatric lists for ophthalmology, ENT and orthopaedics services which all operate on children. Children were allocated the first slots on the speciality list. Approximately 40 children a month were operated upon including a dedicated community dental list. All paediatric patients were admitted on the day of surgery to the children's ward as day cases. The trust did not do emergency surgery on children aged eight years and under.

There was no rapid access to services for general practitioners, although there were plans to start a new service for them in February 2018. The matron told us that she intended to address friends and family test concerns pertinent to waiting times by introducing a rapid access pathway forward attenders requiring blood tests in February 2018.

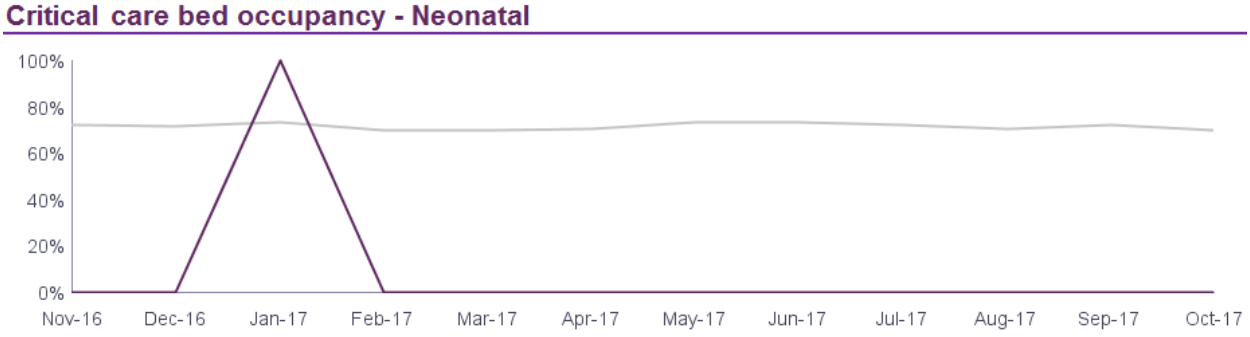
There was currently no 'hotline' that GP's could use to contact a duty consultant. However, GP's could telephone the on call registrar for advice and information and referral.

The outpatient department updated families with clinic waiting times and delays within the outpatient department through a special notice board. This strategy allowed families to leave the department to have for example a coffee.

Data from September 2017 showed that the outpatient department had a 91% attendance rate. The department had a policy to manage children who were not brought to attend.

Neonatal Critical Care Bed Occupancy

From November 2016 to October 2017 the trust reported neonatal bed occupancy to be 0% in all months except for January 2017 where they reported bed occupancy of 100%, this is better than the England average.



Note data relating to the number of occupied critical care beds is a monthly snapshot taken at midnight on the last Thursday of each month. The 0% rates reported in this section may be due to no admissions during some months.

(Source: NHS England)

Learning from complaints and concerns

From October 2016 to November 2017, there were five complaints about Children's services. These were all responded to within either the 25 or 45 day internal trust standard in accordance with their policy.

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

During the inspection, we reviewed the complaints from December 2016 through to December 2017 and saw that there were eight complaints and six patient advice and liaison service (PALS) queries. The complaints were rated as very low or low impact and included appointment complaints and communication difficulties. PALS queries were also rated as of low concern and ranged from outpatient waiting times through to concerns about blood tests.

We saw that action was taken to learn from complaints. The matron told us that she was working closely with the outpatient booking manager to develop a dedicated adolescent clinic for patients with diabetes within the outpatient department.

Parents we spoke with told us that they had some concerns about not being able to use their phone chargers because they had not been electrically safety tested; the matron had addressed this by having a supply of suitably tested phone chargers available for parents to use. Parents also told us that there were some problems with accessing food while they were resident on the ward with their sick children. The matron was in dialogue with the catering department to resolve this issue.

Senior ward nurses told us they tried to address concerns as they arose by speaking with patients and families directly and explained how they would address their concerns and follow up with them.

Is the service well-led?

Leadership

There were established and stable leadership teams in the services.

The children's (paediatric) services were part of the acute and integrated care directorate. The directorate was led by a clinical director and associate director. They were supported by a deputy director of nursing in the corporate team. There was a designated clinical lead for paediatrics and clinical manager/matron.

Neonatal services were part of the planned care services directorate. The directorate was led by a clinical director and associate director. They were supported by a clinical lead and head of midwifery.

Staff told us senior leaders of the service were visible, approachable and supportive and they felt that children's services were generally well-led.

All of the staff we met told us that service leadership had a good understanding of frontline challenges on wards and in clinical areas and we found positive and collegiate working relationships.

There was a new matron for children's services who had taken a lead role in addressing areas for improvement identified following the last CQC inspection.

We were told that the chief executive maintained a high profile within the clinical areas and that he conducted walkabouts within children's services and had joined ward meetings.

The director of nursing was the board champion for neonates and children's services.

Vision and strategy

The trust was working with partners to determine the long-term vision and strategy for service provision across the health economy.

At the time of inspection, there was no clear strategy for the children's services.

The trust worked within the neonatal strategic networks for the region. We saw there was a draft regional maternity transformation strategy that included strategic objectives for neonatal care.

Culture

Throughout our inspection we saw that there was an inclusive and constructive working culture within the service. We found highly dedicated staff who were very positive, knowledgeable and passionate about their work and passionate about caring for children and young people.

All of the clinical staff we spoke with, including doctors, nurses, and therapists consistently reported approachable and supportive colleagues and an inclusive and welcoming working environment. The staff we met told us they felt cared for, respected and listened to by their peers and managers.

We saw that the trust values were prominently displayed within the clinical areas and staff were familiar with these.

The doctors and nurses we spoke with told us there was a culture of improvement and the trust was creative in its approach to delivering and developing services. Staff had worked hard since the last CQC inspection and had worked together to make improvements in care delivery.

The staff we met recommended the trust as a place to work and told us the trust was an enjoyable and rewarding workplace, both educationally and managerially. They highlighted the supportive environment as a reason for this.

Governance

Governance structures were in place across the service and staff felt they were effective.

A service specific, comprehensive document, the quality governance data set, was produced monthly. We reviewed this specifically for paediatrics. This included, as standard, information on incidents, complaints, compliments, risk register, information governance and record management, audit, patient feedback/surveys, policies/guidelines and claims.

The services held regular planned governance meetings. There were monthly directorate safety, quality and standards sub-committees. These were attended by the senior members of the management teams, such as matrons. This sub-committee reported by exception to the trust-wide safety, quality and standards committee which was a sub-committee of the board.

The services held quarterly mortality and morbidity meetings.

We saw that children's services were considered at board meetings. Strategic transformation of children's services had been raised at the public board meeting in June 2017. The board had also received an annual report on safeguarding, which included safeguarding children, in June 2017. The director of nursing performance and quality was the named accountable officer.

Management of risk, issues and performance

We examined the risk register and saw that there were five priority areas of risk which had been identified by the trust. These were the non-availability of a transport incubator within the special care baby unit, lack of bespoke parenteral nutrition for babies residing on the special care baby unit, lack of a transition protocol for children with epilepsy, shortages of paediatricians and delays with CAMHS assessments. CAMHS services were provided by another trust. These risks mostly reflected those identified on inspection.

There was a process for reviewing the risk register; this was completed and recorded at the monthly safety, quality and standards sub-committees.

We saw that all incidents were discussed within clinical governance meetings and that root cause analysis, which is the structured method used to analyse serious adverse events, was implemented when required.

Performance was monitored and managed at directorate level. A directorate board meeting was held monthly. A monthly performance meeting was held with the director of nursing performance and quality and the finance director. A performance dashboard was available at directorate and service level.

Children's services contributed to relevant local and national patient outcome and performance audits, including benchmarking activities and peer review with other local NHS hospital trusts. The matron who had been appointed following the previous CQC inspection, had made benchmarking visits to a range of similar children's units. A number of initiatives had been implemented, such as a top tips initiative to make the nursing handover more focused.

Information management

There was an understanding of performance, which sufficiently covered and integrated people's views with information on quality and operations.

Ward-level dashboards were available. Performance dashboards and governance data sets at service level were used to monitor and improve performance.

There were computer stations with intranet and internet access available throughout the service and there were sufficient numbers of computers on wheels for staff to access information.

We saw that there were standardised quality information boards on both the special are baby unit and the children's ward across which provided current quality data such as staffing levels and safety performance. Notice boards along the ward corridors were neatly organised with information for staff and patients, including visiting hours, protected meal times and senior nurse contact details.

Information governance was considered in the quality governance data set and reviewed at governance meetings.

Engagement

The children's ward had developed a "you said we did initiative" to communicate to families what actions had been taken following the raising of an issue. For example, parents reported that the chairs on the ward were uncomfortable when feeding a baby. This had been addressed through the provision of new seating arrangements.

Prominently displayed friends and family test cards and boxes were available on the ward and we saw that there was a patient feedback board which gave details of the customer care service with questionnaires for family members to complete if they wished.

Staff told us there was good communication from the trust and they felt that children's services were well represented in the trust by the senior team. The trust provided a number of communications in the form of regular newsletters and all staff emails which highlighted local news, achievements, changes and policy updates. Most of the staff we spoke with felt well informed and supported, and were passionate about the trust values.

The service had not used 'You're Welcome' or '15 Step Challenge' models of gathering patient feedback.

There were examples of service co-design, for example parental involvement in the redevelopment of the special care baby unit. Parents and families who had used the service had participated in a comprehensive survey about the facilities of the unit.

Learning, continuous improvement and innovation

The service had taken action to address the main areas that required improvement at the previous inspection.

There were trust recognition awards in place. The neonatal unit was awarded best infection control team of the year.

The neonatal unit was part of the maternity unit accredited UNICF level 3 award where the focus was on ensuring that the Baby Friendly standards were implemented for all pregnant women and new mothers.

Consultant paediatricians and nurses were involved in research with a regional children's hospital.

Community health services

Community health services for adults

Facts and data about this service

Information about the community adults services

There are five community nursing teams in East Cheshire plus an out of hours service, which operates between 5pm and 8am. The teams cover the following areas: Macclesfield, Congleton, Holmes Chapel, Knutsford, Poynton, Bollington, Disley, Chelford, Alderley Edge and Wilmslow.

The community nursing teams provide palliative care, wound management including management of pressure ulcers and leg ulcers, injections, phlebotomy and bladder and bowel care to people in their own homes. In addition there is community matron input to each team. They are advanced clinical practitioners who manage a caseload of patients with complex needs with the support of the patient's own GP.

The community rehabilitation team is a multi-professional therapy team, who work jointly to assess and treat a wide range of musculoskeletal, respiratory, and neurological conditions, and adults with acquired communication difficulties and/or dysphagia (swallowing difficulties) within a patient's own home. The rehabilitation team aim to reduce a patient's functional limitations that may arise from a physical disease, disability, injury or degenerative condition, promoting maximum levels of independence and quality of life.

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

Details of sites providing community services for adults

Information about the sites, which offer services for adults at this trust, is shown below:

Macclesfield District General Hospital: Victoria Road, Macclesfield, Cheshire, SK10 3BL

Team/ward/satellite name	Number of clinics per month	Geographical area served
Community Nursing (Leg ulcer Clinic)	2 per week	East Cheshire CCG footprint
Community Nursing (Dopler Clinic)	1 per week	East Cheshire CCG footprint

Handforth Clinic: Wilmslow Road, Handforth, Cheshire, SK9 3HL

Team/ward/satellite name	Number of clinics per month	Geographical area served
Community Nursing (Leg ulcer Clinic)	1 per week	Handforth
Audiology	N/A	
Rheumatology	N/A	
Epilepsy	2	Handforth
Parkinsons	1	Handforth

Respiratory	N/A	
Weight management	1 x biweekly	Handforth
Podiatry	16 per week	Handforth
Continence	1	Handforth

Poynton Clinic: The Civic Centre, Park Lane, Poynton, Cheshire, SK12 1QY

Team/ward/satellite name	Number of clinics per month	Geographical area served
Community Nursing (Leg ulcer Clinic)	2 per week	Poynton
Physio - AHP	52 per month	Poynton
Midwives	3 per week	Poynton
Parkinsons	1	Poynton
Epilepsy	1	Poynton
Speech and Language	NO clinics currently running	Poynton

Wilmslow Health Centre: Chapel Lane, Wilmslow, Cheshire, SK9 5HX

Team/ward/satellite name	Number of clinics per month	Geographical area served
Community Nursing (Leg ulcer Clinic)	1	Wilmslow
Continence	No clinics currently running	Wilmslow
Audiology	6	Wilmslow
Podiatry	22 per week	Wilmslow
Physio-AHP	74 per month	Wilmslow

Other locations and services

Location/Site Name	Team/ward/satellite name	Number of clinics per month	Geographical area served
Congleton War Memorial Hospital, Canal Street, Congleton, Cheshire, CW12 3AR	Community Nursing (Leg ulcer Clinic)	2 per week	Congleton
Holmes Chapel Health Centre, London Road, Holmes Chapel, Crewe, Cheshire, CW4 7EB	Community Nursing (Leg ulcer Clinic)	2 per week	Crewe
Knutsford & District Community Hospital, Bexton Road, Knutsford, Cheshire, WA16 0BT	Community Nursing (Dressing Clinic)	1 per week (weekends)	Knutsford

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

Is the service safe?

Mandatory training

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

Mandatory training for staff included a range of core statutory and clinical modules. Core statutory modules included health and safety, safeguarding adults and children, infection control, fire safety, equality and diversity, and preventing radicalisation.

Core clinical e-learning modules included consent, Mental Capacity Act 2005, deprivation of liberty safeguards, learning disabilities awareness, and record keeping.

Annual core classroom modules varied by staff group in the hospital. For community-based staff this included training modules in end of life care, infection prevention and control, anaphylaxis and record keeping. Community staff told us they were trained in basic life support.

At the time of the inspection, across the directorate, 95.4% of staff had completed statutory and mandatory training, against the trust's target of 90%. 84.1% of staff had annual clinical update training (target 74%), while 73.4% had completed core clinical e-learning training (target 65%). Ninety-one per cent of directorate staff had completed the information governance training against a target of 95%.

The service's allied health professionals had completed 99% of core statutory and mandatory training. Ninety-four per cent of these staff had completed core clinical e-learning training modules.

Some staff told us the trust's mandatory training booking system was difficult to manage as staff had to be booked individually rather than as a block booking. Staff also told us that some e-learning still showed outstanding when they had been completed.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff were able to recognise and describe the types of concerns that would be reported as potential safeguarding referrals. This included an awareness of female genital mutilation and child sexual exploitation.

The service's electronic system displayed warning alerts on any patient records where there had been previous safeguarding concerns raised.

At the time of the inspection, across the directorate, 95.4% of staff had completed safeguarding vulnerable adults and children level one; 84.7% had completed safeguarding adults level two and 82.9% had completed safeguarding children level two; and, 92.7% of eligible staff had completed safeguarding children level three training. These were against the trust's targets of 90% for level one training and 80% for level two and level three training.

We do not have a separate breakdown for safeguarding training completion rates for community matron and nursing staff. However, 93% of allied health professional staff had completed safeguarding vulnerable adults level two training and safeguarding children level two training. One

hundred percent of nutrition and dietetics staff (the only group for which this training had been identified as necessary) had completed safeguarding children level three training.

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 have 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.

Figures provided by the trust covering all community services are provided in the table below.

Total number of referrals		
Adults	**Children**	**Total referrals**
381	67	448

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

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff kept equipment and the premises clean. They used control measures to prevent the spread of infection.

We observed staff adhering to cleanliness, infection control and hygiene practices including aseptic non-touch techniques. Staff wore personal protective equipment, including disposable aprons, when providing clinical care to patients.

We observed staff washing their hands before and after contact with patients in clinics and within patients' homes. Community nursing staff also had, and used, antibacterial spray when visiting peoples' homes. Hand hygiene audits were carried out across the range of community services. We viewed a range of these audits, which all showed high levels of compliance. Areas of improvement were discussed with the individual staff members involved.

We observed staff adhering to the 'arms bare below the elbow' protocol.

There were sufficient antibacterial gel dispensers and hand washing facilities in the premises we visited.

Premises used in the provision of care and treatment were visibly clean and tidy. Environmental cleaning was undertaken by cleaning contractors, or through arrangement with the landlords of the premises. Cleaning schedules were in place; however, we were unable to view the daily cleaning logs during our visit as these were held by the external cleaning contractors. Community adult staff were responsible for cleaning any equipment used.

Environment and equipment

The service had suitable premises and equipment and generally maintained them well; however, the facilities in some locations were limited by the aging environment or issues outside the service's control.

Care and treatment provided in clinics was delivered from a range of premises and locations, including community hospitals, shared use modern polyclinics, and GP surgeries.

The design, maintenance and use of the facilities in the premises we visited was appropriate for the services being delivered and kept people safe.

However, staff in a number of the older premises told us they were concerned about the aging environment, and responsiveness of the administrative and computing equipment. We were told that, in the Knutsford community nursing office, staff only had use of two telephones due to limitations of the building's telephone service. In Holmes Chapel, staff were unable to connect to the trust's computer system due to an inability to reach agreement on installation of appropriate server equipment and lines with the building's landlord. The community nursing office in Congleton was in a poor state of repair with large cracks in the wall and a faulty boiler, which staff told us required maintenance 'most weeks'.

Staff across the service broadly felt they had the equipment needed to provide safe care and treatment to their patients. This included any specialist equipment needed to provide care and treatment in patients' homes. Staff knew how to report faulty equipment used in patients' homes.

Community nursing staff had computer tablets with remote connectivity to access and update patient records. This was in line with the trust's move towards a 'paper light' environment. The service was in the process of rolling out larger tablets that were easier for staff to use, which included an offline facility for use when no mobile signal was available.

Clinical waste was appropriately segregated with posters displayed in some clinic rooms to assist staff in identifying which items should be disposed of in which bin.

We checked a range of equipment in store rooms across the community adults' service. The majority of items checked were stored appropriately and within the manufacturers' recommended expiry dates. We identified a minimal number of pieces of equipment, such as syringes that had passed their expiry dates. We raised this with staff on-site who immediately removed the items.

Portable electronic appliances were tested appropriately and maintenance logs were up to date. The trust's procurement team prompted sites two months prior to the expiry of equipment maintenance dates.

Community audiology staff confirmed they had all the necessary equipment to carry out their roles.

Assessing and responding to patient risk

Staff were not supported by the systems and processes in place to consistently identify, assess, respond to, or manage patient risks and care needs appropriately.

Referrals to the community matron and community nursing teams were triaged on receipt and were prioritised according to clinical need in line with the service specification. Urgent referrals required a visit within four working hours, non-urgent within 48 hours, and routine referrals at a mutually convenient time.

Daily reviews of clinical need demand against capacity were undertaken by team leaders using a red (capacity less than 60%), amber (capacity between 60% and 75%), yellow (capacity between

75% and 90%) and green (capacity greater than 90%) system. This included triggers for escalation of staff shortages and fed into the service's risk assessed data report.

A separate red, amber, green review was undertaken of daily individual community nurse caseloads. This had been commenced in November 2017 and was still embedding but aimed to provide flexibility for staff to move appointments. The review looked at clinical need, which enabled staff to postpone visits to non-urgent (green) patients by 24 hours. Reclassification of rescheduled visits was a manual process.

Community nursing handover meetings were carried out twice a week to ensure all team members were aware of any relevant patient issues. These meetings were in addition to daily staff discussions about any relevant patient information. The meetings were structured using a tool (the 'Five P's' that reviewed patients by 'primary visits' (new referrals); 'pins' (lower leg problems); pressure ulcer management; palliative care; and prevention/avoidance of hospital admission.

We saw evidence that appropriate falls, pressure ulcer, mobility, and nutritional risk assessments were carried out in line with the service's standard operating procedure for the district nurse/community matron nursing record.

The operating procedure indicated that care provided by community matron and nursing teams was template driven on the electronic system. Electronic templates were available within the system for a range of visit types, such as wound assessment and treatment. The procedure required staff to review and update the template with any change in condition, details of the care provided, and notes or instructions that needed to be considered for future care.

We reviewed 16 sets of records held on the service's electronic system and paper summary records held in patients' homes. However, the electronic system did not support, nor were staff able to show us, the development of detailed, individualised holistic care assessment or treatment goal plans or evaluation and re-assessment of any treatment interventions carried out. The patient treatment summaries were brief and consisted mainly of a list of interventions to be carried out.

One staff member told us staff relied on knowing their patients to understand future plans for the patient's care. Staff also told us of two examples where they felt a lack of detailed care planning and treatment summaries were contributing factors in patient harm in two cases. In the first case, an agency nurse had repeatedly not recognised or taken action on the deterioration a patient's leg wound. A second case involved a potentially preventable reportable pressure ulcer. Another staff member told us that although the electronic system enabled wounds to be photographed, if more than one wound was being treated at any one time the system did not easily enable staff to update the details of each wound.

Therefore, although community matron and nursing staff completed records in line with the trust's standard operating policy for the electronic system, we were not assured that the treatment plans were of sufficient detail or quality to enable staff to adequately plan individualised patient treatment and care goals, to assess progress against these, or to reasonably mitigate the risks to the health and safety of patients receiving care and treatment. This meant there was an over-reliance on staff knowledge of individual patients to mitigate any ongoing or developing risks to patients. This was particularly relevant in situations where care was provided by staff, or agency staff, who may be unfamiliar with the patient.

Staff in the physiotherapy team also told us the electronic system did not have an option to develop a care plan that could be updated. The Parkinson's service solely used paper records. We saw clear evidence of detailed care planning, risk assessments, and evaluation of care.

However, the community adult's service was linking with other health and social care organisations in the area to provide wrap around care. This meant that, for example, podiatry staff attending to a patient within a nursing home could, if there were concerns that the patient may fall, refer the patient directly to a physiotherapist for a falls assessment.

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.

Caseloads within community adults' services

The trust provided the below information about their caseloads within community adults services.

Name of team	Number of patients with an open referral	Average Caseload per WTE
Community Health and Wellbeing Team	1,109	61.68
Congleton / Holmes Chapel	910	68.73
Knutsford	695	81.19
Poynton/Bollington	614	68.53
Waters Green Team 1	1,119	90.39
Waters Green Team 2	874	70.94

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

Caseloads varied between community nursing teams and individuals due to the demographics of the different areas, and the complexity of the patients. Although staff told us they felt caseloads were high, staff were able to triage and plan visits to patient by clinical needs.

Safer Staffing levels

Staffing levels were recognised as one of the main challenges faced by the service and were included on the directorates risk register. However, at the time of the inspection, the community matron and community nursing services had a workforce of 76.6 whole time equivalent against a planned establishment of 78.9 whole time equivalent staff. This equated to a low vacancy rate of 2.8% whole time equivalent staff. Leaders in the service were aware there would be future pressures on staffing levels as a result of an aging staff demographic.

Community matron and nursing staff caseloads took into account patients' location, health conditions, and complexity of individual needs and levels of acuity. Caseloads therefore varied within each team. However, although staff expressed views that caseloads could be heavy at times, our review of staffing caseload diaries did not indicate any evidence of impact on patient safety.

We reviewed staffing level information between August 2017 and December 2017 provided by the trust for the allied health professionals within the community adult's service. Available data supported the service leaders' views that staffing levels within the physiotherapy and occupational therapy specialisms was a pressure point as these had the largest numbers of staff vacancies. However, we found no evidence to indicate that allied health professional staffing levels within the service had impacted on patient care or safety; the therapies services continued to meet the service's referral to initial assessment targets.

The service manager told us that retention and recruitment was a particular challenge, with low levels of interest in a recent band five job advert. The service planned to start work with Keele University in January 2018 to identify physiotherapy and occupational therapy students due to graduate and to work with them to highlight the benefits of working for the service and the NHS.

The community physiotherapy service had also introduced a telephone triage system. Staff were able to prioritise patients with the greatest needs which, in conjunction with staff covering additional shifts, reduced the impact of the vacancies.

Vacancy rates

Vacancy rates data provided by the trust between September 2016 and August 2017, reported a vacancy rate of 3.5% for nursing staff within community services for adults. In the most recent month August 2017, vacancy rates for medical staff were reported to be 5%, however for some months over the whole year medical staffing was reported to be over establishment. The trust target was 7.0% so for this core service was met for both medical and nursing staff.

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

Turnover rates

Between September 2016 and August 2017, the trust reported a turnover rate of 19.7% in community services for adults (this figure covers nursing staff only as no medical staffing turnover rates data were provided for community services for adults); this did not meet the trust target of 15.6%. Overall trust turnover rates for nursing staff were 11.5%.

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

Sickness rates

Between September 2016 and August 2017, the trust reported a sickness rate of 0% for medical and dental staff and 4.8% for nursing and midwifery staff in community services for adults, just marginally above the trust target of 4.6%. Overall sickness rates at the trust were 4.9% for nursing staff and 1.8% for medical staff.

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

Bank and agency rates for nursing staff

Between September 2017 and December 2017, 311 community nursing shifts were covered by bank or agency staff.

Medical staffing

The service only classed GP out-of-hours doctors as medical staff within the community's specialisms. Sixteen staff (4.8 whole time equivalent) carried out regular out of hours duties, while the remaining shifts were covered by locum doctors.

Locum and agency rates for medical staff

Between August 2017 and December 2017, 433 GP out-of-hours shifts were covered by locum staff.

Suspensions and supervisions

Between August 2016 and July 2017, the trust reported no staff were either suspended or placed under supervision within community adults.

Quality of records

Staff kept up-to-date records of patients' care and treatment in line with the trust's standard operating procedure. Records were available to all staff providing care.

The community nursing and community matron teams primarily used the service's electronic system, which could be accessed and updated remotely using electronic tablets. Records were therefore clear, legible and appropriately date and time stamped with the staff members' names.

The electronic records enabled staff to access patient GP records and records from other health professionals that had access to the shared system. This meant staff could access other relevant information about their patients, although we observed the need for staff to access a number of screens and tabs in order to find all relevant information.

Staff updated the electronic and/or paper records after each episode of patient care. Records we viewed had been updated. The trust's 2016 records audit provided the latest information available on compliance on the quality of record keeping within the directorate. Overall compliance against the audited standards for community nursing and community matron staff, adult physiotherapy, the epilepsy service and the tissue viability service was 85% against the trust's target of 75%.

The therapies teams developed integrated physiotherapy and occupational therapy assessment documentation which meant patients had one set, rather than multiple sets, of notes.

Medicines

The service prescribed, gave, and recorded medicines well. Patients received the right medicine at the right dose at the right time.

Community nursing staff (with the exception of those caring for patients at the end of life) did not administer controlled medicines.

None of the premises we visited stored stocks of medicines. Where it was necessary to transport temperature sensitive medicines, such as vaccines, staff had access to cold storage bags. Staff only transported the minimum amount of medicine needed for each episode of care provided. Maximum and minimum temperature levels in the cold storage bags were monitored.

Community nurses carried emergency anaphylaxis kits on visits to patients' homes. These were provided in sealed containers with a clear expiry date displayed.

We received inconsistent information from staff about notification of kits that were due to expire. Two staff members told us that expiry dates for the anaphylaxis kits were logged by trust pharmacy staff and that email notifications were sent to community nurses when a kit was due to expire. However, another staff member told us this notification process had been discontinued and community nursing staff were responsible for checking the expiry date.

A pharmacist technician confirmed that the pharmacy managed the replacing of expired stock, and held a log of the batch number, expiry dates and the name of the staff member the kit had been issued to. Pharmacy staff scheduled checks with staff each month, but it was recognised there may be gaps in the contact details for community staff who may not have updated their contact telephone number. Although we found no evidence of expired anaphylaxis kits, there was a risk that expired kits would not be identified and replaced if community staff failed to carry out the individual checks and if the pharmacy staff did not have up to date contact details.

Community nursing staff were authorised to administer influenza, pneumococcal polysaccharide, and shingles vaccines under a patient group direction. A patient group direction, signed by a

doctor and agreed by a pharmacist, enables an authorised nurse to supply or administer prescription-only medicines to patients using their own assessment of patient need, without referring back to a doctor for an individual prescription. We viewed the authorisation forms which were completed and signed appropriately.

Community matrons and a number of community nursing staff had received nurse prescriber training and were able to prescribe a range of medicines. This reduced any delay in the administration of medicines to patients.

We reviewed seven community patient prescription and administration records during our visits to patients' homes. The prescriptions were legible, recorded patient's allergies, and noted medicine batch numbers and expiry dates.

Safety performance

The service used safety monitoring results well. Staff collected safety information and the service used it to improve the service.

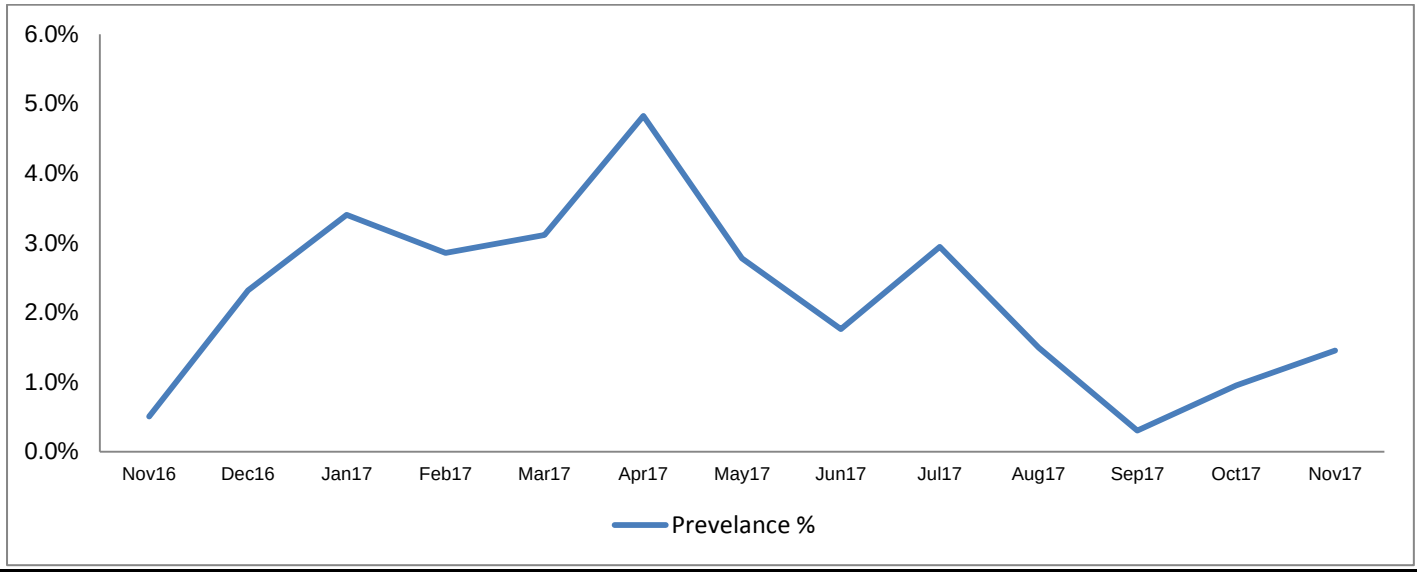
Safety Thermometer November 2016 to November 2017

The NHS Safety Thermometer allows teams to measure harm and the proportion of patients that are 'harm free' during their working day. The NHS Safety Thermometer helps teams in a wide range of settings to measure, assess, learn and improve the safety of the care they provide.

New Pressure Ulcers

The trust reported 85 new pressure ulcers across all its services between November 2016 and November 2017. Every month between December 2016 and July 2017 the trust reported between six to 11 new pressure ulcers while the other months reported between one and five. Four of these new incidents were reported as moderate harm and two as severe harm.

Leaders described the prevention and reduction of pressure ulcers as one of the service's risks. Priorities for the service included the earlier identification of pressure ulcers to reduce grade three and four ulcers and to reduce the number of unstageable ulcers. The service put in place a pressure ulcer champion, an e-learning training module for staff, and developed closer links with the tissue viability team.

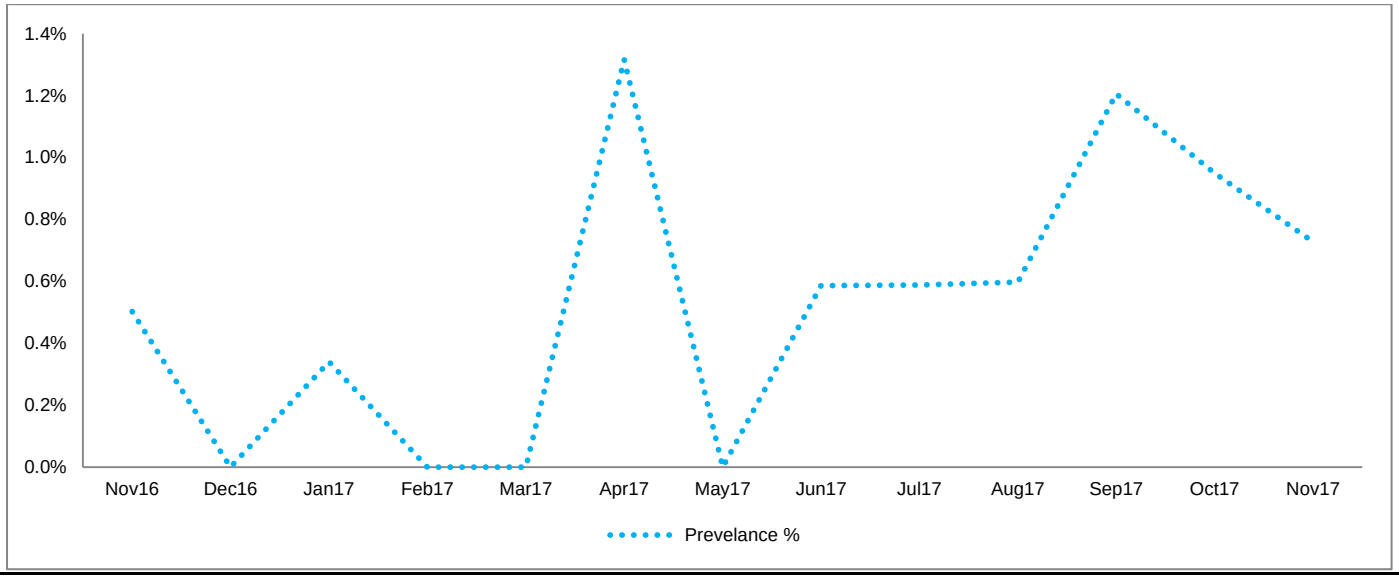


Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17

Prevalence %	0.5%	2.3%	3.4%	2.9%	3.1%	4.8%	2.8%	1.8%	2.9%	1.5%	0.3%	0.9%	1.5%
Number	2	6	10	8	10	11	9	6	10	5	1	3	4

Catheter and Urinary Tract Infections

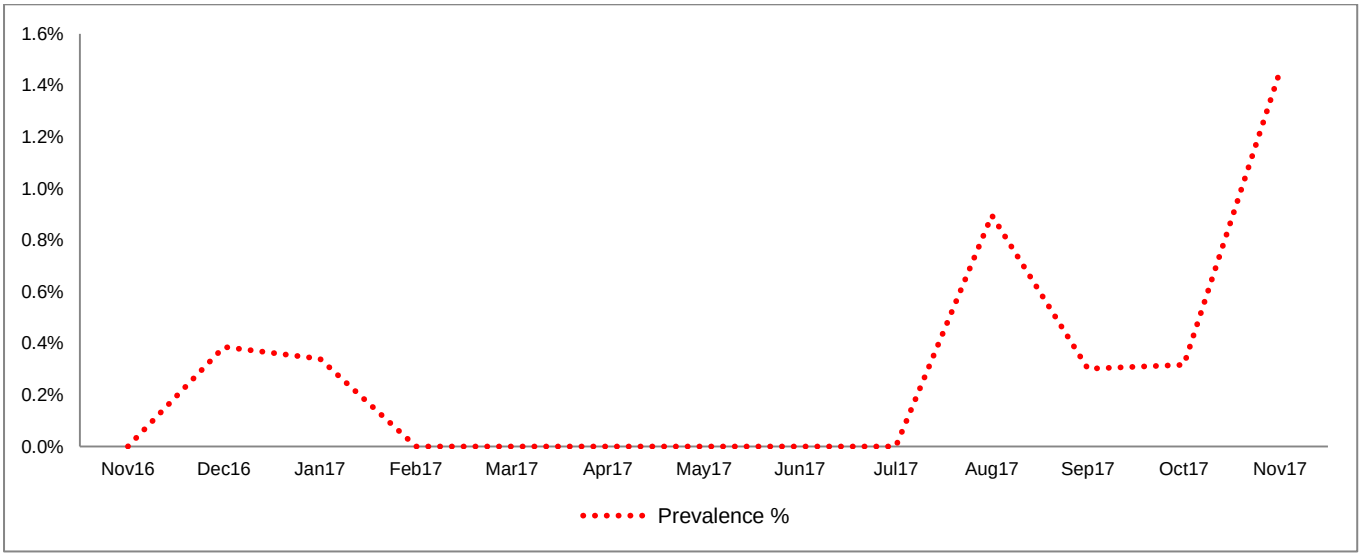
The trust reported 21 catheter and urinary tract infections between November 2016 and November 2017. No catheter and urinary tract infections were reported in four months in the period and the most that was reported in one month was in September 2017. Every month after May 2017 the trust reported more than two catheter and urinary tract infections.



	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17
Prevalence %	0.5%	0.0%	0.3%	0.0%	0.0%	1.3%	0.0%	0.6%	0.6%	0.6%	1.2%	0.9%	0.7%
Number	2	0	1	0	0	3	0	2	2	2	4	3	2

Falls with Harm

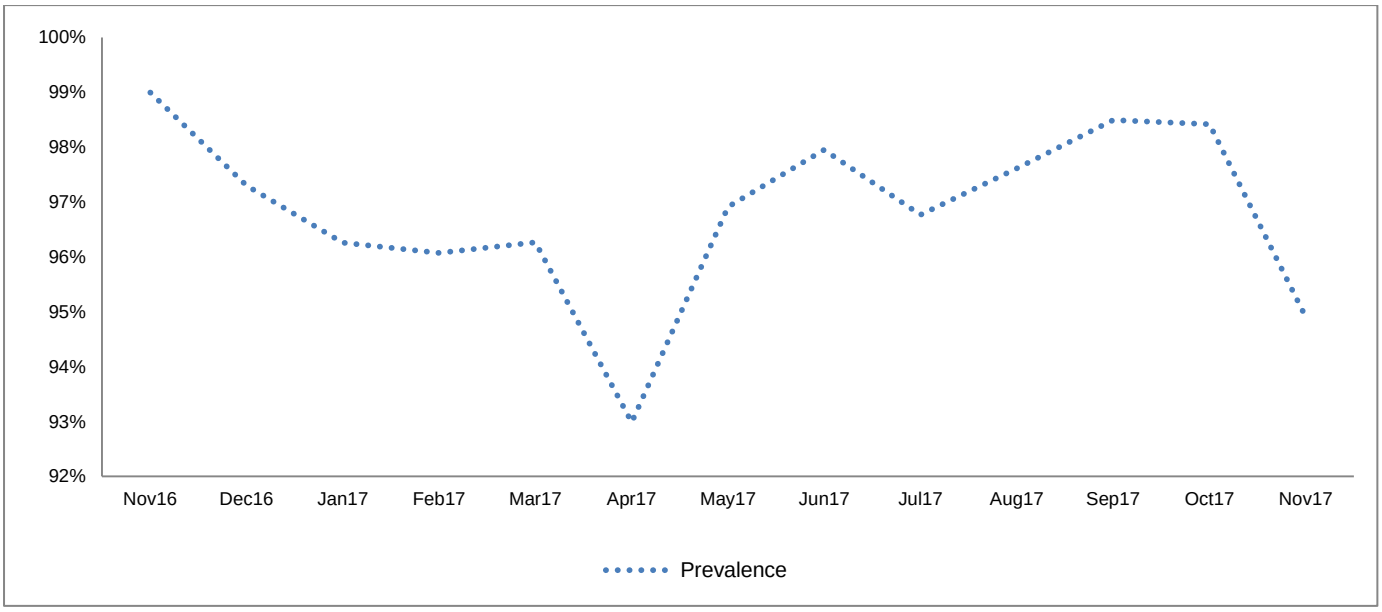
The trust reported 11 falls with harm between November 2016 and November 2017 which made up 23% of all falls (43). The most falls were reported in January 2017 of which one was a fall with harm and six in November 2017 of which four were falls with harm. There were only two falls with harm until August 2017and nine falls with harm occurred in the last four months of the reporting period.



	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17
Prevalence %	0.0%	0.4%	0.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.9%	0.3%	0.3%	1.5%
Number	0	1	1	0	0	0	0	0	0	3	1	1	4

Harm Free Care

Between November 2016 and November 2017, the trust recorded 3,922 cases of 'harm free' care out of 4,043. 93% of patients received harm free care for this period, 95% in September 2017 and 88% in April 2017. Other than the 93% harm free score for April 2017 community adult services scored between 95% and 99% for the period.



	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17
Prevalence %	99%	97%	96%	96%	96%	93%	97%	98%	97%	98%	98%	98%	95%
Number	394	252	283	269	309	212	314	334	329	327	327	311	261

(Source: NHS Safety Thermometer website)

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.

Incidents were reported through the trust's online incident reporting system. The director of nursing, performance and quality was the trust's safety lead.

There was an improved level of staff awareness of incidents and the reporting of these. Staff also reported 'interface incidents', which were incidents staff identified but were related to care or treatment provided by another health or social care organisation.

Between January 2017 and December 2017 there were 199 no harm incidents, 558 low harm incidents and 37 moderate harm incidents recorded by staff in community services. Staff reported a further 199 interface incidents.

Between October 2016 and September 2017, community adult staff reported 25 serious incidents, all of which related to reportable stage three and four pressure ulcers. Serious Incident Summary Sheets were introduced to provide staff with an overview of these incidents, lessons learnt and recommendations. Learning was reviewed through the directorate's safety, quality and standards meetings.

There was corporate governance oversight of the declaration of reportable serious incidents, and root cause analysis investigations and action plans. Directorate leaders reviewed incidents in the monthly safety, quality and standards meetings and shared learning through a quarterly report of complaints incidents claims and patient experience.

Learning from incidents was shared with staff in team, department and directorate meetings, and staff newsletters (Learning into Practice, Safety Matters and the Maternity Newsletter). Shared learning was also delivered through the trust's computer screen saver system. Staff told us there had been an improvement in the level of feedback provided following the reporting of incidents.

We saw evidence of learning from incidents being shared and put into practice. This included the provision of feedback to an individual staff member, discussion of the incident within the team meeting, and the development of a new standard operating procedure to reduce the likelihood of a similar incident occurring in the future.

However, some staff working remotely told us they did not have access to the incident reporting system while working in the community. This meant staff had to return to the base office to report incidents and there was a risk that staff may forget or omit to report incidents that had occurred.

Incidents

Trusts are required to report serious incidents to Strategic Executive Information System. These include 'never events' (serious patient safety incidents that are wholly preventable).

In accordance with the Serious Incident Framework 2015, the trust reported 25 serious incidents in community services for adults, which met the reporting criteria, set by NHS England between, October 2016 and September 2017. All of the reported incidents were pressure ulcers.

(Source: Strategic Executive Information System (STEIS))

We reviewed seven serious incident files during the inspection, six of which related to the development of pressure ulcers. We reviewed the root cause analysis investigation reports, recommendations and action plans. The investigations were detailed with evidence of immediate actions taken to ensure individual patient safety. Explanations were provided to patients, with the Duty of Candour process appropriately followed. Recommendations and action plans were in place and there was evidence of sharing and learning with staff.

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness.

Staff within the community adult service provided care in line with national guidance from the National Institute for Health and Care Excellence, and in line with the requirements and guidance from their professional bodies.

Care and treatment templates on the trust's electronic system took account of relevant guidance, and we observed staff delivering care in line with this. Staff worked within their scope of practice and competencies.

The service's policies and clinical guidelines were available on the trust's intranet, and staff knew how to locate them.

The podiatry service's clinical pathways were in the process of being updated to incorporate latest clinical and professional guidance and were being made 'user friendly'.

Best practice was shared through the clinical effectiveness and northwest leads groups which met bi-monthly.

Patient outcomes

The service monitored the effectiveness of care and treatment. Patient outcome results were positive.

The trust told us that community nursing service's aim was "to improve quality of life, maximise independence and wherever possible prevent inappropriate admission to, and facilitate timely discharge from, hospital". Performance was to be measured against the safety thermometer, the Royal Marsden manual for clinical procedures, and the CQC standards of care.

The diverse nature of patient conditions across the community services meant that collection of patient outcomes varied depending on the service provided.

Community nursing services measured a range of metrics including, although not limited to, the number of discharges home that had been supported, emergency department admission avoidance, and the percentage of patients receiving intensive community nursing prior to admission. Data provided by the trust indicated high levels of compliance, achieving the trust targets for all these measures.

Podiatry patient outcomes were monitored monthly and results were sent to the local clinical commissioning groups. These measures included the number of patients whose condition had deteriorated, remained, improved or had completely recovered. Data was available from April to December 2017 and indicated the majority of patients either maintained or improved their condition.

The physiotherapy musculoskeletal service monitored patient outcomes through a recognised tool which helped staff identify modifiable risk factors and match patients to treatment packages appropriate for them based on their prognosis. Between September and November 2017, 97% of patients had maintained or improved their condition. In December 2017, 94% of patients completed their expected outcome at their first appointment, while 89% of patients who had more than one treatment had an outcome of better (improved) and 8% had stayed the same.

A similar approach was taking for measuring patient outcomes in the speech and language therapy service. Between October 2017 and December 2017, an average of 71% of patients had achieved their treatment goals and an average of 27% of patients had mostly achieved their treatment goals.

Audits

The trust participated in three clinical audits in relation to this core service as part of their clinical audit programme.

Audit	Objective
Adult MSK Physiotherapy audit of compliance to Quality Standards for OA (NICE guidance CG177)	Identify baseline compliance. No provision of ARC leaflets to patients to improve access to self-management to improve advice regarding aerobic exercise by education/training of physiotherapy staff. To improve documentation of BMI in patient notes by education/training of physiotherapy staff to promote local exercise classes.
Audit of falls assessment documentation against current NICE within community setting East Out-patient	Full compliance identification of falls history. 76% multifactorial assessments. Most sections paperwork only partially completed. Osteoporosis risk poorly completed identified as training issue. Non-compliance with cardiovascular assessments due to lack of HR & BP monitors. Include FRAX risk assessment tool to identify appropriate onward referral. Review the layout of the form to allow a more appropriate flow of questioning. To include prompt to complete FESI for fear of falling. Ensure all members of the team feel confident completing all sections of the assessment documentation correctly. To look into the availability of HR & BP monitors to be able to complete a cardiovascular assessment.
PHY10 - Low Back Pain & Sciatica	To fulfil all the recommendations the work force will be advised to: Document the education given to patients. To cease the use of acupuncture for lower back pain and sciatica. (There were 6 cases in 100). To continue to utilise the Start back tool for assessing risk of chronicity. To document within treatment plan treatment/management linked to risk stratification. The service is currently involved in a research Study with Oxford which involves group exercise classes for a specific group of lower back pain patients, therefore this will be used to support and direct future provision of group exercise. In addition the team will be reminded of local classes for example the One You Cheshire East service available to residents of East Cheshire.

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

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.

Staff competencies were held electronically within the trust's intranet system. The competency record included staff corporate and local induction, clinical competencies, training and appraisals. The service leaders told us the competency 'package' was to be reviewed this year. A trust-wide record of staff competency was held. We were not able to disaggregate the data to identify just those specialisms which fell within the community adult's areas we inspected; however, the data indicated that by January 2018, 64% of staff had met the competency requirement.

Staff, including team leaders, were not always clear about where staff competencies were held or how to access them on the system. However, we viewed competency records for three community nursing staff members; all records we viewed were up to date.

The community matron team told us nursing clinical supervision was available; however, staff had individually decided not to take this up, although the leaders told us that community matron staff had been invited on GP review days to shadow the grand rounds focusing on discussing and learning about patient care and needs. Frailty supervision was available externally.

The service received information about agency staff training, competencies and experience direct from the agency prior to a staff member commencing work.

Staff told us there was good engagement with nursing students. A mentorship register was in place to ensure students had a mentor.

Therapies staff referred to the locally held, colour coded, training matrix to ensure staff were up-to-date with training and scheduled to provide an appropriate skill-mix.

Appraisal rates

The trust reported appraisal rates of 87% for nursing staff within community services for adults in 2016/17, just short of their target of 90%.

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

By the time of the inspection, the appraisal rate across the community services directorate for non-medical staff was 90.3% and 94.1% for medical staff. We do not have a separate breakdown for community matrons and nurses; however, the appraisal rate for allied health professionals within the community adult service was 97%.

Multidisciplinary working and coordinated care pathways

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

Community matron and nursing services were geographically aligned with local GP practices, and the service's electronic system enabled staff to view information entered by patients' GPs. This enabled a close working relationship and regular meetings with the primary care, social care, community rehabilitation, and voluntary care provider teams.

We saw examples of co-ordinated care in the community with community nursing staff working with other services to arrange social care, equipment, and where appropriate financial help for patients. Similarly we saw an example of the podiatry team referring a patient, who was living with dementia, onto the continence service. The ability to refer to other specialities meant any delay in providing necessary treatment to patients was reduced

The therapies team worked closely with the community rehabilitation and neuro-physiotherapy teams in the care of complex patients to discuss patient care and discharge plans.

The therapies teams developed integrated physiotherapy and occupational therapy assessment documentation which meant patients had one set, rather than multiple sets, of notes. A falls group had been developed which was, linked to six local nursing homes (which had the highest falls rates). This reduced the number of hospital admissions for patients from those homes.

A pilot integrated podiatry assessment and treatment unit was set up in Handforth. The unit enabled staff from the podiatry and physiotherapy teams to work together in a joint clinic to share best practice and to provide debridement and pressure relief treatment. Although there was insufficient data to report on the outcome measure of healing time, staff told us the pilot was working well. The model was expected to be rolled out to the wider teams from February 2018.

Health promotion

Staff across the service encouraged patients to make healthy lifestyle changes and choices where appropriate. This included promoting smoking cessation and referral to alcohol and social isolation services, where appropriate.

A local area care co-ordinator was available to identify and assist patients with links into other health services.

Within the leg ulcer clinics, staff provided patients with self-care advice and leaflets on the prevention of leg ulcer recurrence.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care. Staff were aware of the Mental Health Act 1983 and the Mental Capacity Act 2005 including the Deprivation of Liberty Safeguards.

We observed staff taking consent appropriately. This included both verbal and implied consent. Staff understood their duties to ensure patients had capacity to consent. We saw documented evidence of consent being obtained previously.

Where a patient potentially lacked capacity, a mental capacity assessment was carried out and recorded by appropriately trained staff or the patients' GPs. We did not observe any decisions being made specifically in a patient's best interests where they lacked capacity; however, staff were aware of the relevant processes.

Community nursing staff were aware of their duties under the deprivation of liberty safeguards. However, staff told us that deprivation of liberty orders generally only applied to patients living in residential accommodation or within intermediate care. As such the majority of orders were initiated by care homes or intermediate care organisations. Staff liaised directly with the patients' GP practices in relation to any of the applications made or orders issued.

Deprivation of Liberty Safeguards

East Cheshire NHS Trust told us that 347 Deprivation of Liberty Safeguard (DoLS) applications were made to the Local Authority between August 2016 and July 2017, 19 of which were pertinent to community health services for adults. This compares to 165 direct notifications from East Cheshire NHS Trust between August 2016 and July 2017.

Number of DoLS applications made by month from August 2016 to July 2017

	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17	June 17	July 17	Total
Made	1	1	1	1	1	6	2	2	0	0	2	2	19
Approved	1	1	1	0	0	1	1	0	0	0	0	0	5

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

Is the service caring?

Compassionate care

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

We observed staff in the community nursing teams and in the adult therapies teams delivering care and treatment in a kind, caring and compassionate manner.

The trust's quarterly patient survey for 2016 to 2017 indicated that 98% of community nursing patients surveyed said they were 'definitely treated with care and compassion'. This was supported by the patients and carers we spoke with who told us staff always treated them kindly. The same percentage of community nursing patients responded in the survey that they were 'always treated with dignity and respect'.

A patient in the podiatry clinic told us staff were "fantastic and friendly". A patient in the physiotherapy clinic told us staff were "very efficient and take account of what works best"; the patient noted that they were "getting everything [they] wanted" and they could not see "what improvements could be made [to the service]".

The trust undertook a range of patient surveys of the podiatry service in November 2017. The results showed that 92% of patients who responded were involved in decisions in their care. Ninety-eight per cent said they were given an explanation for their treatment and 95% were told of the risks and benefits to their treatment. Ninety-nine per cent of respondents said they were treated with dignity, respect, care and compassion and their privacy was maintained, and overall 91% rated the care provided as excellent.

Emotional support

Staff provided emotional support to patients to minimise their distress.

We saw numerous examples of thank you cards sent by patients and carers to the community nursing teams. These included cards from bereaved relatives thanking staff for the care and support provided. Community nursing staff told us they attended funerals wherever possible.

Patients were able to request a chaperone, if needed, in line with the trust's chaperone policy.

Community matrons and nurses were able to refer patients onwards to other specialists, relevant health professionals, counsellors or social work teams, or to signpost them to appropriate voluntary organisations for additional support.

Understanding and involvement of patients and those close to them

Staff involved patients and those close to them in decisions about their care and treatment.

We spoke with patients and carers before, during and after care had been provided. Patients told us that staff clearly explained the care that was being provided and patients were given the opportunity to ask any questions.

Patients told us they were aware of the plans and goals for their treatment, and felt that these were being achieved. We observed staff providing advice and contact details to patients and carers.

A patient in the physiotherapy service told us the service was “fantastic” and fitted around the patient’s needs.

This was reflected in the trust’s 2016 to 2017 patient survey which indicated that 82% of community nursing patients surveyed said they felt ‘definitely involved in decisions about their care and treatment’. In the same survey 88% of community nursing patients said that the care and treatment provided to them was ‘excellent’.

A further patient survey carried out between July and September 2017 showed 98% of respondents (in a 42% response rate) rated their overall care as excellent or good, and said they were treated with dignity, respect, care and compassion. Ninety-three per cent of respondents said nurses explained their care in a way they could understand; however, 85% felt they were involved as much as they wanted to be in their care.

We observed staff asking patients’ for their consent before administering treatment, and clearly explaining the care to be provided.

In a podiatry clinic we observed staff taking a clear history from the patient including a check of the patient’s medicines, allergies, falls history and any other health problems experienced. After treatment, the staff member checked with the patient if they were happy with the outcome of the treatment.

In a physiotherapy clinic we observed staff carrying out similar checks with patients. Staff also asked patients what their expectations were for any treatment being provided.

Is the service responsive?

Planning and delivering services which meet people’s needs

The service planned and provided services in a way that met the needs of local people.

The service worked with the local clinical commissioning groups in a check and challenge exercise to review the commissioning model and the service specifications. Funding for the services was subsequently agreed.

The community adult’s service worked with external partners in the wider East Cheshire area under the ‘Caring Together’ programme. The aim was to achieve the trust’s vision and mission through developing local community hubs aligned to the needs of their local populations and avoiding admissions to hospital through closer integration with acute hospital services, intermediate and primary care services in the community.

In line with the directorate’s aim for greater integration between community, primary and hospital acute services, the frailty service had developed to provide ‘wrap-around’ treatment. This supported patients at home before and after hospital admission. The service linked in with local care homes and meant that, for example, a podiatrist could refer patients to physiotherapy for a formal fall assessment if the patient was thought to be at potential risk of falling.

A ‘neighbourhood meeting’ was held each quarter in Holmes Chapel to help the service understand how it could best meet the needs of the local community.

Meeting the needs of people in vulnerable circumstances

The service took account of patients' individual needs.

The community audiology service implemented drop-in hearing aid repair clinics. This meant that patients no longer needed to make an appointment and reduced the waiting time for repairs. Patients were also able to present an audiology card at clinic to receive replacement hearing aid batteries.

In October 2017, the community nursing team in Holmes Chapel set up a wound dressing clinic at the weekend for patients who were able to walk. This provided more flexibility for patients and reduced the need for them to travel further for treatment at the minor injuries unit in Congleton.

Nutrition leaflets were available to staff in the Congleton area to provide to patients who were at potential risk of malnutrition. A diabetic pocket guide for staff was held by community nursing teams.

Accessibility

	Ethnic minority group	Percentage of catchment population (if known)
First largest	White: Polish	1.00%
Second largest	White: Irish	0.60%
Third largest	Asian/Asian British: Indian or British Indian	0.60%
Fourth largest	White: Other Western European	0.40%

Staff were able to access translation services and patient information leaflets in a range of languages, and in easy read documentation; however, staff told us this was rarely needed due to mainly older white British demographic of patients using the community adults services. Similarly British sign language translation, and information on braille could be obtained if required.

Staff had access to a specialist dementia nurse (an admiral) nurse, who was available to provide help and support. Staff were aware of how to contact the nurse. The trust also supported 'John's Campaign'. Staff told us of an example where they had worked closely with the carers of a patient living with dementia to keep the patient out of hospital. This included arranging for a tracker to be fitted to the patient's walking stick, and meant the patient could be still be cared for at home.

However, while there had been improvements in communication between the acute and community services, the community matron and community nursing staff in some areas felt that more progress was needed in timely communication and planning of patient discharges from the hospital to the community.

A range of posters and leaflets were displayed in a number of the clinics which provided contact details for patient support groups. Staff could also make referrals to the trust's chaplaincy service.

Access to the right care at the right time

People could access the service when they needed it. The service monitored a range of metrics across its specialisms including referral to initial assessment/treatment waiting times, did not attend rates and follow up rates. Waiting times from referral to assessment or treatment were within locally agreed targets.

The majority of specialisms within the community adult's service had set locally agreed referral to initial assessment targets. The targets varied according to the service provided. The median waiting time in all but two of the services' locations provided were within the agreed targets. The two services that did not meet their targets were the adult bladder and bowel service (median waiting time of 26 days against a target of 20 days) and the Macclesfield lower limb physiotherapy class (median waiting time of 41.5 days against a target range of 14 to 28 days).

The therapies service manager told us that key performance indicators (two days response for a GP referral, seven day response for an acute referral, and 14 days response for a routine appointment) had not previously been reported on. However, the new computer system had enabled the service to commence data collection since September 2017. The manager told us the service's key performance indicators were being met, and this was supported by the therapies' services performance dashboard.

Staff across the services told us that patients rarely missed appointments due to the generally older demographic of the patient population.

The physiotherapy manager estimated the service's did not attend rate at 2%. Patients were sent an appointment letter to 'opt-in' to the service, and were discharged if they did not attend a routine appointment; however, patients requiring urgent appointments were always followed up.

A therapies rapid access therapies team, in conjunction with cross referral between specialities, had reduced the number of patients admitted to hospital. Patients could be referred directly to the therapies team with telephone triage, which reduced the need for patients to be physically assessed by their own GP prior to referral.

One patient told us they felt coordination between services could be better with the appointment systems. The patient expressed their view that the physiotherapy appointment system did not communicate with other services which the patient felt caused confusion and led to cancelled appointments.

Referrals

The trust provided the following data on the median number of days from referral to initial assessment.

Service Type	Median days from referral to initial assessment	Target from referral to initial assessment
Community Matron Service	24 hrs	2 - 72 hrs
Chronic Pain Service	67	90
Podiatry Domiciliary Service	60	84
Therapies Physiotherapy Women's Health Congleton Specialist	58	14 - 28
Dietetics Inpatients MDGH and spec Weight Management Service	42	No target
Physiotherapy Macclesfield Leisure Centre OA Lower Limb Class	41.5	14 - 28
Dietetics Outpatients	39	No target
Podiatry Routine Service	38.5	42
Therapies Physiotherapy Spinal MDGH Specialist	27	14 - 28
Physiotherapy Service	25	14 - 28
Therapies Physiotherapy MSK Poynton AQP	23	14 - 28
Therapies Physiotherapy MSK Wilmslow AQP	22	14 - 28

Therapies Physiotherapy Knutsford Macclesfield & Waters Green	21.5	14 - 28
Therapies Physiotherapy MSK Congleton Specialist	20	14 - 28
MCATS Triage List	19	14 - 28
Therapies Physiotherapy Spinal Congleton Specialist	18	14 - 28
Therapies Physiotherapy MSK MDGH Specialist	17	14 - 28
Therapies Rheumatology MDGH Specialist	17	14 - 28
Therapies Physiotherapy MSK Congleton AQP	16	14 - 28
Therapies Physiotherapy Neuro MDGH Specialist	16	14 - 28
Therapies Physiotherapy Women's Health MDGH Specialist	16	14 - 28
Community Rehab Physio Service	15	56
Community Rehab OT Service	14	56
Rheumatology A/S Measurement Waters Green Specialist	14	14 - 28
Adult Bladder & Bowel Service	13	20
Therapies Physiotherapy Thoracic MDGH Specialist	11.5	14 - 28
Therapies Physiotherapy Women's Health MDGH AQP	10	14 - 28
Therapies Rheumatology Wax Group	8	14 - 28
Community Rehab Palliative Physio	7	14
Therapies Physiotherapy Women's Health Knutsford Specialist	7	14 - 28
NIMO Pharmacy Outreach	6.5	20
Community Prescribing Support	6	No target
Therapies Physiotherapy Amputee MDGH Specialist	6	14 - 28
Community Rehab Palliative OT	5	14
Home Enteral Feeding Service	3	No target
Adult SALT Service, District nursing (CHAW, Congleton, Holmes Chapel, Poynton/Bollington, WGMC2 teams), Rapid Access (Physio and OT).	24 hrs	2 – 72 hrs
Cardiac Rehabilitation, Community Frailty, District Nursing Knutsford and WGMC team 1, Integrated Respiratory Service, MCATS Podiatry, Out of Hours DN East and Tissue Viability.	24 hrs	2 – 72 hrs

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

Learning from complaints and concerns

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

Staff across the community adult's service told us they received very few complaints, particularly in the community nursing teams. Staff explained that the demographic of their patients was mainly older and patients appeared to be very grateful for the care and treatment provided to them.

This appeared to be reflected in the very low number of formal complaints for community adult services that were available for us to review during the inspection. Only two out of the five formal complaints received by the directorate and available to us for review were directly relevant to the community adults' services we were inspecting.

Of the files we reviewed, all were appropriately acknowledged, investigated and responded to with action plans developed where appropriate. All the complaints we reviewed were responded to within the trust's policy targets of 25 or 45 working days.

Complaints received were reviewed within the monthly directorate safety and quality standards meetings. Learning from complaints was shared individually with staff involved and with the wider teams in team meetings.

The trust received 116 complaints from August 2016 to July 2017, none of which were for community services for adults.

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

The trust received 11,826 compliments during the last 12 months from August 2016 and July 2017. Of these, 1,153 related to community services for adults, which accounted for 9.7% of all compliments received by the trust as a whole.

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

Is the service well-led?

Leadership

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

Community adult services were clinically lead and provided within the trust's allied health and clinical support services directorate and the acute and integrated community care directorate. Staff were able to describe the leadership and reporting structure for their teams and directorates.

Staff told us, with one exception, that senior and executive manager responsiveness and visibility had improved with senior staff visiting the majority of the community bases and teams. Staff referred to the chief executive's regular online podcast/webinar.

The departmental, directorate and divisional leaders we spoke with understood the challenges facing the service. The leaders were able to clearly describe the actions that had already been taken, or were planned to be taken, to meet these challenges.

At the time of inspection a number of staff were 'acting up' into managerial positions. This meant that a number of community nursing team leaders continued to hold clinical caseloads alongside their managerial duties. However, staff described an improved level of support from their acting managers during this time.

The community matrons (band 8a) continued to be operationally managed by community nursing team leaders (band 7). This has not changed since our last inspection, and remains an area of frustration for community matron staff. This, in conjunction with lack of clinical supervision, meant that community matrons felt there was no over-arching managerial oversight of the community matron service.

Vision and strategy

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

The trust had a vision “to ensure our patients receive the best care in the right place”. The vision was supported by a mission “to work in partnership to provide high quality affordable integrated services”. Development of the service’s strategy was ongoing and included staff from team leader level upwards.

The service’s strategy aimed to develop a model of community hub working. To this end, two community team prototypes were being developed by the community nursing teams. Each team identified their own strengths, weaknesses and local needs on which to build their local prototype.

Knutsford’s key priorities were to improve the diagnosis and treatment of people with dementia, through development of a unified approach to nursing and end-of-life care, providing community paramedic support to a local care home, and by creating a service directory and improved signposting to services. In Bollington, Disley and Poynton, the team adopted a whole-system approach to older people’s services, introduced unified management of diabetes and established a medicines management hub.

The service envisaged trialling other prototypes with the remaining teams with a view to rolling out best practice across all the teams, and to removing duplication of work.

However, in the Holmes Chapel area staff felt the service could do more to share its strategy. This included improving the area’s links with the acute teams (particularly around patient admission and discharge) and to understand the changing needs of the local population.

Culture

Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

Staff we spoke with throughout the service were positive about improvements in the culture within their teams, and in their cross-team interactions with other health professionals, particularly over the past few months.

Staff described the culture as being open and honest and the level of support from their senior leaders was good. Staff told us they felt able and confident to discuss issues of concerns with their leaders. One staff member told us they knew, and would feel able, to raise concerns with the trust’s freedom to speak up guardian.

However, some staff in the Holmes Chapel and Congleton areas expressed a sense of isolation from the rest of the service due to their geographical distance from the other teams. This was exacerbated by poor communication surrounding concerns relating to the expiry of the lease of the building.

Some staff across the service also expressed concerns that the link between community and acute hospital services needed to be further improved.

The trust had a freedom to speak up guardian who reported directly to the board.

Governance

The trust used a systematic approach to continually improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.

There was a clear reporting and governance structure within the directorate through the Safety, Quality and Standards Committee, and the heads of service meetings, which reviewed performance, quality, risks and resources. These subsequently fed into the corporate governance meetings. Staff were aware and able to describe the structure, understood their roles and what they were accountable for.

The directorate received monthly governance data packs, which included a range of risk management and patient experience data. Therapy staff received monthly reports and data packs containing risks, incidents, quality and workforce metrics. Feedback was also provided through the community nurse forum.

Management of risk, issues and performance

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

The monthly directorate safety and quality standards meeting reviewed the service's incidents, complaints, patient advice and liaison service enquiries, compliance with duty of candour reporting, information governance and training, and high and moderate level risks on the directorate's risk register. We reviewed the risk register which covered risks we expected to see.

Leaders in the community teams were aware of and able to describe the challenges facing their individual teams. Action plans were in place for each team leader, which were tailored to each team's risks and challenges. Action owners and target completion dates were detailed on each plan.

The podiatry service was fully staffed and operating effectively and, as such, leaders in the service had not identified any risks.

The service had performance dashboards for the acute and integrated care directorate and the allied health and clinical support directorate. This enabled the service's leaders to understand performance at a directorate level on a range of measures for each community specialism. The dashboards focussed on measurable metrics such as number of referrals waiting times, follow-up appointments and did not attend rates. It was not possible for us to consistently disaggregate the performance dashboard data against the service's targets for the individual services we inspected from the information we were provided.

Lone working risk assurance systems for staff were not consistent as staff working in the county could not always get a mobile signal. However, in most teams a manual process had been developed for staff to contact their teams' co-ordinators at the start and end of shift. Staff also kept their electronic work diaries up to date to ensure that co-ordinators were always aware of where each staff member should be.

Information management

The trust collected, managed and used information to support all its activities, using secure electronic systems with security safeguards. All staff had access to the service's electronic and paper records system which held information on patients' care and treatment.

Electronic and paper records were used throughout the service. The community nursing and community matron teams primarily used the service's electronic system within the framework of the trust's 'paper light' protocol.

The teams were able to access the electronic system on home visits remotely using electronic tablets. This meant staff could access the information needed to undertake their role. Although the wide geographical area covered by the teams meant that mobile signals were not always available, an offline version of the electronic system enabled staff to view and record notes that were later synchronised to the main system.

Community nursing staff based in Holmes Chapel had remote tablet access to the patient electronic system, they did not have access to the trust's other IT system. Staff told us this was because they were only able to access the landlord's IT server. This meant staff did not have access to the trust's intranet, shared drives for policies and procedures, and could not log incidents or carry out e-learning. Staff travelled to Congleton in order to access the trust's systems.

Although the electronic system was being gradually rolled out to other specialisms within the service this was ongoing and specialisms such as the Parkinson's service and the physiotherapy service were paper based. Within these areas, the electronic record system was mainly used for scheduling appointments. This meant that staff either had to securely transport paper patient records with them or wait to update notes on their return to base. However, we were told the service was due to review the cost and funding of updating to full electronic records in the next financial year.

Two years (current and previous year) of paper records were stored securely on-site in locked cabinets and locked rooms. Older records were archived off-site.

Engagement

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

The Friends and Family Test gives patients the opportunity to submit feedback to providers of NHS funded care or treatment, using a simple question which asks how likely, on a scale ranging from extremely unlikely to extremely likely, they are to recommend the service to their friends and family if they needed similar care or treatment.

The trust collated NHS Friends and Family Test data for the community health services. In November 2017, the trust received 507 friends and family responses; a response rate of 48%. Of those who responded 95% said they would recommend the service, and only 2% would not recommend the service.

Other than community nursing services, it was not possible to break the data down further for other community health specialisms. In the same month, although there were only limited numbers of responses (32), 91% of patients who received care from community nurses would recommend the service.

The trust undertook a range of patient surveys in 2017 across all its services. For the community adults service this included surveys of care provided by the community nursing teams, and the podiatry teams. In both surveys, over 90% of respondents rated their care and treatment as excellent or good overall.

Staff told us that engagement by the senior and directorate leads had improved since the previous inspection. Monthly newsletters were sent by directorate leads. However, although joint staff meetings in the Holmes Chapel and Congleton community nursing teams were seen as a positive improvement, staff told us they felt 'out on a limb' in terms of location and general communication with the trust's headquarters.

The therapies service planned to start working with Keele University from January 2018 to work with students and to highlight the benefits of working within the NHS.

The trust carried out a staff survey with results published in June 2017. The survey highlighted areas for improvement within the allied health and integrated services directorate. These included limited staff development opportunities and limited ability to make improvements.

The trust had an engagement, wellbeing and inclusion action plan. This included regular monthly activities such as job fairs, community engagement, equality focus groups, employee and team of the month, pulse surveys, and staff stress risk assessment. Additional focused events and actions were scheduled for each month of the year. For example in November 2017, the trust scheduled the 12-month review of the fast-track physiotherapy service, stress awareness week, domestic violence campaign, alcohol awareness week and the staff awards event.

Learning, continuous improvement and innovation

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

A community nursing sister and nursing student were awarded the Philip Goodeve-Docker Memorial Prize, which is a Queen's Nursing Institute (QNI) award.

The muscular skeletal service worked with AQuA (Advanced Quality Alliance) on shared decision making. This work helped the service to map patient pathway journeys to identify were pressure points impacted on quality standards.

The muscular skeletal service also worked on two projects with Oxford University. The first project looked at pushing suitable patients over 65 years of age with spinal stenosis (a narrowing of the spaces within the spine) further than their usual treatment plan for a period of 12 weeks. The project was ongoing so although there was little data for the service to analyse, initial outcomes appeared positive. The second project, which started in September 2017, looked at treatment for patients with rotator cuff (shoulder) issues.

The therapies service had a service level agreement with the end of life partnership to provide an educator to support community therapies staff working with end of life patients.

Community end of life care

Facts and data about this service

End of Life care is delivered within the community by the core community teams - GPs and District nursing teams. The delivery is supported by guidance and documentation developed in conjunction with East Cheshire Specialist Palliative Care Team, the End of Life Partnership and Greater Manchester and Eastern Cheshire Palliative and End of Life Care Network.

The East Cheshire NHS Trust specialist palliative care team receives referrals based upon their referral criteria to support the core teams in delivering end of life care for those patients with complex physical, social or psychological needs. East Cheshire Hospice provides both inpatient and outpatient services to provide specialist palliative care and end of life care to further meet the needs of the most complex patients.

The specialist palliative care team is based at East Cheshire Trust and is made up of health professionals who provide support and advice to individuals affected by cancer or other progressive life limiting conditions, as well as their carers. The team work alongside other health and social care providers such as GP's, hospital ward teams, East Cheshire Hospice community nurses, social workers and other therapists. The primary goal of the palliative care team is to promote quality of life for people living with life limiting illnesses.

Support Includes:

- Psychological and emotional support for individuals and their carers.
- Advice on the management of pain and other symptoms.
- An opportunity to discuss care and what is important to the patient.
- Support with planning future care.
- To link with other services that can provide care, advice and equipment if needed.
- To provide information on financial help.

The Electronic Palliative Care Co-ordination System is used by the specialist palliative care team and enables the recording and sharing of people's care preferences and key details about their care at the end of life between primary, secondary and voluntary care organisations in Eastern Cheshire.

(Source: Routine Provider Information Request (RPIR) – Context CHS Tab)

The Care Quality Commission carried out a comprehensive inspection between 2 and 4 September 2014 at the trust however end of life services were not inspected therefore we cannot compare our new ratings with previous ratings.

During this inspection we visited locations across the community and two intermediate care unit wards one at Macclesfield District General Hospital and Congleton War Memorial Hospital.

We spoke with seven patients and eight relatives. We also spoke with 57 members of staff, including senior managers, the specialist palliative care team, nurses and allied health professionals.

We observed care and treatment and looked at ten care records of patients that were either palliative or receiving end of life care. We reviewed twelve Do Not Attempt Cardio Pulmonary

Resuscitation forms. We received comments from our focus groups and we reviewed the hospital's performance data.

Is the service safe?

Mandatory training

Mandatory training consisted of core clinical training and core statutory training and was either delivered in the classroom or via e- learning.
Core clinical training included consent, learning disabilities awareness and record keeping and was accessed via e-learning. Data provided by the trust showed that the service was below the trust target of 90% with 71% of staff completing core clinical training with the two remaining members of staff booked on training in April 2018.

Core statutory training was delivered to staff face to face and included Health & Safety, Infection Control and Equality Diversity & Human Rights. Data provided showed that 100% of the specialist palliative care team had completed core statutory and mandatory training.
The two new members of staff were booked onto mandatory training in March 2018.

Community staff also attended classroom annual updates regarding end of life care. The training was a three hour programme and provided information around the five priorities of care planning and the use of the end of life care plan, advanced care planning and symptom management. Data provided showed that 57% of 119 community nurses had attended the training.

Safeguarding

Staff participated in training for safeguarding adults and children to varying levels depending on role and clinical exposure. Safeguarding training was available from level one to level three for children and adults.

Safeguarding training for both adults and children level 1 and 2 was mandatory for all community clinical staff. Data provided showed 75 % of staff had attended level two adults safeguarding training however no evidence was provided that two members of staff (25%) had attended any training. 100% of staff had completed level two children safeguarding training.
The new members of staff were awaiting a date for safeguarding training.

There were trust wide adults and children safeguarding policies and procedures in place, which were accessible to staff using the trust's internet site. Staff had support and guidance from the safeguarding team during office hours and advice out of hours and at weekends from the community senior manager.

Staff we spoke with understood their responsibilities around safeguarding and were aware of the safeguarding team and how to access them if required. Staff shared with us examples of when they had contacted and escalated concerns to the safeguarding team.

Cleanliness, infection control and hygiene

Staff undertaking community visits had adequate supplies of hand sanitiser and personal protective equipment such as disposable gloves and plastic aprons.

We were told that syringe drivers were decontaminated in line with trust policy between each use and although all the syringe drivers we saw were visibly clean there was no record to confirm that this had been done.

At each location we visited we observed pouches were available which could be used to discreetly store the syringe driver whilst attached to the patient however we could not see any guidance for staff to follow or evidence that it had been cleaned in between use.
Staff we asked were not aware of any guidance with one member of staff stating they wiped it with disinfectant cloth and another member of staff told us they did not routinely clean the pouch, this did not assure us that all precautions were taken to minimise the risk of cross infection.

Environment and equipment

The trust used syringe drivers, which were portable, battery operated devices used for delivering continuous subcutaneous infusions. All the pumps were lockable, which prevented accidental changes to rate of infusion.

Each syringe driver was presented in a case with a combination lock. The case also contained other essential equipment required when setting up to use, for example 20ml syringe, infusion lines, new batteries and relevant documentation including prescription sheets and syringe driver guidelines as per trust policy. However during inspection we observed one 30ml syringe, two 20 ml syringes and one ampoule of water for injection out of date in three of the ten cases we viewed. This was escalated and removed from use at the time of inspection.

Syringe drivers were serviced and maintained by the medical engineering department and were accessible at all times from the community or the hospital out of hour's team.
During our inspection we observed syringe drivers were available for immediate use at each location we visited however two of the ten we checked had exceeded their service dates, this was raised during inspection and staff told us they would ensure these were not used and contacted the medical engineering team.

Syringe driver training was mandatory although it was not clear how often staff were expected to complete the training as one policy indicated every three years and another at least bi annually. Data provided showed compliance across the district nursing teams ranged from 43 % to 78%, with at least four members of staff trained at each location. However it was documented that the three members of staff who only worked out of hours had not attended the training and we did not see evidence that training was planned. We observed during inspection that day staff regularly worked additional hours during the evening. Data provided stated that patients were allocated to staff in line with their competencies and this reflected what staff told us.

District nurses supplied and transported sharps bins to and from the patient's home. Staff told us sharps bins were stored within the lockable syringe driver case and were used to dispose of syringes, needles and opened ampoules.

Staff told us hospital beds and pressure relieving equipment could be fast tracked and delivered the same day seven days a week however staff at Congleton clinic told us that specialist pressure relieving equipment was not available at the weekends and gave us an example of one patient who waited until Monday for a specialist mattress.

Assessing and responding to patient risk

Staff told us risk assessments were completed in people's homes in order to keep staff and patients safe and ensure equipment could be accommodated and used without it presenting a risk to the patients or their families.
Patient assessments included malnutrition universal screening tool scores, mobility, pressure ulcer and falls assessments. We saw risks assessments completed in the ten records we reviewed.

The specialist palliative care team and the lung cancer nursing team held daily board rounds on weekdays to discuss and review patients and update the electronic systems available to professionals within the primary care setting.
Each community nursing team held regular team meetings to discuss individual cases and update staff regarding any deteriorating patient or changes in treatment.

During our inspection we observed staff respond and manage challenging behaviour in a calm manner and in the patient records we observed the assessment of changes to patient's conditions and actions taken documented.

Community staff told us there was a mobile phone available for staff to carry and the number was given to relatives of patients in their last hours of life so they could ring directly to the nurse if they needed assistance. Staff told us they also checked the team answer phone remotely every half hour at the weekends.
Relatives told us they knew how to access help and advice 24 hours. We saw phone numbers both in and out of working hours documented on patients paper records within their home.

Staffing

Staffing for end of life care was the responsibility of all staff in the community and not restricted to the specialist palliative care team.

The district nurses were available 24 hours a day, seven days a week and managed end of life patients as part of their general caseload with the specialist palliative care team reviewing and supporting complex patients.

The palliative care team provided support and advice during weekdays to the hospital, hospice and community teams from 9am to 5pm. The palliative care team consisted of two part time consultants who worked a total of 0.9 whole time equivalent this included 0.2 whole time equivalent working at the hospice.

The planned nurse staffing level was 5.3 whole time equivalent however at the time of inspection there were 3.9 whole time equivalent specialist nurses who worked a variety of part time hours and an operational manager who also managed the lung cancer nurses.
We were told that three members of staff had recently left and although these vacancies had been successfully recruited to with all new members of staff expected to be in post by the end of March 2018, these staff would be supernumerary for a period of time whilst they completed induction and competencies.

The palliative care nurses told us that due the current staffing levels they regularly worked extra hours to ensure patients were reviewed. All staff we spoke to told us that they had accrued time owing, but found it difficult to take back. In response to the staffing levels the service had

introduced a triage system along with nurse led clinics to assist the staff with workload and time management.

Staff on the palliative care team told us that agency and bank staff were not utilised as nursing staff on the team would work extra hours if required to cover leave and sickness.

Between August 2016 and July 2017, the trust reported no staff either suspended or placed under supervision within community end of life care.

(*Source: Routine Provider Information Request (RPIR) – Suspensions and supervisions tab)*

Quality of records

Patient records within the community setting were predominantly completed on an electronic system and care was recorded and reviewed by health professionals within the primary care setting including GP's and community nurses. However limited paper records including do not attempt cardiopulmonary resuscitation document were held within the patient's home.

During our inspection we observed all staff complete patient's records when they returned to the office despite having access to a remote electronic device; this was a risk that staff could forget to record all information regarding their visit.

The electronic system did not support, nor were staff able to show us, the development of detailed, individualised holistic care assessment or treatment goal plans or evaluation and re-assessment of any treatment interventions carried out. We reviewed ten palliative or end of life patient's records and we observed the patient treatment summaries completed by community nurses were mostly brief however summaries completed by the specialist palliative care team were comprehensive and included individualised assessment and evaluation.

Medicines

A dedicated end of life pharmacist provided support to the specialist palliative care team. During our inspection we saw an occasion where advice was sought from the pharmacist by the specialist palliative care team.

Staff had access to a syringe driver policy which included a step by step visual guide to setting up the equipment, a list of drug indications along with compatibility with other medications that could be used in a syringe driver.

Anticipatory medicines were prescribed in a dedicated 'blue book 'for patients in the community, identified as requiring end of life care. These are medicines that may be required and can be prescribed in advance to ensure prompt responses to the management of symptoms that could occur in the last days or hours of life.
Anticipatory medicines were usually prescribed by the patient's general practitioner (GP), specialist palliative care team or by a doctor at the hospital prior to patient discharge.
There was a medication guide on the back of the book for staff to refer to if required and staff we spoke to felt the blue book was easy to use. The blue book was currently under review and we saw minutes in meetings which showed that the revised document was going to be discussed at a district nursing working group, non-medical prescribers group and focus group of GPs.

We reviewed seven records and found that all anticipatory medications were prescribed with relevant medications discontinued.

Community staff had access to a DOOP kit (Destruction of Old Pharmaceuticals Kit) which was used to dispose of unused syringe driver contents and ampoules of above 5mls in volume. These were stored in each syringe driver box.

Community nurses who administered controlled drugs were provided with anaphylaxis kits to carry with them at all times and all anaphylaxis kits we reviewed were within the expiry date.
The pharmacy were responsible for providing the kits and replacing stock prior to the adrenaline expiring. We observed an inventory list of all kits issued by the pharmacy.

Incident reporting, learning and improvement

The trust had an incident reporting policy for staff to follow which included a link to a video as to how to use the electronic reporting system.
Staff knew what incidents to report and could demonstrate how to use the electronic reporting system. Staff gave examples of incidents they had reported but told us they did not always receive any direct feedback but incidents were discussed within the team.

Incidents relating to end of life care were mostly reported and captured within the community teams rather than directly to the end of life service. However the specialist palliative care consultants told us they reviewed all incidents relating to end of life and palliative care and monitored any trends or themes and shared these with staff at team meetings.

Between December 2016 and December 2017, there had been 28 incidents reported by trust staff regarding community end of life care. Of these, 15 were trust incidents and 13 were not related directly to the trust. Data provided for December 2017 showed one incident was reported relating to end of life care with community staff not able to administer pain relief to a patient at home as this was not prescribed and a GP had to be called out.

Staff demonstrated an understanding of their individual responsibilities in relation to duty of candour. The duty of candour is a legal duty on hospital trusts to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. The duty of candour aims to help patients receive accurate truthful information from health providers.

The trust reported no serious incidents relating to community end of life care.

(Source: Strategic Executive Information System (STEIS))

Is the service effective?

Evidence-based care and treatment

In response to the ‘More Care Less Pathway’ report which was published in July 2013, the Liverpool Care Pathway was withdrawn and the specialist palliative care team had devised an end of life care plan for all staff to use when caring for a patient who was at the end of their life.

At the last inspection we saw little use of the document with community staff telling us the document was cumbersome and focussed on patients within the hospital setting rather than the community. At this inspection we found that the end of life care plan reflected current national guidance and staff told us it had been revised since our last inspection however community staff continued not to use these as they felt the document was lengthy with duplication of information already inputted on the electronic record.

During our inspection we did not observe any end of life care plans in use and documentation regarding care to patients was inconsistent and sometimes brief within the records. We found it difficult to evidence in the patient's electronic records whether care provided to patients at the end of their life care included the five priorities of care and reflected national guidance.

The specialist palliative care team were aware of the poor uptake of end of life care plans in the community and we also observed this documented in minutes from meetings with a plan to review through a task and finish group in January 2018. However we did not see any audits, actions plans or risk assessments completed to monitor and address compliance and risk.

Nursing staff on the intermediate care wards told us that although they rarely used the plan due to low numbers of deaths when they did use it they found it to be a useful tool when caring for someone at the end of their life. There were no patients in the last days of their life when we visited the two intermediate care wards.

Data provided showed self-assessments of adherence to The National Institute for Health and Care Excellence guidance for example strong opioids for pain treatment (NICE clinical guideline CG40) and we observed documented actions taken to mitigate risk where recommendations were partially or not met.

The self-assessment of The National Institute for Health and Care Excellence quality standard QS 144 care of the dying adults in the last days of life showed that all recommendations had been met as the end of life care plan was used. However we were not assured the trust was meeting this guidance as it was recorded in other documents there was poor uptake and utilisation of the end of life care plan and during our inspection this was confirmed by staff we spoke with

The Gold Standard Framework is a programme that enables good quality care for people nearing end of life irrespective of diagnosis by planning care in line with their needs and preferences. Staff told us they worked closely with all GP's, with the majority having implemented the Gold Standard Framework.

There was a continuing health care team who worked in both the hospital and community setting and supported staff in fast track process when care in the community was identified for patients at the end of their life. During our inspection we observed community nurses refer patients through this process.

Nutrition and hydration

Patients nutritional and hydration needs were assessed and monitored, with those requiring additional assessment referred and reviewed to the community dietician. However we saw no documented evidence in two out of ten records we reviewed that patient's nutrition and hydration needs had recently been discussed or reviewed.

A recent audit of seven records showed all patients nutritional and hydration needs had been assessed.
Staff on the intermediate care wards shared with us examples when patients at the end of their life had been prescribed appropriate fluids.

Leaflets were available to families and carers which included information regarding the reduced need for food and drink in the last days of life.

Pain relief

Patients in the community who received end of life care remained under the care of their GP. GPs were responsible for prescribing medication for community patients although there were some specialist nurses who had completed prescribing training and could prescribe medication. Palliative care consultants were available to provide advice and guidance to GPs on the most effective treatments for patients on end of life care.

Staff told us they used a tool to assess and monitor a patient's pain, and pain control was a priority for staff involved in patient care and they would speak to the GP or the specialist palliative care team if pain relief was not effective. During our inspection we observed staff assess and discuss pain relief with patients along with contacting the GP for further review.
An audit performed showed that all of the seven patient's records they reviewed had received assessment of their pain.

We reviewed patient records and saw assessments of patient's pain but symptom management was not consistently recorded by the community nurses. However we observed during home visits patients pain was reviewed and managed appropriately.

Patient outcomes

The specialist palliative care team consultants told us that the patient outcomes for end of life care within the community were led and monitored by the clinical commissioning group or the End of Life Partnership.

We reviewed audits and performance data which were performed across the organisation through the End of Life Partnership. Results shared with us were reported at organisation level and therefore the trust were able to see areas of compliance along with areas for improvement.
We saw in the minutes of an End of Life Partnership meeting which discussed results and identified areas for improvements including assessments of patients spiritual needs, mouth care and shortness of breath. The next steps agreed included considering devising an electronic version of the end of life care plan and arrange a separate task and finish group in January 2018 with representation from all areas to take actions forward. However we did not see any action plans devised by the trust in response to the audits therefore we are not assured whether actions were taken or progress was achieved in the key areas requiring improvement.

The specialist palliative care team meeting minutes showed that the service had started to use the Karnofsky scale which records the phase of illness as a measure for patient outcomes and we observed this in some of the patient records we reviewed.

The service were currently reviewing the blue book documentation and just starting to audit the use of the end of life care plan for in patient deaths and staff we spoke to were aware of the audits.

We reviewed results of an audit of seven patients records at one location which showed that end of life care plans were not completed for any of the patients however the records demonstrated that in at least five of the seven, patients received holistic assessments in pain, nausea, vomiting, nutrition, bladder and bowel function, agitation and anxiety.
The audit captured compliance from other areas around Cheshire and we saw in the minutes from an End of Life Partnership meeting there were 'next steps' documented including the possibility of devising an electronic version of the end of life care plan which would be discussed at a task and finish group.
We requested action plans following audits but we did not receive any we are therefore unsure as to what the trust were specifically doing to address the areas for improvement.

The Ambitions for Palliative and End of Life Care 2015/2020 is a national framework to ensure all patients receive high- quality end of life care. Data provided showed the service was working towards and had plans in place in achieving the six Ambitions which included each person is seen as an individual, gets fair access to care and that care is coordinated.

Competent staff

Community staff had access to additional end of life training through the End of Life Partnership with some of the training facilitated by the specialist palliative care team. Staff told us it was sometimes difficult to access training due to staffing issues and workload and this was reflected in data provided which showed from November 2016 to January 2018 small numbers of nurses had accessed the training with dementia training having the most with 38 members of staff.

Staff told us they could also access PEACH (palliative education of East Cheshire hospice) which were held monthly and provided support, education and open discussion to staff on a needs basis.

Staff had access to e-learning modules in palliative care via the trust internet. Community staff told us they felt competent in caring for palliative or end of life patients but welcomed any further training.
Junior doctors received education in palliative and end of life care as part of their induction programme and ongoing education programmes.

An end of life facilitator had recently been employed in collaboration with the End of Life Partnership to lead on developing education and training for palliative and end of life care within the trust. The practice educator told us they were looking at having a working group to identify learning needs of the community nurses with the plan to offer lunch time sessions.

We were told the advanced care plan was part of the End of Life Partnership initiative with a working group in place and a train the trainer programme was being rolled out. One of the specialist palliative care nurses told us they had recently been trained and was keen to teach staff across the trust.
The specialist palliative care team told us they accessed additional training through Macmillan funding.

Between December 2016 and January 2017, 100 % of staff within the specialist palliative care team at the trust had received an appraisal.

Newly appointed staff received an induction and were supported through the MacMillan competencies before working unsupervised. During the induction period, the new starters were supernumerary (in addition to the staffing establishment) and we observed this during our inspection.

The palliative care team told us they received clinical supervision every six weeks. The purpose of clinical supervision is to provide a safe and confidential environment for staff to reflect on and discuss their work and their personal and professional responses to their work. The focus is on supporting staff in their personal and professional development and in reflecting on their practice to encourage improvement.

The trust had a policy for checking clinical professional registration and revalidation which outlined the trust and employees responsibilities and requirements. Staff told us they felt supported by the trust with the revalidation of their registration.

Multidisciplinary working and coordinated care pathways

Members of the specialist palliative care team participated in multidisciplinary meetings in the trust and also as part of the End of Life Partnership working with other specialities in providing a holistic approach to care where patient's physical, psychological and social needs were considered.

During our inspection, we were able to observe a multidisciplinary meeting at the hospital which was attended by a variety of specialists, including the specialist palliative care team, medical staff, radiographers, lung cancer nurses and research nurses along with a video link to professionals at a specialist cancer hospital. There was a co-ordinated approach to the management of new and current patients along with transfer and discharge of patients.

In addition to the specialist palliative care nurses there was an integrated respiratory team which included two lung cancer nurses who cared for patients in the hospital and community setting through to the patient's end of life. Staff told us this allowed for continuity of care but also familiarity for patients especially those with chronic lung conditions. However a couple of community nurses felt this was confusing as to whether to contact the specialist palliative care team or the integrated respiratory team if advice or review was sought.

The specialist palliative care team, community nurses and matrons worked closely with primary care services and staff shared examples of when they had performed joint visits to review patients. Specialist palliative care nurses and community nurses were aligned to GP practices to increase communication, continuity and give points of contact. The specialist palliative care nurses told us they had excellent working relations with the GP's.

Staff told us the majority of local GP's had implemented the Gold Standard Framework and held regular multidisciplinary meetings which were attended by the community nurses and palliative care team. The palliative care nurses told us they added new patients to the list for discussion at the meeting.

Health promotion

Patients with long term conditions were empowered and supported to monitor their own health, care and wellbeing and take proactive measures in maximising their independence. A matron for example, told us patients with COPD (chronic obstructive pulmonary disease) were educated and provided with medication to take on the onset of symptoms of an exacerbation rather than wait to see the GP. Patients were advised to inform the matron for a review if the patient required any further support.

Staff told us patients on long term oxygen therapy received advice regarding not smoking and using oil- based products such as petroleum jelly to the face or upper parts of the body due to the risk of fire or burns.

During our inspection we observed staff identifying and discussing with a patient, difficulties in administering large amounts of medication and arranging for medication to be dispensed in a blister pack.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

East Cheshire NHS trust reported no Deprivation of Liberty Safeguard (DoLS) applications were made to the Local Authority between August 2016 and July 2017 that were pertinent to end of life care services.

(*Source: Routine Provider Information Request (RPIR) – DOLS tab)*

There was a Mental Capacity Act 2005 policy in place, which provided guidance to staff about the Mental Capacity Act 2005 and Deprivation of Liberty safeguards. The policy included roles and responsibilities, consent, capacity, best interests and process of a Deprivation of Liberty application**.**

Training on consent, the Mental Capacity Act, and Deprivation of Liberty safeguards was part of the mandatory core clinical training for staff. Staff could explain when patients might need an assessment or their capacity to make decisions about their care or when staff might need to make a decision in their best interests. During the team meeting we observed discussion around patient's capacity and identified those who required best interest decisions.

The trust had a unified do not attempt cardiopulmonary resuscitation (DNACPR) policy in place which included guidance for people in their homes and communication of the decision to other services.

Staff in the community told us they would actively review the DNACPR documentation and any incomplete areas or concerns were escalated to the GP to review and action as required.

The records we reviewed that had a unified DNACPR in place had been completed either by a senior clinician or by the patient's GP. Out of the twelve do not attempt cardiopulmonary resuscitation we reviewed we found two of the forms indicated there was no discussion regarding the decision with the patient despite them having capacity; this was escalated at time of inspection.

All DNA CPR forms were readily available within the patient's records within their homes or on the ward.

The specialist palliative care team attended the DNA CPR community and primary care subcommittee meetings. Minutes from a meeting provided by the trust showed areas of discussion regarding patient information leaflets and implementing the ReSPECT document, training plans and feedback from a regional meeting. The ReSPECT document is a personalised summary of recommendations to assist health care professionals to make immediate decisions about the persons care and treatment in an emergency.

Is the service caring?

Compassionate care

During this inspection we saw examples of staff compassion and commitment towards their patients and families. Staff shared examples of actions they had taken to ensure patients at the end of their lives received the very best care they could provide.

We saw examples where staff had gone above and beyond for example a community nurse visited a patient very early in the morning prior to their shift starting to ensure the patient received prompt pain relief and support. Another member of staff travelled outside work hours to collect a patient's medication when there was no next of kin, and tracking down a specialist medication only available in intensive care and then going to collect it. Although staff felt this was part of their day to day role we felt this demonstrated the selfless and compassionate attitude which staff had for caring for their palliative patients.

Staff told us despite staffing issues they always prioritised and made time to care for those patients who were dying and their families.

Staff said it was a privilege to care for a person in their last days of life and one district nursing team leader told us 'the care provided by my team is second to none'. Another team leader told us a long term patient had recently passed away and this had affected the team and they ensured staff had time to discuss and reflect as a team before they went out on their calls.

Staff were aware of the benefits for and supported patients in completing advanced care plans. However staff respectfully acknowledged that not all patients wanted or were ready to discuss their preferences of care and we observed a member of staff approaching this in a sensitive manner during inspection.

During our inspection we were able to visit seven palliative or end of life care patients in their homes and we observed planned, thoughtful and careful interactions by staff both dealing with patients and family members. Staff were polite and courteous and displayed genuine empathy with the patients and their families.
Patients and their families we spoke to were all positive about the staff and the care and support they had received with comments including 'staff have been kind, considerate, and very supportive 'although one patient felt there were too many staff coming in and out of the house.

Staff were seen to be skilled at supporting people with their emotional needs and enabling people to understand and deal with the complexities of approaching the end of their life or that of a loved one.

Patients and their relatives had access to the trust chaplaincy team which included representatives from the Church of England, Roman Catholic and Free Church with links to other faith communities, including Muslim and Sikh. The team was supported by volunteers who visited various churches in the community holding Sunday services.

Emotional support

All end of life care patients were allocated a named nurse so that they had a single point of contact. Patients told us they had found all the staff, either in person or on the telephone, to be helpful, responsive and attentive to their needs.

Staff told us they would support the patient and their families in any way they could and would ensure they were given the time they needed. Patients and those close to them who required psychological support could access the local hospice.

Bereavement support for relatives was provided by an independent organisation and staff told us they would sign post those who required this support.

Following the death of a patient, relatives were given a bereavement booklet which provided information about what to do after a death, including the death of a loved one at home, registering the death, collecting the death certificate, information regarding coroners along with contacts for emotional support. Staff told us they always contacted the patients loved ones following their death in addition to a bereavement visit to provide support and if it was appropriate they would also try their best to attend the funeral to pay their respects. One district nursing team leader told us that they would note down the date of death for those patients who they had cared for many years and contact the family on the anniversary of the death to offer support.

The specialist palliative care team also made contact with loved ones of patients known to the service and send a sympathy card which had contact details for support services printed on.

Understanding and involvement of patients and those close to them

Contact details were given to patients when identified as requiring palliative care and these details were also available on the trust website. Each patient was told the name of their specialist palliative care nurse.

During the inspection we were able to observe positive interactions between patients and staff. Staff were caring, practical and supportive to both the patient and those close to them and we observed they were given time to reflect and think along with the opportunity to ask any questions they had.

We also observed written feedback from a GP who reported that after speaking with an anxious patient ‘’ the palliative care nurse had done a fantastic job in supporting and reassuring with practical advice – they feel much better now ‘’.

Staff at Congleton hospital told us that the family of a patient who they cared for in the last days of their life had purchased items for the ward to show their gratitude.
During our inspection the specialist palliative care team shared with us a large number of thank you cards and letters of gratitude for the care that had been received in addition we observed cards from patients and those close to them at all the locations we visited.

Is the service responsive?

Planning and delivering services which meet people's needs

The specialist palliative care team had active partnerships driving coordinated end of life care across local health, social and voluntary care providers; key partnerships included End of Life Partnership, Greater Manchester and East Cheshire Strategic Clinical Networks, Greater Manchester Cancer Vanguard and clinical commissioning groups.

The specialist palliative care team were based at the Macclesfield District General hospital and travelled to patients homes throughout the East Cheshire area. Due to staffing issues the specialist palliative care nurse's now worked in two teams with each team aligned to a number of GP services and district nursing teams but staff still worked across both teams if required.

Nurse led clinics alongside consultant led clinics were introduced in response to the increase in referrals to the service and staffing levels for patients who were able to travel were invited to clinic. Staff told us this also provided an opportunity for patients to be introduced to the cancer resource centre on site. The weekly clinics were at Macclesfield District General hospital but we were told there were plans to expand them into other community locations.

The specialist palliative care team and community nurses worked collaboratively with other services within the community to provide a comprehensive service to patients.

A verification of expected death policy was in place specifically for community nurses, this focussed on roles and responsibilities of medical and nursing staff and the procedure for trained nurses to follow in the verification of an expected death. Data provided showed that 40 members of staff across the locations in the community had been trained. Staff we spoke to told us they felt this was a very important aspect of their job and felt strongly that this had a positive impact for patients as they did not have to wait for the GP or have an out of hours GP visit who was not familiar with the patient.

On the intermediate care wards staff told us that side rooms were prioritised for patients who were at the end of their life and if a patient was in the main ward area, then they would keep the curtains around them to maintain dignity and respect. Staff told us they would encourage those close to the patient to stay and ensure they were kept as comfortable as possible.

Each ward had a day room which families and friends could use and staff said they would provide drinks and snacks for those who were staying with the patient. There was also a free parking pass provided for relatives staying at the hospital.

There were no mortuary services available at Congleton War Memorial hospital: mortuary services were available at Macclesfield General Hospital. Staff told us following a patient's death, a

designated funeral director would come within a few hours of contacting them and take the body to the funeral home.

Meeting the needs of people in vulnerable circumstances

There was a dedicated area in the patient's electronic records which recorded patient's specific needs or problems including diagnosis for example dementia, learning disability or if an advance care plan was in place, so that staff were aware of the patient's wishes.

Staff had access to a dedicated dementia nurse for support and advice with care provided to patients with dementia.

Dementia training was delivered as part of mandatory training. Data provided by the trust showed that four members of the specialist palliative care team had completed the training with a further three scheduled to complete it by March 2018. Additional dementia training specific to end of life or palliative patients was available to all staff across the trust.

Staff had access 24 hours a day to interpreters over the phone for patients whose first language was not English and face to face support when booked in advance. Staff were aware of how to access these services if required.

There was no specific area on the electronic record to record patient's cultural or religious needs other than in the general text. All staff we asked were aware of the importance of meeting the cultural and religious needs of the patient and told us they discussed any requirements with the patient and their loved ones.

Leaflets and booklets were available to patients and carers giving advice including ' what to expect in the last days of life' for families and carers which briefly discussed the end of life care plan, communication, medication, food and drink along with contact numbers for day and night time.

Access to the right care at the right time

The specialist palliative care team worked as an integrated team with local hospices, primary care providers and community services. The service was available to staff and patients on weekdays Monday to Friday from 9 am to 5pm, with telephone advice and support from a local hospice and the GP out of hours service at other times.

There was an open referral system to the service and any member of the public could contact the team for advice or information. Staff told us referrals to the palliative care team were received mainly from GP's or community teams either by a generic email, faxed, the electronic record or by phone.

Between December 2016 and November 2017, the community specialist palliative care team received 489 patient referrals of those 73% had a cancer diagnosis and 27% had a non-cancer diagnosis. 67% of these patients were reviewed within 24 hours of referral either by telephone contact (50%) or face to face (16%). Due to current staffing issues a scheduling and triaging system had been implemented. Staff told us this had helped with efficiency in prioritising patients based on urgency and need. Where appropriate patients received a telephone consultation as this

was more time productive than visiting all patients across a varied geographical area. Staff told us at the time of inspection there were no patients on the waiting list to be seen.

The patients' preferred place of care was documented in the patient's electronic record and we observed this was also discussed during the specialist palliative care team daily handover. An audit performed by the clinical commissioning group in December 2017 showed 51% of people across East Cheshire with an Electronic Palliative Care Co-ordination System template had a recorded preferred place of death.

Community end of life services enabled rapid discharge of patients from the acute hospital, providing support to meet patient's individual needs and wishes. A rapid discharge referral pathway provided staff across the trust with guidelines and support through the pathway. We requested the data regarding the number of patients who had been discharged via the pathway. We were told that this information was not currently collated or able to be extracted however the service had recognised this as a priority for the newly appointment end of life facilitator to review in their work plan.

Patients who deteriorated following admission to intermediate care wards were cared for and remained on the ward if that was their wish. Staff told us they would do everything possible to ensure the patients preferences were respected and acknowledged. Doctors on the wards provided medical cover weekdays with GP cover out of hours and at weekends. Staff also had access to the hospice out of hour's team and we were told that the specialist palliative care team also reviewed patients on the ward.

Accessibility

The largest ethnic minority group within the trust catchment area is White Polish with 1.00% of the population.

	Ethnic minority group	Percentage of catchment population (if known)
First largest	White: Polish	1.00%
Second largest	White: Irish	0.60%
Third largest	Asian/Asian British: Indian or British Indian	0.60%
Fourth largest	White: Other Western European	0.40%

Waiting times

The Trust advised that all patients are prioritised and are seen on either the day of referral or on the next working day.

(Source: Routine Provider Information Request (RPIR) – Waiting times tab)

Referrals

The trust has provided the below data on time from referral to initial assessment within community end of life care, these are provided in the table below.

Service Type	Days from referral to initial assessment (Median)

Community Specialist Palliative Care	1
Hospital Specialist Palliative Care	0
Macmillan LCN Community	1
Macmillan LCN Inpatients	3
Macmillan LCN Outpatients	47.5
Macmillan Nurses Service	0

Learning from complaints and concerns

The trust received 116 complaints from August 2016 to July 2017, none of which related to community end of life care services.

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

Staff we spoke with knew the complaints procedure. There was information available for patients or families about who to contact if they had any concerns or complaints.

Managers and staff told us there had been very few complaints received but shared an example of how the service had responded and updated the sympathy card following a complaint.

Staff told us details of complaints or issues raised were shared amongst teams during team meetings.

Is the service well-led?

Leadership

The service had an experienced leadership team with the skills, abilities, and commitment to provide high-quality services.

The palliative care consultant's and lead nurse managed the specialist palliative care team. Each told us they were well supported by their line managers. The Medical Director was the executive lead and ensured there was an awareness of end of life issues at board level.

Staff within the specialist palliative care team told us there had been recent changes within the managerial and team structure of the service however they saw this as a positive change.

All staff we spoke with had a good understanding of the importance of high quality end of life care and staff consistently told us that end of life care was prioritised based on patient need.

Staff knew who the Chief Executive and senior managers were however some of the specialist palliative care nurses told us they were not always visible.

Vision and strategy

The strategy for palliative and end of life care 2016 to 2019 was devised collaboratively by the End of Life Partnership which consisted of multiple organisations with experience and responsibility for palliative and end of life care, including the specialist palliative care team.

The strategy was based on the Ambitions for Palliative and End of Life Care 2015 with four priority areas identified and agreed at workshops, events and meetings.

Each organisation had a lead that was responsible for implementing the priorities in their area. We observed that the lead person documented within the strategy was the nurse palliative care lead who had recently left the team, however when we spoke with staff, they were not clear who was responsible for managing and implementing the strategy.

We observed a self-assessment around the Ambitions for Palliative and End of Life Care 2015 and saw evidence in locality meetings of review of progress and actions to be taken. The action plan for the National Care of the Dying audit of hospitals also covered the priorities within the community setting.

Community staff we asked were not aware what the end of life strategy entailed but most were able to discuss the national five priorities of care for the dying.

Staff told us the vision for end of life care was to keep the patient at the forefront of everything and ensure every patient dies in their preferred place and we saw this documented in the trust Quality Strategy 2015-2019.

Culture

Staff we spoke with were proud and passionate of the work they achieved and felt caring for a patient in the last days of their life was an honour with the priority to ensure the best possible care for the dying patient.

Staff told us that morale fluctuated due to staffing and workload pressures but staff felt valued by their patients, their peers and managers.
Members of the team told us there was no hierarchy within the team and they felt they could be open and honest and were able to raise any concerns they had.

Staff we spoke with across the community were positive and knew the names of individuals on the specialist palliative care team. They described the specialist palliative care team as responsive and good however some nurses felt that although contactable they recently were less visible due to staffing levels.

Governance

The End of life care service was based within the allied health and clinical support division and there was a clear management structure with processes in place which allowed for risks to be escalated or de-escalated to the board.

The managers we spoke with knew about the quality issues, priorities and challenges within the service and we saw evidence that they attended key governance meetings.

Staff were clear about their role within the trust and how the team integrated with the community and other providers.

Management of risk, issues and performance

The directorate safety and quality standards meeting were held monthly and attended by senior managers for the service. We reviewed minutes from the meetings and saw performance, incidents, complaints, compliance, information governance, along with the risk register were reviewed and discussed.

Senior managers worked with the specialist palliative care team to identify key priorities. Actions were taken to help mitigate risk for example administration staff hours had increased and the introduction of nurse led clinics and telephone consultations.

Nurse staffing and recruitment and induction of the three nurse vacancies was on the risk register and we saw all the actions documented to mitigate risk reflected what staff told us.

A business case had been devised to increase the current medical and nursing staffing levels with the aim to develop the service in line with the vision of the Ambitions framework which included expanding the service to seven days a week. Staff told us the business case had been discussed at the clinical management board but due to lack financial support this had not been implemented. Senior managers told us that the Chief Executive was going to discuss this with the clinical commissioning group.

We reviewed three sets of team meeting minutes and saw that operational issues and performance was discussed and actions documented against a responsible person.

Performance and patient outcomes in the community were monitored by the clinical commissioning group and although we observed one piece of data had been shared we did not see any evidence of monitoring, actioning or sharing results across the service.

The service worked collaboratively with other services as part of the End of Life Partnership with issues and performance specific to each area were discussed, shared and monitored through the End of Life Partnership. We observed minutes from meetings which discussed service delivery performance and actions taken to monitor performance for each service.

Senior staff told us that mortality reviews or meetings were not undertaken for community patients and if required individual GP practices reviewed deaths at practice level.

Information management

Community staff had access to an electronic integrated primary care record which they recorded care provided. An information sharing agreement was in place for staff to access and view only GP records.

All devises were password protected and during our inspection we observed that computers were locked in between users.

Senior managers told us that although they thought the electronic system could collate specific data to measure patient outcomes and services delivery this was not in place. We reviewed minutes from a meeting in November 2017 which identified an 18 month timeline to implement national codes.

All staff had access to electronic palliative care co-ordination systems which was used to record and share people's care preferences and key details about their care at the end of life between primary, secondary and voluntary care organisations in East Cheshire. Staff told us the GP's and the specialist palliative care team would input the information.

Community staff we spoke with told us they had not received any training in using the system and during our inspection it was evident that the majority of community staff did not know how to access the information with some not understanding what it was for or how to use it therefore it was difficult for us to review the electronic palliative care co-ordination systems at every location we visited. However of the three electronic records we reviewed we saw all of these had specific information including preferred place of care and do not resuscitate status clearly documented.

Staff across the trust had access to information, tools and support regarding patients at the end of their life through a local electronic prognostic assessment and information guide for end of life care.

Engagement

The service engaged with the public and local organisations and stakeholders to plan and manage end of life and palliative care services through the End of Life Partnership.

The trust adopted the greater Manchester cancer vanguard ''I want great care'' which gave patients and family members the opportunity to give feedback regarding their care and treatment on a website. We observed that although there was only small numbers of feedback all of those were positive.
Loved ones were invited to provide feedback regarding care received either over the phone or completing a brief questionnaire electronically or on paper in the bereavement booklet. However staff told us only a few people had responded.

The specialist palliative care team acknowledged that apart from the care of the dying audit, there was lack of patient feedback at trust level. We observed team meeting minutes which discussed the issues and a task and finish group was going to be arranged.

We asked staff how they knew they had provided good end of life care and they told us by feedback from patients, families and other professionals including GP's along with reflection at Gold Standard Framework meetings.

The trust undertook patient feedback and experience surveys including community services although it was not possible to identify specific responses relating to palliative or end of life care.

The only survey we saw in relation specifically to palliative and end of life care was a patient and visitor survey in relation to the environment in the Macmillan Cancer Resource Centre at the hospital.

Staff engagement was primarily through locality and team meetings, email and intranet services including updates, trust wide newsletters and a monthly pod cast presented by the Chief Executive. All staff we spoke with described the service as supportive.

Learning, continuous improvement and innovation

The specialist palliative care team were part of the End of Life Partnership which is a charitable collaborative set up and funded by providers and commissioners in Cheshire. Local hospices and hospitals, commissioning care groups and GP's were part of the partnership with the aim to work collaboratively, lead and facilitate excellence and best practice in palliative and end of life care.

We observed minutes from meetings which reviewed and discussed dashboards, the collaborative strategic plan along with updates from each organisation.

There was an oncology research team at the trust who were responsible for setting up and conducting cancer clinical trials at Macclesfield District General hospital; this gave patients who were unable to travel to a specialist cancer hospital an opportunity to participate in clinical trials. We observed a member of the team at a multidisciplinary team meeting who identified if any of the patients that were discussed could be offered the opportunity to participate in a clinical trial.

The trust celebrated staff achievements at the annual staff awards, we observed minutes from a meeting which stated that this year there had been 210 nominations and more than 7,000 on line and postal votes received.

Accreditations

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

The table below shows which services within community end of life care core service have been awarded an accreditation, together with the relevant dates of accreditation.

Gold Standards Framework Accreditation process, leading to the GSF Hallmark Award in End of Life Care	Not applicable	Not applicable
MacMillan Quality Environment Award (MQEM)	MacMillan Cancer Resource Centre	15/08/2017

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