The Pennine Acute Hospitals NHS Trust

Quality Report

Trust Headquarters
North Manchester General Hospital
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This report describes our judgement of the quality of care at this trust. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this trust	Inadequate
Are services at this trust safe?	Inadequate
Are services at this trust effective?	Requires improvement
Are services at this trust caring?	Good
Are services at this trust responsive?	Requires improvement
Are services at this trust well-led?	Inadequate

Summary of findings

Letter from the Chief Inspector of Hospitals

The Pennine Acute Hospitals NHS Trust serves the communities of North Manchester, Bury, Rochdale and Oldham, in the North-East sector of Greater Manchester and has a population of around 820,000.

It is a large Trust with a total operating budget of over half a billion pounds. Its main commissioners are NHS Bury, NHS Heywood, Middleton and Rochdale, NHS Oldham and NHS Manchester.

The Trust provides a range of elective emergency, district general services, some specialist services and operates from four main sites:

- **North Manchester General Hospita**l has a full accident and emergency department, which includes a separate paediatric A&E unit. It also provides a range of general and acute surgical services. The site is also the Trust's main headquarters.
- **The Royal Oldham Hospital** has a full accident and emergency department and offers a comprehensive range of acute and general surgical services, including vascular surgery. The site also offers more specialist services including clinical haematology and gynaecological services.
- **Rochdale Infirmary** provides a range of hospital services including a 24/7 Urgent Care Centre (UCC), a short stay inpatient Clinical Assessment Unit, the Oasis Unit for acute medical patients with dementia, day surgery, in addition the hospital provides , antenatal services, early pregnancy unit, outpatient clinics, and a specialist Eye Unit.
- **Fairfield General Hospital,** in Bury is one of three primary stroke units in Greater Manchester. It is also the main site for elective surgery in the North Manchester area.

The trust also provides a range of community services in North Manchester, Bury, Rochdale and Oldham,

Community Services Adults

- The trust had five community inpatient units for adults, including The Floyd Unit, Wolstenholme Unit, J5 (enhanced immediate care), Henesey House and Tudor Court. The inpatient units were part of the trusts community services directorate.
- The trust also provided community-based health services for adults. Services included district nursing, continence, podiatry and orthotics, phlebotomy, physiotherapy, dietetics, tissue viability, occupational therapy and specialist muscular skeletal therapies.
- The community based Out of Hours (OOHs) service provided professional nursing assessment and advice, management and nursing treatment for patients with palliative care needs and those patients who were in the terminal phase of their illness. This service also aimed to reduce hospital admissions out of hours and also provided the following services, Assistance with the provision of emergency loans and equipment. Psychological support and advice. Administration of drugs in the out of hour's periods.

Community Services for Children and Young People

- The trusts community children and young people services delivered a limited range of allied health professional (AHP) led specialist services for children and young people across four specialties; audiology, dietetics, orthoptics and orthotics. Other children's community services, such as universal child health services, were provided by other healthcare providers.
- The number of patients referred to the services was relatively small and reflected the limited number of services provided by the trust.
- We carried out an announced inspection of The Pennine Acute NHS Hospitals Trust between the 23 February and March 3 2016 as part of our comprehensive inspection programme.

Community Services for people at the End of Life.

- The trust provided 24-hour end of life care services in the community for adults over the age of 18 years and children less than 18 years, including patients with individual and complex nursing need.

Summary of findings

- End of life care is provided in a variety of organisational settings by a range of health care professionals. The range of services includes facilitation of discharge from the acute hospital and co-ordination of care provision in the community. District nurses provided end of life care with specialist and additional support provided by the Specialist Palliative Care Team.

We carried out our inspection as part of our planned inspection programme 23 February - 3 March 2016

And we inspected all 4 hospitals and all 4 community based services.

Below are our individual ratings for each location/service.

- We rated North Manchester General Hospital as Inadequate overall
- We rated Royal Oldham Hospital as Inadequate overall
- We rated Fairfield General Hospital as Requires improvement overall
- We rated Rochdale Infirmary as Good overall
- We rated Community Services as 'Good' overall with 'Outstanding' for the Caring domain in the Community End of Life service.

Following a comprehensive inspection we have rated Pennine Acute Hospitals NHS Trust inadequate in both safety and well-led domains. In line with CQC policy we have considered recommending the trust go into special measures, such is the level of concern we have around quality and safety.

Special measures would involve the appointment of an improvement director and supporting infrastructure which would assure CQC that the trust had the capacity to improve at pace. Immediately following our inspection, Salford Royal NHS Foundation Trust was asked to assume leadership of the trust. Salford's leadership team, rated outstanding in by CQC in its most recent comprehensive inspection of the trust, has put in place a comprehensive plan for further investigation into the challenges faced by Pennine Acute, with action plans to deliver improvement. Through regular engagement with the Salford team we are assured that the support being provided to the trust is commensurate with that of special measures package of support. As such, the Chief Inspector of Hospitals will not be recommending the trust be placed in special measures at this time.

Our key findings were as follows:

- **Vision and Values**

The trust vision was to be "a leading provider of joined up healthcare that will support every person who needs our services, whether in or out of hospital to achieve their fullest health potential.' The mission statement was "to provide the very best care, for each patient, on every occasion".

The underpinning values were 'Quality Driven, Responsible, and Compassionate'.

The trust had overarching strategic goals and had produced a 'trust transformation map', This was displayed around the trust and was well known to staff, although at the time of our inspection this work had not yet resulted in clearly defined quality priorities and objectives for all of the divisions and consequently there was variance in both progress and understanding of its implementation and requirements.

Leadership

Following the appointment of the CEO in April 2014 there had been significant changes to the Executive team with the team only completed just prior to the inspection when the recently appointed Medical Director took up post. The Chief Nurse had been in post 10 months. In addition, the secondment of the CEO to manage another trust was announced during the inspection and the Chair's tenure also came to an end at the time of the inspection.

From 1 April 2016, the Chair and Chief Executive of Salford Royal NHS Foundation Trust were appointed as Interim Chair and Chief Executive at to provide leadership and support to the Trust.

Staff were very positive about the visibility and responsiveness of the former Chief Executive (recently seconded) and the Chief Nurse. Staff felt that they both listened to concerns and took action to address them where possible; staff stated that historically this had not

Summary of findings

always been the case and that in the past the raising of concerns was not encouraged. However, staff did not feel that the Non-Executive Directors were accessible and were not visible throughout the organisation.

We found poor leadership and oversight in a number of services, notably maternity services, urgent care (particularly at North Manchester Hospital) the HDU at Royal Oldham hospital and in services for children and young people.

In all of these services leaders had not led and managed required service improvements robustly or effectively. In addition service leads had tolerated high levels of risks to quality and safety without taking appropriate and timely action to address them.

Culture within the trust

Staff told us that historically the culture in the trust had been quite closed and the raising of concerns and ideas was not supported or encouraged. Staff felt that the culture had (until recently) focused on financial matters and operational delivery rather than service quality.

Since 2014 the trust had been working on developing and encouraging a more open and inclusive culture where staff raise issues and concerns without blame.

In many services including community services we found that there was a positive culture emerging where staff felt well supported by their managers and colleagues and were positive about service changes and improvements. Staff reported being better heard and valued by the organisation and were positive about the new ways of staff engagement.

However, in a number of services and in particular maternity services we found low morale. In maternity services we also found a poor culture with deeply entrenched attitudes where some staff accepted sub optimal care as the norm and patients individual and specific needs were not appropriately considered or met.

Governance, risk management and quality measurement

The trust had recently made changes to the divisional and corporate structures to support an improved system of governance, performance management and clinical leadership. The Division of Medicine and the Division of Anaesthetics & Surgery were now managed by a triumvirate of 3 senior staff that included a clinical, nursing and managerial lead. The Division of Women & Children had 4 leaders (including Divisional Nurse Director for Midwifery and Nurse Director for Children), Integrated and Community Services by 2 leaders and Support services 2 leaders. There was one vacancy still to be filled in both Integrated and Community Services and support services.

However, at the time of our inspection the new structures had not yet been fully embedded and were not well understood, many of the new divisional management triumvirates were new in post and there was degree of misunderstanding as to how the processes should work in relation to the management and reporting of both performance and risks.

Consequently, the trust did not have a robust understanding of its key risks at departmental, divisional or board level. In a number of services such as urgent care, critical care ,maternity and services for children and young people key risks were not understood , recorded , escalate or mitigated effectively.

Performance reporting was not consistent we saw a number of performance reports prepared in various formats that contained no commonality. This had been acknowledged by the trust and work was underway to address this, however, this was work was still in its early stages at the time of our inspection.

We also had concerns in respect of the quality of data provided to support performance reporting and underpinning metrics. We did not see any evidence of testing data quality in respect of performance monitoring and management as part of our inspection.

Incident reporting and learning from investigations

The trust had an on line incident reporting system that staff were aware of and able to use. The application of the incident reporting process was inconsistently applied. In some services incident reporting was well established and staff reported appropriately, feedback and learning was applied and helped to improve practice.

However, we found that there was not a strong culture of reporting and learning from incidents across the trust as a whole. This was evident by the practices we found in emergency care, medicine, maternity and gynaecology

and children and young people services where staff stated that they did not enter all reportable incidents on to the system as there was often no managerial response or feedback.

Although improvements in relation to incident reporting and investigation were underway (led by the Director of Clinical Governance and Head of Patient Safety) that included the introduction of standard operating procedures, clarity of role and responsibility and staff training, the historical poor governance systems for the management of incidents had led to backlogs and significant delays in investigations.

There were a number of historical look back exercises conducted in 2015/16 (3 year look back at maternity incidents to inform, the maternity improvement plan and 5 year look back at diagnostic incidents to inform the diagnostic improvement plan).

This, along with improved reporting accounted for an increase in Serious Incidents that contributed to a significant delay in completing investigations due to capacity issues.

The backlogs were challenging managers in terms of their capability and capacity to address them. As a result, opportunities for identifying causal factors and trends were limited, and opportunities for learning and improved lost or delayed as a consequence.

The previous CEO had recognised that the reporting and management of SIs was of concern when they were appointed in 2014 and subsequently commissioned an external review by HASCAS (Health & Social Care Advisory Service). This report, published in April 15 was presented to all senior managers within the Trust and commissioners from all CCGs as part of a workshop. The review identified 14 key concerns around the management, culture and SI investigation processes. The trust felt that as a result of the scale of the concerns raised at the time of the reports publication that the required improvements would take at least a year to implement and embed changes.

Additionally, as part of the HASCAS -SI review it was identified that the quality of investigations both in terms of analysis, identifying root causes and producing recommendations was poor. We were informed that there had been no root cause analysis training had been delivered for the previous 3 years.

As a result in May 2015 the Director of Clinical Governance commissioned an external provider to deliver a 2 day programme of RCA training over 2015/16. As part of this programme 103 senior managers and clinicians have been trained.

However, it was evident that the trust still had much to do as despite the investment in improving incident reporting and investigations, we found incident reports and investigations with no recommendations or learning points identified or recorded, staff, including senior managers, were unaware of the outcomes of serious incident investigations and the process for quality checking of reports was not properly understood by those completing investigations.

Mortality and Morbidity

The Trust mortality indicators such as the Hospital Standardised Mortality Ratio (HSMR) and the Summary Hospital-level Indicator (SHMI) did not highlight any elevated risks at the time of our inspection.

The key mortality indices were included within the Trust Integrated Performance report that was submitted monthly to the Board.

The Trust had reviewed its mortality review process to ensure that mortality alerts are reviewed at the Trust's Safety Committee, reporting to the Trust Quality and Performance Committee as well as the Board to support the investigation of mortality outliers and appropriate action taken to secure improvement.

In some services we found that there was evidence of shared learning and improvements in practice as a result of mortality and morbidity reviews.

However in other services there was limited evidence of the sharing of learning and opportunities for improvement. We also noted that in some specialty's poor attendance at mortality and morbidity related meetings and poor recording and ownership of improvement actions.

However, since our inspection the trust has confirmed that the process for ensuring implementation of actions in respect of findings from reviews has been identified as a key clinical effectiveness priority for 2016-17, and in order to develop this further, the trust was aiming to

improve the sampling for mortality reviews to focus on areas of risk in line with new Department of Health guidance: The Good Governance Guide for Mortality. (Issued in December 2015).

Safeguarding

Staff in all service areas were able to identify and escalate issues of abuse and neglect.

There were safeguarding policies and procedures in place that covered a range of issues regarding abuse and neglect.

Staff had 9am -5pm Monday to Friday access to and support from the safeguarding team. Outside of these hours staff could seek support and guidance to escalate issues of abuse and neglect from managers on call, a paediatrician on call and the Social Care Emergency Duty Team.

Safeguarding practice was supported by mandatory training Compliance for level 2 safeguarding training indicated that 94% of staff have completed Level 2 training against a target of 80%.

The trust had set a target that 80% of staff working with children and young people had to have level three safeguarding training. In the children and young people's service at North Manchester General Hospital the trust provided information that supported 72% of staff in paediatrics had completed this training and 30% of neonatal staff had completed this training.

In addition, there were low levels of level 3 safeguarding children's safeguarding in the urgent care services

It was of concern that the trust's target for training staff at level 3 was not met.

Nurse Staffing

Nurse staffing establishments in adult services were determined using a recognised tool and were reviewed every six months. Never the less there were significant shortages in medical, midwifery and nurse staffing establishments. Although a substantial amount of work had been undertaken by the Chief Nurse to address staffing shortfalls, wards and departments were not always adequately staffed to meet the needs of patients in terms of numbers or skills. In addition, in 2015 the Chief Nurse had introduced an escalation process that supported staff in raising issues so that managers could make an appropriate response in managing staffing related risks.

Nevertheless the nurse staffing in critical care services failed to meet the standard set by the Intensive Care Society for supernumerary shift co-ordinators at band 6/7. This issue was well known to the trust and was highlighted as a concern in the May 2015 review by the Greater Manchester Critical Care Network.

Nurse staffing levels and skills mix in paediatrics did not reflect Royal College of Nursing (RCN) guidance (August 2013). There were no advanced paediatric life support (APLS) or European paediatric life support (EPLS) trained nursing staff. Only 23.7% of nursing staff were up to date with paediatric immediate life support training.

We reviewed neonatal staffing in line with BAPM (British Association of Perinatal Medicine) guidance over the course of a month. In 25.8% of shifts, nurse staffing did not comply with BAPM guidance for the nurse: patient ratio. On average in each of these shifts the unit was understaffed by at least one registered nurse. When we reviewed the planned vs actual staffing information, this showed in 83.3% of shifts the unit was understaffed by on average 2.2 nurses.

Midwifery Staffing

Maternity staffing did not meet the national benchmark set out in the Royal College of Obstetricians and Gynaecologists (RCOG/RCM) guidance RCOG recommendation of 1:28 births. In addition the labour ward frequently had lower than the planned number of midwives on duty; consequently Midwives were not always able to provide one to one care for women in labour in accordance with good practice.

At the time of our inspection we found that the maternity service triage facility was not staffed appropriately and women were left unsupervised. We raised this at the time and the trust took action to address this matter immediately.

An escalation processes in relation to midwifery staffing had been introduced that included mitigating actions that should be taken when midwifery staffing levels fell below establishment. There was also a divert policy in

place and an ongoing recruitment programme. However, maintaining the required staffing levels in maternity services was a daily managerial challenge and midwifery staffing shortages were a frequent occurrence.

Community Nurse Staffing

Community nursing services were suitably staffed and there were minimal staffing shortages.

Medical staffing

North Manchester General Hospital

There were a number of departments in the hospital where there were concerns regarding medical staffing. This was particularly significant within the Urgent and Emergency Care, medicine, maternity and gynaecology and children's and young people's services (CYP)

Within the Urgent and Emergency (U&E) care department an establishment of nine consultants had been commissioned. Only one consultant was employed substantively at the time of our inspection. However, consultants from other areas of the trust worked in the department on a rotational basis to provide senior support.

The A&E department was established for seven middle grade positions and 13 junior doctor positions. However, only three middle grade doctors and five junior doctors were employed substantively at the time of the inspection. As a result, the department relied heavily on locum doctors of all grades. There was a local induction process for locum staff, however on our unannounced visit to U&E care we noted that one locum doctor had not been subject to a local induction and was reliant on nursing staff to assist in locating key items and equipment.

There was limited assurance that the performance of locum doctors with U&E was being reviewed on a regular basis. This was important as locum doctors formed a large percentage of the medical workforce within the department.

There was no consistent consultant presence on the paediatric wards during peak times in accordance with 'Facing the Future Standards'. The trust advised that consideration had been given to new rotas as part of the paediatric improvement plan. However, no implementation date had been set at the time of our inspection.

The 'Facing the Future' Standards also recommend that every child who presents with an acute medical problem is seen by a consultant, or equivalent, within 24 hours. In one paediatric serious incident investigation we reviewed this had not occurred and was deemed a causal factor in the delay of diagnosis.

The trust did not monitor this standard at the time of our inspection.

Royal Oldham Hospital

There were a number of departments in the hospital where there were concerns regarding suitable and appropriate medical staffing. This was particularly significant within the critical care, maternity and gynaecology and children and young people's services.

There were medical staffing vacancies in medical services and this had been identified as a risk. There were actions identified to mitigate this risk such as an ongoing recruitment programme.

At the time of our inspection there was no dedicated medical cover for the High Dependency Unit (HDU). The unit was 'open' unit with potential referral and admissions from any speciality within the hospital. Consequently this meant that on the HDU many of the standards for critical care as set out in the "Core Standards for Intensive Care "(Nov 2013) the Draft D16 Service Specification for Adult Critical Care and the Guidelines for the Provision of Intensive Care Services (GPICS) Standards. (2015) were not being met. Of particular concern was that the inappropriate medical cover for the HDU had been known to the trust in 2013 and it was only during our inspection that arrangements were made to provide adequate medical cover in this area.

In the hospitals services for children and young people 'Facing the Future' Standards recommend there should be consultant presence on the ward at self-defined peak times. Staff informed us that their peak times were between 4pm and 9pm. The hospital had consultants scheduled to be on site up until 5pm. The trust confirmed that consultant presence during peak times was not in

place. The trust advised us that consideration had been given to new rotas as part of the paediatric improvement plan. However, no implementation date had been set at the time of our inspection.

More positively, the emergency department had sufficient numbers of medical staff with an appropriate skill mix to ensure that patients received the right level of care.

Fairfield hospital

There were medical staffing vacancies in medical services and this was on the trust risk register. There were actions identified to mitigate this risk such as a recruitment programme. Existing vacancies and shortfalls in surgery were covered by locum, bank or agency staff when required, such staff were provided with local inductions to ensure they understood the hospital's policies and procedures. The information we reviewed at the time of our inspection indicated medical staffing was appropriate at the time of the inspection.

Rochdale Infirmary

Medical staffing levels and skill mix in surgical services was recognised as being appropriate to meet patient need and reflected current guidance. Operating theatres were established against the 'Association for Perioperative Practice (AfPP) staffing recommendations.

Medical cover was provided 24 hours a day and senior advice was available from Fairfield General Hospital if required.

Assessing and responding to risk.

In the U&E departments there were a high number of patients experiencing unacceptable waits for ambulance handover, triage and initial treatment. Performance against the Royal College of Emergency Medicine (CEM) standard of patients being triaged within 15 minutes of arrival was poor in all 3 departments.

The trust had a deteriorating patient programme as part of its safety improvement plan and Sign Up to Safety initiative that included a review of the EWS policy, review of critical care outreach, development and review of educational programmes as well as the development of a business case for IT solution of e-observations. However at the time of our inspection these improvements were not yet implemented or embedded and although we found that the Early Warning Systems in place to promptly identify deteriorations in patient's condition, we found that these were not consistently recorded and escalated in a number of services including urgent care, medical services, maternity services and in services for children and young people. This meant that risks to patients were not always identified and medical intervention provided in a timely way.

Staff on the Medical Emergency Unit (MEU) at North Manchester Hospital had not received training to use the continuous cardiac monitoring in place and there was no monitoring system in place at the nurse's station.

Royal College of Nursing (RCN) standards (August 2013) recommends that in children's services a member of the nursing staff should have Advanced life Support (APLS) training at all time throughout the 24 hr period. The trust did not have any APLS trained nursing staff members in paediatrics. Only 13/46 (28.3%) nurses had current paediatric life support (PILS) certification on paediatrics. We raised this with the trust at the time of our inspection and immediate action was taken to mitigate and manage this risk.

Neonatal records showed that only 23.9% of nursing staff had current NLS training at the time of our inspection.

However, in surgical services we found good use of systems to ensure that risks to elective and emergency patient groups were identified pre-operatively, venothromboembolism (VTE) assessment was completed for all hospitalised patients within 24 hours of admission. In Rochdale surgical services Audit data for 2015 against the trust target of 95% confirmed completion of VTE assessments as 97%.

Similarly there was good use of the 5 steps to safer surgery checklist in most surgical settings. Compliance rates were consistently above 90% across the trust.

The trust had undertaken improvements in Sepsis, as part of its Safety Programme and Sign Up to Safety work, including development of algorithms, development of training tools and auditing practice via the Advancing Quality programme. However, in A&E we found that patients with symptoms of sepsis were not always identified and treated in a timely way.

In community services we found that systems and processes to maintain patient safety were appropriately applied, reviewed and monitored.

Summary of findings

Staff were clear and consistent in maintaining steps to protect patients from avoidable harm.

Evidence based care and treatment

Care and treatment was based on evidence-based guidance and the policies and procedures, assessment tools and pathways followed recognisable and approved guidelines such as the National Institute for Health and Care Excellence (NICE).

There was use of clinical audit to monitor and improve performance. However, where audits highlighted areas for improvement we did not find always find evidence of implemented and monitored action plans to secure improvement.

Patient outcomes in medical services particularly for patients with heart failure, diabetes and children's diabetes required improvement.

Competent staff

The trust had a system in place for staff to receive an annual appraisal. However compliance rates across the hospitals and services varied considerably, in some services such as community services and outpatients departments 100% of staff had received an appraisal, yet in medical services at North Manchester General Hospital compliance rates were as low as 23%.

This meant that there were significant numbers of staff that had not had the opportunity to meet with their managers to discuss their performance and continued professional development.

There was an induction and a preceptorship plan in place for new staff. This included agreed supernumerary periods so that staff could develop their competency and skills with supervision and support. However we found that due to staffing pressures the plans and support for new staff were not always adhered to and staff formed part of the staffing establishment sooner than anticipated. This was a particular issue in urgent and emergency care.

Compassionate care

Care and treatment was delivered by caring, committed, and compassionate staff.

In community end of Life services we found outstanding care and excellent examples of staff displaying an individualised person centred and compassionate approach to patient's needs and preferences. There was a compassionate approach for patients whose condition or circumstances made them vulnerable. However, there were examples when due to staffing pressures, care had become task focused and we observed little positive interaction with patients other than at those times. There were times when care delivery was functional and impersonal.

Access and Flow

In the 3 A&E departments the proportion of all patients that attended the emergency department and were treated within four hours was consistently and significantly below the national target. Patients were subject to delays in triage, initial assessment and waited for unacceptable lengths of time for transfer from the A&E departments.

A review of patient records indicated that there had been a high number of patients waiting for over 12 hours in the U&E departments. As a result of the trust's decision to admit policy these were not always recorded appropriately, potentially providing an inaccurate picture of performance and limiting the ability to improve the service. The trust acknowledged the need to review the Decision To Admit Policy to ensure clinical leaders and senior staff were fully appraised about the time patients spend in A&E. This trust has confirmed that a new policy was fully implemented in early March 2016.

In addition there were times due to bed capacity and availability; patients were placed in areas not best suited to their needs. (Known as outliers) Patients also experienced frequent moves between wards and departments often during the night without there being a clinical need for the transfer to take place.

Despite a focused approach to discharge planning, people remained in hospital longer than they needed to be and there were examples of delays in patient discharges particularly in medical services.

However, performance at the urgent care centre at Rochdale Infirmary consistently met national expectations.

The trust had an urgent care improvement plan in place , however, this had not yet secured significant improvement at the time of the inspection.

Summary of findings

In terms of referral to treatment times the information available to us indicated that the trust met internal and national referral to treatment targets in all specialties. and that national cancer treatment targets were met. However, since our inspection we have been made aware of a number of concerns in relation to the quality and accuracy of the data provided by the trust in respect of referral to treatment times. This matter is under review by the new Executive Team and we will be monitoring the trusts response and actions in respect of this matter through our ongoing regulatory activity.

Meeting individual needs

There were positive examples of initiatives to meet the needs of patients whose circumstances or illness made them vulnerable including patients who were living with dementia or who had a learning disability.

The trust also used a leaf symbol to indicate that a patient was frail and a butterfly symbol to indicate that a patient was at the end of life. These discreet symbols alerted staff to so that assessments and care plans considered any reasonable adjustments required to meet the patient's needs.

Interpreters were available on demand for patients whose first language was not English. British Sign Language interpreters were also available for patients who were deaf.

Learning from complaints

We found that overall the management of complaints was poor. The previous two full calendar years; 01.01.2014 – 31.12.2015, the Trust received 1455 complaints. The two full calendar years prior to the date of inspection; 21.02.2014 – 21.02.2016, the Trust received 1414 complaints. At the time the inspection commenced 22.02.2016, the Trust had 227 open complaints, and over 80 had remained open for over 100 days.

In addition, we found limited oversight and review of action planning in response to complaints and recurring themes in respect of causal factors. We found that learning from incidents and complaints was not systematically implemented and monitored and as a result opportunities for improving services, patient experiences and confidence were lost.

Importantly the trust must

Urgent and Emergency Services

- Ensure there are sufficient numbers of suitably qualified, competent, skilled and experienced staff deployed in the Urgent and Emergency department to assess and meet patients needs
- Ensure that there are sufficient numbers of staff with the appropriate skills available at all times. This includes ensuring that there are sufficient numbers of staff available to resuscitate adults and children.
- Ensure that patient risk is monitored and documented appropriately through the use of the early warning scores (EWS) and the Manchester early warning score (MANCHEWS) for children.
- Ensure that daily checks and relevant documentation of controlled drugs are completed correctly and accurately in line with legislation and trust policy.
- Ensure that patients attending the department are assessed and treated in a timely manner.
- Ensure that the effectiveness and timeliness of treatment is measured on a regular basis so that there is the opportunity to improve services where required.

Medical services

- Ensure that there are sufficient nursing staff on duty to meet patients needs at all times.
- Ensure that patients staying overnight at the Manchester treatment centre have facilities to wash and store personal belongings.
- Ensure that records are completed in line with best practice guidance and are maintained and stored securely.
- Ensure that incidents are investigated promptly and learning is shared through formal, established channels.
- Ensure that plans are in place for wards sharing facilities and staff in the case of an outbreak of infection.
- Ensure that staff receive training on and understand how to apply the Mental Capacity Act and deprivation of liberty safeguards.
- Ensure that staff follow the agreed standards for adult patient observation practice.

Summary of findings

- Ensure that assessments of patient's nutrition and hydration needs are fully completed and patients receive appropriate support where necessary.
- Ensure that the discharge lounge and ambulatory care unit is fit for purpose.

Surgical Services

- Ensure that there are sufficient nursing staff on duty to meet patients needs at all times.
- Ensure that DNACPRs are reviewed regularly particularly when a patient's condition has changed.
- Ensure that staff understand and act in line with the legal requirements of the Mental Capacity Act 2005 and Deprivation of Liberties Safeguards.
- Ensure all nursing and medical staff have annual appraisals completed.
- Ensure that staff complete training in 'Sepsis six' so staff are aware of the process to follow when a patient is put on a 'Sepsis six' treatment pathway.
- Ensure that critical care beds are available for surgical patients who require their initial post-operative care to take place in a designated critical care unit so that they receive treatment and care from staff who have the skills and training in this area.
- Ensure that patients who are outliers on wards have the appropriate care, review and support to ensure a positive outcome results from their treatment.

Critical care

- Take action to ensure that level 2 patients on the high dependency unit at the Royal Oldham Hospital are managed in accordance with the national guidance and standards for critical care.
- Take action to provide suitable medical cover for the High dependency unit at Royal Oldham Hospital.
- Take action to reduce the numbers of delayed and out of hours discharges from both level 2 and level 3 critical care facilities.

Maternity and Gynaecology Services

- Ensure there are sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed in the maternity services. This includes sufficient consultant resident cover in the labour ward.
- Ensure that the risks to the health and safety of patients of receiving the care or treatment are assessed, escalated and met.
- Investigate incidents within agreed timescales and take action to prevent recurrence.

Children and Young People

- Ensure there are sufficient numbers of suitably qualified, competent, skilled and experienced Nursing and Medical staff deployed in the paediatric and neonatal services to meet patients needs at all times.
- Assess the risks to the health and safety of patients of receiving the care or treatment and escalate and managed appropriately.
- Investigate incidents robustly within agreed timescales and take action to prevent recurrence
- Ensure that electrical equipment is appropriately maintained and fit for purpose.

End of life services

- Take action to ensure that any DNACPR decision is supported by the consent of the patient. Take action to ensure that where a patient appears to lack capacity to consent to a DNACPR decision, a mental capacity assessment must take place prior to the decision being made.
- Take action to ensure where a patient has been assessed as lacking capacity to make the DNACPR decision a documented discussion with patient's family takes place prior to the decision being taken.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Background to The Pennine Acute Hospitals NHS Trust

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

The trust provides a range of elective emergency, district general services, some specialist services and operates from four main hospital sites and community clinics:

- Fairfield General Hospital, Bury
- North Manchester General Hospital
- The Royal Oldham Hospital
- Rochdale Infirmary

The trust provides services in the following principle specialties:

- Accident and Emergency
- Diagnostics, comprising: Anaesthetics; Pathology; Radiology; Critical Care and Clinical Professions
- Medicine, comprising: sexual health and infectious disease; Endocrinology and Diabetes; Elderly Care and Rheumatology; Cardiology, Respiratory, Oncology and Palliative Care and General Medicine
- Specialist services, comprising: HIV/ AIDS, renal care, breast and vascular surgery plus Oral and Maxillofacial / Dental
- Surgery, comprising: General surgery; Orthopaedics; Ear, Nose and Throat Surgery; Dental; Ophthalmology; Urology and Gastroenterology
- Women and Children, comprising: Gynaecology; Obstetrics; Community Midwifery and Paediatric care
- Community Services in North Manchester; comprising: Active Case Management, Community Nutrition, Continence, District Nursing, Falls and Navigator, Funded Nursing Care, Home Enteral Feeding, Intermediate Care, Macmillan Nursing & Therapy, Physiotherapy, Podiatry/Vascular Triage, Stroke, Tissue Viability/Leg Ulcer Service.
- The trust employs almost 9,000 staff and is one of the largest non-teaching trusts in the country.

Our inspection team

Chair: Mr Paul Morrin, Director of Integration at Leeds Community Healthcare NHS Trust

Head of Hospital Inspections: Ann Ford, Care Quality Commission

- The team included two CQC inspection managers, sixteen CQC inspectors, two CQC analysts, a CQC assistant inspector, a CQC inspection planner and a variety of specialists including: Consultant anaesthetist, Consultant physician; Consultant Upper GI and Bariatric Surgery, Consultant in palliative care, Consultant Paediatrician, Director of Nursing and quality, Lead Nurse in Critical Care & Trauma Senior Independent Hospital Director, Radiology Manager, Pharmacist, Modern Matron for Intermediate Care Beds, senior midwife an experts by experience (lay members who have experience of care and are able to represent the patients voice).

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

The inspection took place between 23 February - 3 March 2016

Summary of findings

Before visiting, we reviewed a range of information we held, and asked other organisations to share what they knew about the hospital. These included the clinical commissioning group (CCG); Monitor; NHS England; Health Education England (HEE); General Medical Council (GMC); Nursing and Midwifery Council (NMC); Royal College of Nursing; College of Emergency Medicine; Royal College of Anaesthetists; NHS Litigation Authority; Parliamentary and Health Service Ombudsman; Royal College of Radiologists and the local Healthwatch.

We held a public engagement event on February 15 2016 when people shared their views and experiences of the trust. Some people shared their experiences with us via email or by telephone.

We carried out an inspection during the period of 23 February and March 3 2016. We spoke with a range of staff in the hospitals including nurses, junior doctors, consultants, administrative and clerical staff, radiologists, radiographers, and pharmacists. We also spoke with staff individually and held 'drop in' sessions for all staff.

We talked with patients and staff from all the ward areas and outpatient services. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment.

We would like to thank all staff, patients, carers and other stakeholders for sharing their balanced views

What people who use the trust's services say

- The trust scored better than the England average in 2015 for all four indicators in Patient Led Assessments of the Care Environment (PLACE).
- In the Cancer Patient Experience Survey the trust scored in the middle 60% of trusts for 25 out of 34 questions. The remaining 9 questions scored in the bottom 20% of trusts.
- In the CQC Inpatient Survey 2014 the trust scored about the same as other trusts for all questions.
- The trust saw a small increase in the number of written complaints received in 2012/13 and 2013/14 which then decreased in 2014/15.
- The trust fell below England average between April 15 and October 15 in the Friends and Family test for percentage of patients that would recommend the trust as a place for care and treatment.

Facts and data about this trust

Population served:

- The trust provides general and specialist hospital services to around 820,000 residents across the north east of Greater Manchester in Bury, Prestwich, North Manchester, Middleton, Heywood, Oldham and Rochdale and parts of East Lancashire.
- The trust works with local Clinical Commissioning Groups (CCGs) in Manchester, Bury, Oldham and Heywood, Middleton and Rochdale and also with East Lancashire

Deprivation:

- The health of people in Bury is varied compared with the England average. Deprivation is lower than average, however about 16.9% (6,400) children live in poverty. Life expectancy for both men and women is lower than the England average.
- The health of people in Oldham is generally worse than the England average. Deprivation is higher than average and about 25.3% (12,700) children live in poverty. Life expectancy for both men and women is lower than the England average.
- The health of people in Rochdale is generally worse than the England average. Deprivation is higher than average and about 25.2% (11,300) children live in poverty. Life expectancy for both men and women is lower than the England average.

Summary of findings

- The health of people in Manchester is generally worse than the England average. Deprivation is higher than average and about 33.9% (32,900) children live in poverty. Life expectancy for both men and women is lower than the England average.
- Health profiles not available for Prestwich, Middleton or Heywood.

Numbers of Beds

1,313

• General & acute

1,144

• Maternity

135

• Critical Care

32

Numbers of Staff

9,081

• Medical

773

• Nursing

2,961

• Other

5,347

Activity Type (2014/15)

2014-15

• Inpatient admissions

117,656

• Outpatients (total attendances)

688,262

• Accident & Emergency (Q4 attendances)

317,347

Summary of findings

Our judgements about each of our five key questions

	Rating
Are services at this trust safe? We rated safety as **Inadequate** overall because; • In the trusts acute hospital settings the maintenance of patient safety was of significant concern. • This was a particular issue in the trusts A&E departments, maternity services, services for children and young people, critical care services (HDU in Oldham hospital) and medical services in both North Manchester and Oldham hospitals. • Although there were systems in place to protect, prevent and monitor avoidable harm to patients we found that they were not used consistently and appropriately. • Incidents and risks were not escalated in a timely way or at times not escalated at all; consequently they did not gain robust executive scrutiny or the required response from managers and the senior team. • We also found examples where the senior team and the board had been made aware of risks and had failed to address them. • In terms of the investigation of reported incidents including those resulting in severe harm there were unacceptable delays in investigations coupled with failures to effectively investigate. • Opportunities to identify and apply learning to prevent recurrence were also missed. Learning was not always identified and shared through established systems and channels. • This was the case despite staff training and trust wide publications to support staff learning and improvement in relation to incident management and patient safety including; a quarterly 'Pride in Safety' publication that identified learning across incidents, complaints, claims and coroners inquests and a monthly 'Lessons Learned' bulletin relating to Serious Incidents that was developed for each division, as well as a weekly 'Spotlight on Safety' included in the Chief Executive's bulletin, • In some services staff stated that they no longer reported incidents as they did not receive a managerial response or feedback. This was a particularly evident in A&E medical, maternity and children's services.	**Inadequate** 

Summary of findings

- Although the trust had systems, communication channels and training in place to support its obligations in respect of the duty of candour regulation, the processes and requirements were not widely understood by all staff on the wards and departments
- There was a process in place to review mortality and morbidity. In some services the learning from these reviews was shared through divisional governance meetings and staff newsletters (although this was very recent initiative). In other services there was a lack of learning and sharing of knowledge from reviews we also noted in some services poor attendance at mortality and morbidity meetings and poor recording and ownership of improvement actions.
- In the A&E departments there were a high number of patients experiencing unacceptable waits for ambulance handover, triage and initial treatment. Performance against the Royal College of Emergency Medicine (CEM) standard of patients being triaged within 15 minutes of arrival was poor in all 3 departments. Additionally we found that the Early Warning Systems in place to promptly identify deteriorations in patient's condition were not consistently recorded and escalated. This meant that risks to patients were not always identified and medical intervention provided in a timely way.
- There were significant shortages in midwifery and nurse staffing. Although a substantial amount of work had been undertaken by the Chief Nurse to address staffing shortfalls, there were times when the wards and departments were not adequately staffed to meet the needs of patients in terms of numbers or skills.
- Medical staffing was a particular concern in the A&E department in North Manchester Hospital where the lack of consultant cover was having a negative impact on the timely care and treatment of patients.
- In Oldham Hospital, the High Dependency Unit did not have designated or suitable medical cover. The trust had been alerted to this matter in 2013 and only took immediate action to address this important safety issue when we raised it during our inspection.
- More positively, in Community services there were no such concerns. We found that systems and processes to maintain patient safety were appropriately applied, reviewed and monitored. Staff were clear and consistent in maintaining steps to protect patients from avoidable harm.

Incidents reporting and investigation.

Summary of findings

- Between December 14 and November 15. 13,669 NRLS incidents 112 serious incidents were reported of which 9,780 resulted in no harm. The trust averaged 6.9 incidents per 100 admissions which is below the England average.
- The trust had an on line incident reporting system that staff were aware of and able to use.
- The application of the incident reporting process was inconsistently applied. In some services incident reporting was well established and staff reported appropriately, feedback and learning was applied and helped to improve practice.
- However, we found that there was not a strong culture of reporting and learning from incidents in the trust as a whole. This was evident by the practices we found in emergency care, medicine, maternity and gynaecology and children and young people services.
- There was an unacceptable level of serious incidents with delays in investigations.
- Staff in the U&E, maternity and services for children and young people stated that they did not enter all reportable incidents on to the system as there was often no managerial response or feedback.
- In the U&E department at North Manchester Hospital some staff had to be prompted to report incidents by inspectors for issues such as equipment that was overdue a service, inappropriately stored drugs and out of date disposable equipment. Staff did not demonstrate an awareness that these were reportable incidents and part of a wider governance and safety system.
- In maternity services an independent review into nine serious incidents in the maternity services at the trust had been completed in January 2015.The review had resulted in a number of recommendations, however at the time of our inspection these recommendations had not been put into practice in the management of the incidents we reviewed within the service.
- We found incident reports and investigations with no recommendations or learning points identified or recorded, staff, including senior managers, were unaware of the outcomes of serious incident investigations and the process for quality checking of reports was not understood by those completing investigations.
- There was a delay in the management of incidents in the maternity services. Information provided by the trust showed as of 21 February 2016 there were 170 unclosed incidents in maternity and gynaecology services. The majority of open

incidents (104) related to the labour ward. At a trust level within the total of open incidents in maternity and gynaecology 44 involved moderate harm, eight severe and five deaths caused by the patient safety incident.

- In services for children and young people there was a disparity in the data provided regarding the number of reported Strategic Executive Information System (Steis) serious incidents. The trust told us that four serious incidents were reported between 7 February 2015 – 28 February 2016. However, during the inspection it was determined that during the same period there had been seven serious incidents.
- The trust's system for collating STEIS information did not collate all serious incidents. We requested the investigation records (root cause analysis) for these incidents and evidence of lessons that had been learnt. Two of these incidents were reported under old criteria for Steis incidents and were appropriately investigated.
- However two of the four paediatric incidents had been reported retrospectively as a result of formal complaints. The need to report and investigate had not been identified at the time of the incidents. The investigations and notifications to Steis were delayed by several months (7 months and 3 months).
- As a result of our inspection findings we concluded that incident investigations were subject to backlogs and substantial delays and associated risks were not consistently monitored or mitigated. This had led to limited opportunities for learning and improvement and consequently posed a risk to patient safety.
- The previous CEO had recognised that the reporting and management of SIs was of concern when they were appointed in 2014 and subsequently commissioned an external review by HASCAS (Health & Social Care Advisory Service). This report, published in April 15 was presented to all senior managers within the Trust and commissioners from all CCGs as part of a workshop. The review identified 14 key concerns around the management, culture and SI investigation processes. The trust felt that as a result of the scale of the concerns raised at the time of the reports publication that the required improvements would take at least a year to implement and embed changes.

  Additionally, as part of the HASCAS -SI review it was identified that the quality of investigations both in terms of analysis, identifying root causes and producing recommendations was poor. We were informed that there had been no root cause analysis training had been delivered for the previous 3 years.

Summary of findings

As a result in May 2015 the Director of Clinical Governance commissioned an external provider to deliver a 2 day programme of RCA training over 2015/16. As part of this programme 103 senior managers and clinicians have been trained.

However, it was evident that the trust still had much to do as despite the investment in improving incident reporting and investigations, we found incident reports and investigations with no recommendations or learning points identified or recorded, staff, including senior managers, were unaware of the outcomes of serious incident investigations and the process for quality checking of reports was not properly understood by those completing investigations.

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 trust was aware of its obligations in respect of the Duty of Candour regulation and had implemented guidance for staff in this regard. A trust wide duty of candour policy was in place with an accompanying leaflet and training to support staff understanding. There was also a trigger to consider the duty of candour on the incident reporting system.
- However at an operational level we found that the requirements of the regulation were not well understood or embedded. We spoke with a number of staff in the acute locations who were unaware of the regulation or their role in its application.
- We found evidence that duty of candour requirements had been applied in the number of serious incidents we reviewed. However, due to the substantial backlog of investigations relating to incidents and concerns we could not robustly ascertain if the trust had fully met its obligations in this regard.

Safety performance (Community Services)

- The trust used the NHS Safety Thermometer to measure and record patient harm. This tool showed the frequency of pressure ulcers, falls, blood clots and catheter-related urinary infections each month. Figures for community services were collected monthly in line with national requirements and rates of avoidable harm were within expected levels.

- We observed safety goals and targets in use and the District Nursing teams monitored these using a dashboard system.
- One example was a key performance indicator in relation to the development and care of pressure ulcers. The indicator was monitored at divisional and executive level. If a patient developed a pressure ulcer at a grade 3 or above the team responsible for the patients care was required to attend a learning and scrutiny panel to examine why the ulcer had occurred and what measures could be taken to prevent a reoccurrence.
- Senior managers within the service routinely reviewed incidents and identified themes in relation to community based services.

Mortality and Morbidity

- The Trust mortality indicators such as the Hospital Standardised Mortality Ratio (HSMR) and the Summary Hospital-level Indicator (SHMI) did not highlight any elevated risks at the time of our inspection.
- The key mortality indices were included within the Trust Integrated Performance report that was submitted monthly to the Board.
- The Trust had reviewed its mortality review process to ensure that mortality alerts are reviewed at the Trust's Safety Committee, reporting to the Trust Quality and Performance Committee as well as the Board to support the investigation of mortality outliers and appropriate action taken to secure improvement.
- In some services for example surgery we found that there was evidence of shared learning and improvements in practice as a result of mortality and morbidity reviews.
- However in other services there was limited evidence of the sharing of learning and opportunities for improvement. We also noted poor attendance at mortality and morbidity related meetings and poor recording and ownership of improvement actions.
- However, since our inspection the trust has confirmed that the process for ensuring implementation of actions in respect of findings from reviews has been identified as a key clinical effectiveness priority for 2016-17, and in order to develop this further, the trust was aiming to improve the sampling for mortality reviews to focus on areas of risk in line with new Department of Health guidance: the Good Governance Guide for Mortality. (issued in December 2015).

Safeguarding

Summary of findings

- Staff in all service areas were able to identify and escalate issues of abuse and neglect.
- There were safeguarding policies and procedures in place that covered a range of issues regarding abuse and neglect which included domestic violence and sexual abuse, female genital mutilation (FGM) and sexual exploitation.
- Staff had 9am -5pm Monday to Friday access to and support from the safeguarding team. Outside of these hours staff could seek support and guidance to escalate issues of abuse and neglect from managers on call, a paediatrician on call and the Social Care Emergency Duty Team.
- Safeguarding practice was supported by mandatory training Compliance for level 2 safeguarding training indicated that 94% of staff have completed Level 2 training against a target of 80%.
- The trust had set a target that 80% of staff working with children and young people had to have level three safeguarding training. In the children and young people's service at North Manchester General Hospital the trust provided information that supported 72% of staff in paediatrics had completed this training and 30% of neonatal staff had completed this training.
- In addition, there were low levels of level 3 safeguarding children's safeguarding in the urgent care services
- It was of concern that the trust's target for training staff at level 3 was not met.

Staffing

- Nurse staffing establishments in adult services were determined using a recognised tool and were reviewed every six months.
- Never the less there were significant shortages in midwifery and nurse staffing establishments. Although a substantial amount of work had been undertaken by the Chief Nurse to address staffing shortfalls, wards and departments were not always adequately staffed to meet the needs of patients in terms of numbers or skills.
- In urgent and emergency care services the nursing and healthcare support worker staffing levels and skill mix was not sufficient to meet patients' needs. The existing establishment did not always have the flexibility to cope with the number of patients attending, especially during busy periods.

Summary of findings

- An independent nurse staffing review in November 2015 recommended an increase to the current establishment by 15.80 whole time equivalent staff in order to fully meet safe staffing standards.
- At the end of November 2015 the vacancy rate for nursing staff in medical services trust-wide was 7%. There were actions identified to mitigate this risk such as a rolling recruitment programme. However the pace of recruitment had been slow.
- In surgical services staffing figures for January 2016 showed some areas had on occasion only 85% of their allocated establishment of registered nurses on duty during the day. Gaps in the rota were filled with hospital bank shifts and external agency staff.
- There was high use of agency staff in theatres but even with additional agency staff, staffing establishments were not always maintained.
- The nurse staffing in critical care services failed to meet the standard set by the Intensive Care Society for supernumerary shift co-ordinators at band 6/7. This issue was well known to the trust and was highlighted as a concern in the May 2015 review by the GMCCN.
- Nurse staffing levels and skills mix in paediatrics did not reflect Royal College of Nursing (RCN) guidance (August 2013). There were no advanced paediatric life support (APLS) or European paediatric life support (EPLS) trained nursing staff. Only 23.7% of nursing staff were up to date with paediatric immediate life support training.
- We reviewed neonatal staffing in line with BAPM (British Association of Perinatal Medicine) guidance over the course of a month. In 25.8% of shifts, nurse staffing did not comply with BAPM guidance for the nurse: patient ratio. On average in each of these shifts the unit was understaffed by at least one registered nurse. When we reviewed the planned vs actual staffing information, this showed in 83.3% of shifts the unit was understaffed by on average 2.2 nurses.
- In paediatrics the trust did not routinely use an acuity tool as recommended by RCN guidance,
- Neonatal staffing records indicated that only 23.9% of nursing staff had current NLS training at the time of our inspection.
- There were insufficient staffing levels to meet the needs of EOL patients with complex care needs at the current levels.

- In those services there was high patient acuity, we found examples where patient care had been delayed or missed due to staffing pressures. Nurses in these areas confirmed that meeting patient's needs in a timely way was challenging and the quality of nursing care compromised as a result.
- In Rochdale hospital there were sufficient numbers of nurses to meet patient's needs on a consistent basis.

Midwifery staffing

- All the midwives and managers we spoke with stated staffing was a major concern for the maternity services. This had been recognised by the trust and the "failure to achieve safe staffing levels" was on the risk register.
- Managers used a 'red flag' system to raise concerns about specific staffing levels. These were documented on the four hourly staffing assessment documentation for all wards.
- Midwives escalated staffing concerns to the manager on call. Managers then would determine the actions to be taken including diverting patients to other maternity units. However, maintaining the required staffing levels in maternity services was a daily managerial challenge and midwifery staffing shortages were a frequent occurrence.
- In addition, there was a high level of sickness among midwives. Covering staff sickness and high staff turnover compounded the staffing challenges within the maternity service. Information provided by the trust showed the turnover rate was 13.4% between 1 February and 31 January 2016.
- Maternity staffing did not meet the national benchmark set out in the Royal College of Obstetricians and Gynaecologists (RCOG/RCM) guidance RCOG recommendation of 1:28 births.
- In addition the labour ward frequently had lower than the planned number of midwives on duty; consequently Midwives were not always able to provide one to one care for women in labour in accordance with good practice.

Community Nurse Staffing

- Community nursing services were suitably staffed and there were minimal staffing shortages.
- A recent review of the acuity levels of patients in the greater Manchester area had been undertaken and measured the quality of service provided and the overall workload of community nursing teams.
- Results of this review indicated that the service had no funded-actual staffing gap and less than average temporary staff were used to address the shortfall.

- The review also indicated that staff had high workloads and that there was a rich mix of registered nurses, so a shift to more employing more support workers was recommended. This change had been implemented and there had been additional band 2 and 3 support staff employed.
- In community based End of Life Services the specialist palliative care nursing team had 6.2 whole time equivalent band 7 specialist nurses, which was in line with their current establishment.

Medical staffing

North Manchester Hospital

- There were a number of departments in the hospital where there were concerns regarding medical staffing. This was particularly significant within the Urgent and Emergency Care, medicine ,maternity and gynaecology and children's and young people's services (CYP)
- Within the Urgent and Emergency (U&E) care department an establishment of nine consultants had been commissioned. Only one consultant was employed substantively at the time of our inspection. However, consultants from other areas of the trust worked in the department on a rotational basis to provide senior support.
- The A&E department was established for seven middle grade positions and 13 junior doctor positions. However, only three middle grade doctors and five junior doctors were employed substantively at the time of the inspection. As a result, the department relied heavily on locum doctors of all grades. There was a local induction process for locum staff, however on our unannounced visit to U&E care we noted that one locum doctor had not been subject to a local induction and was reliant on nursing staff to assist in locating key items and equipment.
- The U&E department had received funding for additional doctors due to winter pressures. However, we found that these had been filled on only a minority of occasions during the same period due to difficulties with recruiting in to the additional posts.
- There was limited assurance that the performance of locum doctors with U&E was being reviewed on a regular basis. This was important as locum doctors formed a large percentage of the medical workforce within the department.

- Medical handovers within the U&E department were not always facilitated on a daily basis. On one occasion that the senior doctor in the department had to request information from the nursing staff to find out about patients who were currently in the department.
- There were high levels of locum use on Medical E Unit (MEU) in particular for junior, middle grade and consultant cover. 70 percent of medical shifts had been filled by a locum doctor between October 2014 and March 2015. Locum usage for general medicine was 51% and care of the elderly was 39%.
- There was no consistent consultant presence on the paediatric wards during peak times in accordance with 'Facing the Future Standards'. The trust advised that consideration had been given to new rotas as part of the paediatric improvement plan. However, no implementation date had been set at the time of our inspection.
- Facing the Future Standards also recommend that every child who presents with an acute medical problem is seen by a consultant, or equivalent, within 24 hours. In one paediatric serious incident investigation we reviewed this had not occurred and was deemed a causal factor in the delay of diagnosis. The trust did not monitor this standard at the time of our inspection.

Royal Oldham Hospital

- There were a number of departments in the hospital where there were concerns regarding suitable and appropriate medical staffing. This was particularly significant within the critical care, maternity and gynaecology and children and young people's services.
- There were medical staffing vacancies in medical services and this had been identified as a risk. There were actions identified to mitigate this risk such as an ongoing recruitment programme.
- At the time of our inspection there was no dedicated medical cover for the High Dependency Unit (HDU). The unit was 'open' unit with potential referral and admissions from any speciality within the hospital. Consequently this meant that on the HDU many of the standards for critical care as set out in the "Core Standards for Intensive Care "(Nov 2013) the Draft D16 Service Specification for Adult Critical Care and the Guidelines for the Provision of Intensive Care Services (GPICS) Standards. (2015) were not being met.

- Of particular concern was that the inappropriate medical cover for the HDU had been known to the trust in 2013 and it was only during our inspection that arrangements were made to provide adequate medical cover in this area.
- Information provided to us by the trust indicated that there had been 135 hours of consultant cover on the labour ward to June 2015. In the past 12 months there had been 5219 births at the hospital indicating that 168 hours consultant cover was required to meet the 2010 Royal college of Obstetrics and Gynaecology guidelines. Following our inspection, the trust confirmed they would review the consultant workforce to provide more consultant cover at the Oldham site. This would be fully implemented in August 2016.
- In the hospitals services for children and young people 'Facing the Future' Standards recommend there should be consultant presence on the ward at self-defined peak times. Staff informed us that their peak times were between 4pm and 9pm. The hospital had consultants scheduled to be on site up until 5pm. The trust confirmed that consultant presence during peak times was not in place. The trust advised us that consideration had been given to new rotas as part of the paediatric improvement plan. However, no implementation date had been set at the time of our inspection.
- More positively, the emergency department had sufficient numbers of medical staff with an appropriate skill mix to ensure that patients received the right level of care.
- Rotas were completed for all medical staff which included out of hours cover for medical admissions and all medical inpatients across all wards. Medical trainees contributed to this rota. The information we reviewed at the time of our inspection indicated that medical staffing was appropriate.
- Existing medical vacancies in surgery were covered by locum, bank or agency staff when required, such staff were provided with local inductions to ensure they understood the hospital's policies and procedures.

Fairfield hospital

- There were medical staffing vacancies in medical services and this was on the trust risk register. There were actions identified to mitigate this risk such as a recruitment programme.
- The information we reviewed at the time of our inspection indicated medical staffing was appropriate at the time of the inspection.

- Existing vacancies and shortfalls in surgery were covered by locum, bank or agency staff when required, such staff were provided with local inductions to ensure they understood the hospital's policies and procedures.

Rochdale Infirmary

- Medical staffing levels and skill mix in surgical services was recognised as being appropriate to meet patient need and reflected current guidance. Operating theatres were established against the 'Association for Perioperative Practice (AfPP) staffing recommendations.
- Medical cover was provided 24 hours a day and senior advice was available from Fairfield General Hospital if required.
- However, there were occasions in the urgent care department when there were insufficient numbers of staff with the appropriate skills to meet patient's needs.

Assessing and responding to risk.

- Guidance issued by the Royal College of Emergency Medicine in 2011 recommended that rapid initial assessment (triage) of patients should take place within 15 minutes of arrival. The trusts 3 U&E departments continuously failed to meet the national target for 95% of patients between January 2015 and January 2016. In North Manchester performance had deteriorated between April 2015 when it was met for 68.34% of patients and January 2016 when it had been met for 45.44%.
- In Royal Oldham hospital the percentage of patients triaged within 15 minutes averaged 85.7% between February 2015 and September 2016. However, the average between October 2016 and January 2016 was 77.9%, indicating a worsening trend in performance.
- In Rochdale infirmary performance between February 2015 and January 2016 ranged from a monthly average of 58.1% to 78.91%, which was worse than the national average.
- The U&E services also continuously failed to meet the Department of Health 1 hour target which measured the median average time of arrival to the start of definitive treatment between August 2015 and the time of inspection. In this period, the average time that patients waited was between 70 and 95 minutes and was higher than the national average.
- The departments used a range of different tools to triage patients and assess their clinical condition. These included the Manchester Triage System (MTS), an early warning score (EWS) system, a patient observation priority (POPS) score and a sepsis indicator warning system.

- The trust had implemented an early warning score system (a system that scores vital signs and is used as a tool for identifying patients who are deteriorating clinically) and carried out routine monitoring based on patients' individual needs to ensure any changes to their medical condition could be promptly identified.
- However we found examples in a number of services (detailed in the specific location and service reports) where the protocol for the use of early warning scores was not always used correctly. Deteriorating patients were not always referred for a medical review and repeat early warning scores were not performed to monitor for any further deterioration.
- Staff on the Medical Emergency Unit (MEU) at North Manchester Hospital had not received training to use the continuous cardiac monitoring in place and there was no monitoring system in place at the nurse's station.
- Royal College of Nursing (RCN) standards (August 2013) recommends that in children's services a member of the nursing staff should have Advanced life Support (APLS) training at all time throughout the 24 hr period. The trust did not have any APLS trained nursing staff members in paediatrics. Only 13/46 (28.3%) nurses had current paediatric life support (PILS) certification on paediatrics. We raised this with the trust at the time of our inspection and immediate action was taken to mitigate and manage this risk.
- Neonatal records showed that only 23.9% of nursing staff had current NLS training at the time of our inspection.
- In surgical services we found good use of systems to ensure that risks to elective and emergency patient groups were identified pre-operatively, venothromboembolism (VTE) assessment was completed for all hospitalised patients within 24 hours of admission. In Rochdale surgical services Audit data for 2015 against the trust target of 95% confirmed completion of VTE assessments as 97%.
- Similarly there was good use of the 5 steps to safer surgery checklist in most surgical settings. Compliance rates were consistently above 90% across the trust.

Mandatory training

- Staff received mandatory training in key topics such as infection prevention, information governance, equality and human rights, dementia awareness, fire safety, medicines management, health safety and wellbeing, safeguarding children and vulnerable adults, moving and handling, major

incidents and resuscitation training. However there were varying rates of compliance across the acute hospitals and services. A number of services had failed to meet the trusts own target of 85%.
- In community bases services there was consistent high take up of mandatory training and high levels of compliance over 90% of staff had completed all required elements of training.

Are services at this trust effective?

Requires improvement

We rated Effective as **Requires Improvement** because

- Care and treatment was based on evidence-based guidance and the policies and procedures, assessment tools and pathways followed recognisable and approved guidelines such as the National Institute for Health and Care Excellence (NICE).
- There was use of clinical audit to monitor and improve performance. However, where audits highlighted areas for improvement we did not find always find evidence of implemented and monitored action plans to secure improvement.
- Patient outcomes were, in the main, similar to the England average particularly in surgery, however there was improvement required in medical services particularly for patients with heart failure, diabetes and children's diabetes.
- The trust had a system in place for staff to receive an annual appraisal. However compliance rates across the hospitals and services varied considerably, in some services such as community services and outpatients departments 100% of staff had received an appraisal, yet in medical services at North Manchester Hospital compliance rates were as low as 23%.
- The was a variance in staff understanding in relation to Consent, Mental Capacity Act & Deprivation of Liberty safeguards that meant we were not assured that patients who lacked capacity were appropriately assessed in terms of their ability to consent.

However,

- Multi-disciplinary team work was well established and focused on securing the best outcomes for patients.
- Staff in all disciplines worked well together for the benefit of patients in their care.

Evidence based care and treatment

Summary of findings

- Care and treatment was based on evidence-based guidance and the policies and procedures, assessment tools and pathways followed recognisable and approved guidelines such as the National Institute for Health and Care Excellence (NICE)
- However, we found that there was limited senior oversight in relation to the updating of guidance and policy. This was in some cases the responsibility of individual teams who did not always have the capacity to carry out this important task and consequently we found examples where guidance and policy had not been updated.
- In services for services for children and young people eight out of 64 policies were out of date. These included policies for pain, diabetes and child abduction.
- At the time of our inspection the paediatric service had recently introduced Partners in Paediatrics (PiP) guidance. However, this had not been localised to the trust. As a result of this the guidance did not work as effectively as it could for junior medical staff and locum staff because they had to look elsewhere for this information.
- We raised this matter with senior staff and were told that the service was in the process of developing further guidance. A definitive deadline for when they would be available was not provided.
- A review of policies and procedures was scheduled, as part of the paediatric improvement plan, to be undertaken at the end of February 2016. At our unannounced inspection in March, the clinical lead told us this review had not been undertaken and seven out of eight policies remained out of date.
- Additionally although there was some use of clinical audit to benchmark and improve performance and we found some very positive examples of action planning to address performance shortfalls, there was limited senior oversight and lack of a robust system on the part of the Audit Committee to ensuring action planning and improvements arising from audits were owned and implemented.

Patient outcomes

- The SSNAP audit shows Fairfield General Hospital scoring A in the overall scores between April – June 15. The Royal Oldham Hospital had too few cases to report so no score is available.
- The Heart Failure audit (Discharge) shows the trust scored better than the England average for 5 out of the 7 indicators.

Summary of findings

- In the MINAP audit 2013/14: North Manchester General was higher than the England average for 2 out of the 3 nSTEMI indicators. National Diabetes Inpatient Audit (NADIA) (Sept 13) Fairfield General scored better than the England median for 16 indicators and worse than the median for 5 indicators.
- The Heart Failure audit (In-Hospital Care) shows the trust scored worse than the England average for all 4 indicators, the only exception being Royal Oldham which scored better for received echo.
- In the MINAP audit 2013/14: Royal Oldham was lower than the England average for 2 out of the 3 nSTEMI indicators.
- Fairfield General was lower than the England average for all 3 indicators.
- National Diabetes Inpatient Audit (NADIA) (Sept 13): Royal Oldham scored worse than

the England median for 13 indicators and better than the median for 8 indicators.

- North Manchester General scored worse than the England median for 10 indicators and better than

the median for 7 indicators. 4 indicators were either not applicable or zero.

- The Hip Fracture audit 2014/15 shows Royal Oldham performed better than the England average

for 8 indicators and worse for 1indicator, 'Surgery on the day of or after day of admission'.

- The Trust scored good on 2 indicators and better than the England average for 1 indicator in

the Bowel Cancer audit 2014.

- The Hip Fracture audit 2014/15 shows North Manchester General performed better than the England average for 4 indicators and worse for 5 indicators.
- In the National Laparotomy audit 2015: North Manchester General had a mixed result with 3 out of the 11indicators achieving 70-100%. Royal Oldham achieved 70- 100% for 7 out of the 11 indicators.
- The trust scored worse than the England average for 2 indicators in the Lung Cancer audit 2014.

- The ICNARC Annual Quality Report 2013/14 shows Fairfield General, North Manchester General and The Royal Oldham Hospitals are performing within the expected range.
- The National Neonatal Audit Programme 2014 indicated North Manchester General is meeting the standard for 1 of the 5 measures and Royal Oldham is meeting the standard for 2 of the 5 measures.
- At the time of our inspection there were two mortality outlier alerts for maternity services recorded that we will be continuing to for monitor improvement - Puerperal sepsis and other puerperal infections and perinatal mortality.
- In paediatric services the median glycaemic level is similar to that of England, (Trust 74, England 72 mmol/mol), NICE define excellent diabetes control as HbA1c levels less than 58 mmol/mol.

The higher the HbA1c levels the greater the risk of complications. 16% of the trust's patients were reported as having a HbA1c under 58 mmol/l which is a lower proportion of children with well managed diabetes than the England average of 19% with a HbA1c under 58 mmol/l.

- The trust achieved the organisational key performance indicator (KPI) in the May 2014 national care of the dying audit of clinical protocols for the prescription of medications for the five key symptoms at the end of life (KPI 5). However, the percentage achieved for clinical KPI 5, medication prescribed prn for the five key symptoms that may develop during the dying phase was slightly lower (worse) than the national average.

Competent staff

- The trust had a system in place for staff to receive an annual appraisal. However compliance rates across the hospitals and services varied considerably, in some services such as community services and outpatients departments 100% of staff had received an appraisal, yet in medical services at North Manchester Hospital compliance rates were as low as 23%.
- This meant that there were significant numbers of staff that had not had the opportunity to meet with their managers to discuss their performance and continued professional development.
- There was an induction and a preceptorship plan in place for new staff. This included agreed supernumerary periods so that staff could develop their competency and skills with

supervision and support. However we found that due to staffing pressures the plans and support for new staff were not always adhered to and staff formed part of the staffing establishment sooner than anticipated. This was a particular issue in urgent and emergency care.

Multidisciplinary working

- Multidisciplinary team (MDT) working was well established. All disciplines worked well together for the benefit of patients.
- Discharge planning adopted focused and multi-disciplinary approach.
- Ward based teams had access to the full range of allied health professionals. Team members described good, collaborative working practices. There was a joined-up and thorough approach to assessing and meeting patient's individual needs.

Consent, Mental Capacity Act & Deprivation of Liberty safeguards

- The majority of staff were aware of key principles of the Mental Capacity Act 2005 (MCA) and how these applied to patient care.
- MCA training was included in safeguarding training. Information provided by the trust showed compliance rates for level 2 training was 95%. Staff told us that more in-depth MCA training was included in level 3 safeguarding training for identified staff above band 6.
- The majority of staff had received training and annual updates on the Mental Capacity Act 2005,
- Some staff were very clear as to their roles and responsibilities and we saw some good examples of staff taking steps to ensure that for those patients with a lack of capacity decisions were made in their best interests.
- Many of the staff discussed mental capacity in terms of enhanced observations and the deprivation of liberty. In this respect they applied the principles correctly and there was evidence of DOLs applications being made appropriately.
- However in respect of the fundamental aspects of assessing a person's capacity to consent to treatment, particularly in cases of patients living with dementia and patients with learning difficulties we found some examples where there was a lack of understanding in both the requirements for assessing and reassessing a patient's capacity to consent.

- In some cases, where patients lacked capacity to be involved in a decision, there was no evidence of mental capacity assessment being undertaken.

Are services at this trust caring?

Good

We rated Caring as **Good** overall because,

- Overall we found that care and treatment was delivered by caring, committed, and compassionate staff, we found outstanding care in Community End of Life services and staff in all disciplines treated patients and those close to them with dignity and respect.
- Staff were perceived as open, friendly and helpful.
- We saw some very good examples of staff providing care in an individualised and person centred way.
- This was particularly evident in the community based End of Life Care service.
- Staff worked well together to actively involve patients and those close to them in the planning of their care and treatment. Patients felt included and valued. There were some very positive examples of staff involving, including and responding to patients needs and preferences
- Patients and those close to them understood their treatment and the choices available to them.
- Meeting people's emotional needs was recognised as important by staff and they were sensitive an in supporting patients and those close to them during difficult and stressful periods.

However,

- There were examples in acute services where due to staffing pressures care had become task focused and we observed little positive interaction with patients other than at these times. There were times when care delivery was functional and impersonal.
- In children's services and in some medical wards staff told us there were times when they had to focus on the task they were undertaking rather than treating patient as individuals to ensure that essential tasks were completed.

Compassionate care

- Care and treatment was delivered by caring, committed, and compassionate staff.
- In community end of Life services we found outstanding care and excellent examples of staff displaying an individualised person centred and compassionate approach to patient's needs and preferences.

- There was a compassionate approach for patients whose condition or circumstances made them vulnerable.
- The NHS Friends and Family Test is a satisfaction survey that measures patients' satisfaction with the healthcare they have received. The latest data showed the trust scored above the England average in many areas of service provision, although response rates remain below the England average.
- In the 2014 CQC Children's survey the trust scored about the same as other trusts in 19 of the applicable questions. In five questions the trust scored worse than other trusts. These questions related to staff members availability; staff playing with children; staff caring for children listening to parents and carers; staff being friendly with children and parents being told different things by different people. The trust scored better than other trusts for the explanations provided to parents before procedures or operations.

However,

- There were examples in acute services, where due to staffing pressures when care had become task focused and we observed little positive interaction with patients other than at those times. There were times when care delivery was functional and impersonal.
- In children's services and in some medical wards staff told us there were times when they had to focus on the task they were undertaking rather than treating patient as individuals to ensure that essential tasks were completed.
- We observed one incident where a child's privacy and dignity was not maintained when carrying out an intimate care task.

Understanding and involvement of patients and those close to them

- Staff respected and understood the patients' rights to make choices about their care.
- Patients and those close to them and received information about care and treatment in a manner they understood.
- Patients and those close to them understood their treatment and the choices available to them.
- Patients felt valued and involved in the planning of their care and treatment.

Emotional support

- Meeting people's emotional needs was recognised as important by most staff disciplines.

Summary of findings

- Staff were sensitive in supporting patients and those close to them during difficult and stressful periods.
- Multi faith spiritual leaders were available 24 hours a day for patients requiring spiritual support.
- Patients and relatives in end of life services told us that they received considerable emotional support from all members of the team involved in their care.
- Chaplaincy services were available for patients seven days a week.
- Patients and those close to them were also able to access the Multi Faith facility as a place of quiet reflection and support.

Are services at this trust responsive?

Requires improvement

We rated Responsive as **Requires Improvement** because;

- In all three U&E departments the proportion of all patients that attended the emergency department and were treated within four hours was consistently and significantly below the national target.
- Patients were subject to delays in triage, initial assessment and waited for unacceptable lengths of time for transfer from the U&E departments.
- A review of patient records indicated that there had been a high number of patients waiting for over 12 hours in the U&E departments. As a result of the trust's decision to admit policy these were not always recorded appropriately, potentially providing and inaccurate picture of performance and limiting the ability to improve the service. The trust acknowledged the need to review the Decision to Admit Policy to ensure clinical leaders and senior staff were fully appraised about the time patients spend in A&E. This trust has confirmed that a new policy was fully implemented in early March 2016.
- In addition there were times due to bed capacity and availability; patients were placed in areas not best suited to their needs. (Known as outliers) Patients also experienced frequent moves between wards and departments often during the night without there being a clinical need for the transfer to take place.
- Despite a focused approach to discharge planning, people remained in hospital longer than they needed to be and there were examples of delays in patient discharges particularly in medical services.

- The maternity assessment unit was frequently relocated leading to temporary facilities being used and confusion for patients returning to the service.
- There were very poor response times in relation to complaints and limited evidence of complaints leading to changes in practice and improvement in services.

However,

- The trust met internal and national referral to treatment targets in all specialities.
- Clinics and diagnostic appointments were planned and arranged to meet the needs of the patients.
- National cancer treatment targets were met.
- However, since our inspection we have been made aware of a number of concerns in relation to the quality and accuracy of the data provided by the trust in respect of referral to treatment times. This matter is under review by the new Executive Team and we will be monitoring the trusts response and actions in respect of this matter through our on-going regulatory activity.
- There were examples of initiatives to meet the needs of patients whose circumstances or illness made them vulnerable including patients who were living with dementia or who had a learning disability.
- Interpreters were available on demand for patients whose first language was not English.
- British Sign Language interpreters were also available for patients who were deaf.

Service planning and delivery to meet the needs of local people

- There was evidence that the needs and preferences of local people were considered when planning services and included national initiatives and priorities.

Meeting people's individual needs

- The trust had in place a learning disability service that was part of the safeguarding team. The team provided help, guidance for staff in relation to meeting the care and treatment of patients with a learning disability in a sensitive and individualised way.
- The team also supported the appropriate consideration and implementation of reasonable adjustments to meet patients individualised needs.

- The trust also used a leaf symbol to indicate that a patient was frail and a butterfly symbol to indicate that a patient was at the end of life. These discreet symbols alerted staff to so that assessments and care plans considered any reasonable adjustments required to meet the patient's needs.
- The trust provided a range of information leaflets in English, However, information could be provided in other languages and formats on request.
- In services for children and young people a play service was provided that included age appropriate activities for patients.
- There was limited support from the 2 bereavement midwives due to them having only 15 hours per week allocated on each site for this aspect of their work.

Meeting people's individual needs Community Services

- There were activities at the Floyd Unit, including a pool table and games consoles to prevent patients getting bored. Alternative therapies were provided (Reiki) and three support workers were trained in delivering these sessions to patients.
- Additionally wheelchair yoga was delivered weekly to the patients who wished to participate.
- However, there was limited evidence of an activity plan for patients to participate in to promote their independence and mental functioning on any of the units we visited.
- However there was a day room in each unit, where patients could choose to socialise and staff told us group activities were organised such as reminiscence, quizzes and crafts. There were books and games available but some patients told us they would like more stimulation.
- The day room at Wolstenholme was a dark, cluttered room with no windows. This was a temporary measure until the move into the new unit in March.
- The environment at Tudor Court was not dementia friendly with dark, wood cladded corridors. As part of the plans for the refurbishment, a representative from the Alzheimer's society had been involved to support the unit becoming dementia friendly.
- Hairdressers visited on a weekly basis and patients could choose to have their hair done.

- Service users at Henesey House were offered to go to 'exercise and ride' (an exercise group in the community) on a weekly basis, if appropriate.
- Patients and their families were given choice over the preferred place for end of life care and there was support available to staff and families from Macmillan nurses and a local hospice.
- Staff were able to provide overnight accommodation for relatives of patients at Tudor court.
- Halal and Kosher food choices were readily available in all the community in patient services.

Dementia

- The trust had a dementia strategy in place (2015 to 2018) that included key objectives and performance metrics.
- Patients over 65 were screened for indications of dementia upon admission. This involved the completion of a short assessment and followed CQIN guidance.
- The Trust had implemented the 'forget-me-not' scheme to support sensitive, safe and individualised care for patients living with dementia.
- The dementia nurse consultant was clinical the identified lead for dementia care and provided support for staff and a central point for information and support. The trust also provided access to a psychiatric liaison team who saw and assessed patients with a cognitive impairment.
- The physical environment had been designed and adapted to support the needs of patients living with dementia.
- Memory boxes were available for staff to share with patients and knitted 'twiddle muffs' were available so that patients could occupy their hands. (This type of aid has been found to provide a source of visual, tactile and sensory stimulation for people living with dementia).
- The surgery and anaesthesia division operated a system for identifying patients with complex needs, particularly those that entered the service through the pre-operative assessment unit. There was evidence that needs were assessed and forward planning for those patients with living with dementia, patients with learning difficulties and patients mental health problems.

Access and flow

- The trust continued to experience significant difficulties in the Accident and Emergency department. The trust had constantly

failed to meet The Department of Health target for emergency departments to admit, transfer or discharge 95% of patients within four hours of arrival in all 3 urgent and emergency care departments. This meant that large numbers of patients frequently and consistently experienced unacceptable waits and were not able to access emergency care in a timely way.

- At Fairfield General Hospital records indicated that between April 2015 and February 2016. The overall average of patients that were seen within four hours was 84.61% during this period.

- At North Manchester General Hospital Between November 2014 and November 2015, records indicated that he department had met the required standard on ten weeks out of 52 during this period. However, performance had continuously deteriorated from July 2015 (93.69%) to November 2015 (77.93%).
- The emergency department at Royal Oldham Hospital also consistently failed to meet the Department of Health (DH) target to admit or discharge 95% of patients within four hours of arrival between April 2015 and February 2016. The overall average of patients that were seen within four hours was 84.38% during this period.
- In addition, the percentage of patients waiting from between 4 to 12 hours for admission varied. Between November 2014 and June 2015, performance at North Manchester was similar to the national average. However, between July 2015 and February 2016, performance had fallen and compliance was continuously higher (worse) than the national average.
- The average wait experienced by patients waiting to be transferred to a ward at North Manchester General Hospital was between 13 and 17 hours. We noted a number of occasions where patients had been in the department for up to 24 hours.
- At Royal Oldham Hospital the department also failed to meet the DH guidelines relating to trolley waits as nine incidents were reported where patients had trolley waits of more than 12 hours between November 2015 and February 2016. This included five breaches reported during February 2016 indicating a deteriorating trend.

Summary of findings

- We also found that there was routine overcrowding in the adult A&E departments. Ambulance crews frequently queued in the department corridors with patients waiting to be admitted place in unsuitable areas and there were considerable delays in patient handovers.
- As a result of bed pressures medical patients were often placed on wards that were outside the specialty. This meant that this group of patients were not always placed in areas best suited to their needs.
- In addition patients experienced a number of moves during their stay. There were also examples of patients being moved across wards out of hours and up to 45% of medical patients experienced one or more moves during their stay in hospital.
- Patients often remained in hospital longer than they needed to be, this was due to a variety of reasons including delays in the provision of community based care packages and placement in long term care settings. The divisional leads for medicine informed inspectors that approximately 20% of medical beds across the trust were affected by delays in patient discharges. This equated to approximately 100 beds across the three main sites.
- Challenges with access and flow within the hospitals had a negative impact on patients' discharge from the critical care units. Once a clinical decision has been made that a patient was fit for step down or discharge from critical care there was often a delay in discharge in all 3 critical care units.
- For example, data for the Royal Oldham Hospital indicated that for April 2014 to March 2015 showed that 36% of patients on the level 3 ITU experienced a delayed discharge and 52% of patients on the level 2 HDU had their discharge delayed. The majority of the delays were between one and three days with the occasional patient waiting as long as a week.
- In Fairfield General Hospital the most recently validated ICNARC data supplied by the trust, for January to June 2015 inclusive, showed that there had been 55 delayed discharges. This represented 43% of all admissions in the first six months of 2015. 28% of all delayed discharges were usually delayed for less than 24 hours although a smaller number of patients experienced a delayed discharge of several days.

- As a result of the layout of the unit at Fairfield Hospital there were difficulties at times in segregating patients in order to meet the single sex accommodation standard. Breaches of the single sex accommodation standard were reported in accordance with trust policy.
- At North Manchester Hospital the ICNARC data for January to June 2015 for the ICU showed that there were 28 reported delayed discharges from 121 admissions (23%) and 22 out of hours discharges. For the period June to September 2015, the HDU reported 82 delayed discharges from 142 admissions (58%) and 15 out of hours discharges.
- The Trust cancelled 977 operations in the last 12 months: 1.12% of the total number of elective patients treated. Of those cancellations there were nine patients who did not have their operation within 28 days of the cancellation. (Trust Quality Accounts 2016)

Learning from complaints and concerns

- The trusts had a 'Complaints Handling Policy (v7, ratified 26 November 2015)
- Patients could access information about how to complain and direct their concerns and complaints either to the hospital complaints department or through the patient advice liaison service.
- For those patients with a learning disability information in an easy read pictorial format could be provided on 'How to Make a Complaint.'
- Information regarding making a complaint could also be provided in languages other than English
- Complaints were managed through the complaints department. Directorate managers, governance leads and the divisional director were made aware of any complaints and their subsequent outcomes.
- However, we found that overall the management of complaints was poor. The previous two full calendar years; 01.01.2014 – 31.12.2015, the Trust received 1455 complaints. The two full calendar years prior to the date of inspection; 21.02.2014 – 21.02.2016, the Trust received 1414 complaints. At the time the inspection commenced 22.02.2016, the Trust had 227 open complaints, and over 80 had remained open for over 100 days.
- In addition, we found limited oversight and review of action planning in response to complaints and recurring themes in

Summary of findings

respect of causal factors. We found that learning from incidents and complaints was not systematically implemented and monitored and as a result opportunities for improving services, patient experiences and confidence were lost.

Are services at this trust well-led?

Inadequate

We rated well led as **Inadequate** because

- Although the trust had recently revised and implemented its governance structures and processes and was strengthening its strategic approach, structures had not yet been fully embedded and were not yet well understood;
- Many of the new divisional management triumvirates were new in post and there was degree of misunderstanding as to how the processes should work in relation to the management and reporting of both performance and risks.
- Performance reporting was inconsistent and we found that a number of performance reports prepared in various formats contained no commonality. This had been acknowledged by the trust and work was underway to address this, however, this was work was still in its early stages at the time of our report.
- Although the trust had implemented a revised risk management strategy and work had been undertaken regarding a review of divisional and directorate risk registers coupled with the implementation of an Executive led risk review group, in a number of services such as urgent care, maternity and services for children and young people key risks were not understood, recorded, escalated or mitigated effectively.
- Consequently, the trust did not have a robust understanding of its key risks at departmental, divisional or board level.
- The (historical) poor governance systems for the management of incidents and complaints had led to backlogs and significant delays in investigation and response times. Although improvements in this regard were underway, the backlog of required investigations and reviews was challenging managers in terms of their capability and capacity to address them. As a result opportunities for identifying causal factors and trends were limited, and opportunities for learning and improved lost or delayed as a consequence.
- We found poor leadership and oversight in a number of services, notably maternity services, urgent care (particularly at North Manchester Hospital) and in services for children and

young people. In all of these services leaders had not led and managed required service improvements robustly or effectively. In addition service leads had tolerated high levels of risks to quality and safety without taking appropriate and timely action to address them.

- In maternity services we found a poor culture with deeply entrenched attitudes where some staff accepted sub optimal care as the norm and patients individual and specific needs were not appropriately considered or met.

However,

- The trust recognised that the capacity and capability of managers and leaders required development and as part of the trusts five-year Leadership and Management Development Strategy, agreed in September 2015 and had introduced The Pennine Transforming Leaders Programme: This was launched in September 2015 and was intended for senior managers from the relatively new divisional triumvirates. The programme focussed developing their capability and confidence as individual and team leaders to create a leadership community within the trust.
- The Pennine Ward Managers' Leadership had also been introduced and it was envisaged that 80 ward managers will complete the programme by November 2016.
- However we were unable to determine the impact of the programmes at the time of our inspection.
- The trust had actively pursued improved staff engagement since 2014. This approach included the use of a number of engagement activities, including crowd sourcing, regular newsletters and updates from the CEO through the 'Monday Message' and an open door policy. In addition the Trust invested heavily in engaging Staff to develop the 'Pride in Pennine' Framework and the 'Healthy, Happy, Here' plan that was approved in September 2015.
- Most staff were positive about these changes and felt it was a significant improvement on what was before. Staff felt that there was a better emphasis on safety and quality issues that could and would lead to service improvement.

Vision and strategy

Summary of findings

- The trust vision was to be “a leading provider of joined up healthcare that will support every person who needs our services, whether in or out of hospital to achieve their fullest health potential.' The mission statement was “to provide the very best care, for each patient, on every occasion”.
- The underpinning values were ‘Quality Driven, Responsible, and Compassionate’.
- The trust had overarching strategic goals and had produced a ‘trust transformation map’, This was displayed around the trust and was well known to staff, although at the time of our inspection this work had not yet resulted in clearly defined quality priorities and objectives for all of the divisions and consequently there was variance in both progress and understanding of its implementation and requirements.
- We had significant concerns in a number of core services as there was no service strategy or objectives in place. For example the paediatric team were following the paediatric improvement plan; however there was no strategy for continuous improvement or sustaining changes resulting from it. Most staff in the team were unaware of the trust’s wider vision and mission for the service.
- There had been a focus on the maternity improvement plan which was developed following the external review in January 2015; however again there was no strategy for continuous improvement or sustaining the changes that had been implemented. Staff were unclear as to the future of the service or their role within it.
- There was a similar situation in a number of services. Staff were unclear about the vision for their service.
- The’ Raising the Bar on Quality’ initiative was launched in October 2015. This was a Ten-Point Plan that identified high-priority actions to improve the quality of services and included immediate and individual actions staff could take to support good quality services for patients.
- Almost all of the staff we spoke with across the trust were aware of the ‘Raising the Bar on Quality’
- Some services had used the ‘Raising the Bar’ initiative to develop local improvement plans and were positive about its impact on service improvement. However, this was not consistent across all services.

Governance, risk management and quality measurement

Summary of findings

- The trust had recently made changes to the divisional and corporate structures to support an improved system of governance, performance management and clinical leadership. The Division of Medicine and the Division of Anaesthetics & Surgery were now managed by a triumvirate of 3 senior staff that included a clinical, nursing and managerial lead. The Division of Women & Children had 4 leaders (including Divisional Nurse Director for Midwifery and Nurse Director for Children), Integrated and Community Services by 2 leaders and Support services 2 leaders. There was one vacancy still to be filled in both Integrated and Community Services and support services.
- Many of the new divisional management triumvirates were new in post and there was degree of misunderstanding as to how the processes should work in relation to the management and reporting of both performance and risks.
- Performance reporting was inconsistent and we found that a number of performance reports prepared in various formats contained no commonality. This had been acknowledged by the trust and work was underway to address this, however, this was work was still in its early stages at the time of our report.
- Although the trust had implemented a revised risk management strategy and work had been undertaken regarding a review of divisional and directorate risk registers coupled with the implementation of an Executive led risk review group, in a number of services such as urgent care, maternity and services for children and young people key risks were not understood, recorded, escalated or mitigated effectively.
- Consequently, the trust did not have a robust understanding of its key risks at departmental, divisional or board level.
- Risk registers were sometimes incomplete with risks remaining on the registers for some time without review or changes to mitigations and controls. The A&E care risk register at North Manchester was a clear of example of this in that there was a divisional risk register that highlighted some but not all risks that were currently faced by the department. The escalation plan in use did not reflect the current risks and had last been updated in 2013. In addition, at the time of our inspection, the risks in Urgent and Emergency care had not been included on the Strategic Risk Register.

Summary of findings

- In maternity services and services for children and young people, senior nurses and managers did not have a robust overview of the performance of risks relating to the service and this had resulted in limited identification or escalation of risks to a corporate level.
- In addition we reviewed the Board Assurance Framework and the Strategic Risk Register our review confirmed that further work was required to ensure that all key risks were reported and recorded in a timely manner.
- Consequently we concluded that there was not an effective system in place for identification and management of risks at team, directorate or organisational level.
- Similarly the historical poor governance systems for the management of incidents and complaints had led to backlogs and significant delays in investigation and response times. Although improvements in this regard were underway, the backlog of required investigations and reviews was challenging managers in terms of their capability and capacity to address them. As a result opportunities for identifying causal factors and trends were limited, and opportunities for learning and improved lost or delayed as a consequence
- Work was underway lead by the new Director of Clinical Governance to update the Risk Management Policy and issue new guidance to staff supported by relevant training; however this had not yet been implemented at the time of our inspection.
- In terms of performance management, the Board and its sub committees were provided with an Integrated Performance Report at each meeting, we had some concerns as to the value of the report as we found that performance metrics were not clearly connected to trust priorities or objectives.
- We also had concerns in respect of the quality of data provided due the historic lack of investment in an IT infrastructure and a continued reliance on paper based systems to collate key performance information.(Paper based systems are more likely to contain errors and misreporting). We did not see any evidence of testing data quality in respect of performance monitoring and management during our inspection.
- A number of services had performance dashboard in place, in paediatrics and maternity we saw performance dashboards aimed to collate and report good metrics in terms of quality and performance. However we found Information collated on the dashboard was not used to inform or improve practice.

- The divisional director for urgent care told us they planned to introduce performance dashboards in the future so that access to performance information could be more accessible there was no urgent care dashboard at the time of our inspection.
- There very limited evidence of internal performance benchmarking in terms of quality and performance.

Leadership of the trust

- Following the appointment of the CEO in April 2014 there had been significant changes to the Executive team with the team only completed just prior to the inspection when the recently appointed Medical Director took up post. The Chief Nurse had been in post 10 months. In addition, the secondment of the CEO to manage another trust was announced during the inspection and the Chair's tenure also came to an end at the time of the inspection.
- From 1 April 2016, the Chair and Chief Executive of Salford Royal NHS Foundation Trust were appointed as Interim Chair and Chief Executive at the trust to provide leadership and support on an interim basis.
- Staff were very positive about the visibility and responsiveness of the former Chief Executive (recently seconded) and the Chief Nurse. Staff felt that they both listened to concerns and took action to address them where possible; staff stated that historically this had not always been the case and that in the past the raising of concerns was not encouraged.
- A number of staff raised concerns with us about the attitude and behaviours of one senior member of staff, we raised these issues at the time of our inspection and the trust immediately began an investigation in to the concerns raised.
- Staff did not feel that the Non-Executive Directors were accessible and were not visible throughout the organisation.
- We found poor leadership and oversight in a number of services, notably maternity services, urgent care (particularly at North Manchester Hospital) the HDU at Royal Oldham hospital and in services for children and young people.
- In all of these services leaders had not led and managed required service improvements robustly or effectively. In addition service leads had tolerated high levels of risks to quality and safety without taking appropriate and timely action to address them.

- Midwives told us they saw the midwifery lead “never”, “rarely” and “occasionally” on the wards and departments. Although they reported having seen other leaders in the service more frequently.
- There were some also concerns regarding the lack of medical leadership and the lack of clinical engagement in clinical governance processes. Some key governance meetings were poorly attended and absences and poor attitudes in respect of attendance and contribution were not always robustly challenged.
- The trust recognised that the capacity and capability of managers and leaders required development and as part of the trusts five-year Leadership and Management Development Strategy, agreed in September 2015 and had introduced The Pennine Transforming Leaders Programme: This was launched in September 2015 and was intended for senior managers from the (relatively) new divisional triumvirates. The programme focussed developing their capability and confidence as individual and team leaders to create a leadership community within the trust.
- The Pennine Ward Managers’ Leadership had also been introduced and it was envisaged that 80 ward managers will complete the programme by November 2016.

Culture within the trust

- Staff told us that historically the culture in the trust had been quite closed and the raising of concerns and ideas was not supported or encouraged. Staff felt that the culture had (until recently) focused on financial matters and operational delivery rather than service quality.
- Since 2014 the trust has been working on developing and encouraging a more open and inclusive culture where staff raise issues and concerns without blame.
- The Trust had also implemented “Speak in Confidence” an external company commissioned to support staff to raise concerns if they wish to do so anonymously and confidentially outside of normal whistle-blowing processes in place.
- In many service of services including community services we found that there was a positive culture emerging where staff felt well supported by their managers and colleagues and were positive about service changes and improvements. Staff reported being better heard and valued by the organisation and were positive about the new ways of staff engagement.

- However, in maternity services, we found a poor culture with deeply entrenched attitudes where some staff accepted sub optimal care as the norm and patient's individual and specific needs were not appropriately considered or met.
- We also found that there was low morale in some services particularly those that were experiencing staffing difficulties such as A&E and paediatrics and a culture of blame in midwifery services.
- It was evident during our inspection, and acknowledged by the trust that addressing some long standing cultural issues required continued managerial input and focus.

Equalities and Diversity – including Workforce Race Equality Standard

- As part of the Workforce Race Equality Standard (WRES) programme we have added a review of the trusts approach to equality and diversity to our well led methodology. The WRES has 9 very specific indicators by which organisations are expected to publish and report as well as put action plans into place to improve the experiences of it Black and Minority Ethnic (BME) staff.
- The staff survey (WRES questions) 2015 indicated a mixed result for Pennine.
- The percentage of staff from a BME background that had experienced harassment bullying and abuse from patients and relatives had improved and is below the England average.24% against an English Average of 28%
- Similarly there had been an improvement for the percentage of BME staff who believed the organisation provided equal opportunities, this has increased by 3%.
- However, there had been an increase in both white and BME staff experiencing harassment, bullying and abuse from staff both are 6% above the average for all trusts but is still below the average for acute trusts by 6%. There had also been an increase in both BME and white staff, who have been personally discriminated against and both are higher than the average.

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- As part of our inspection we held focus groups with staff from a BME background. Staff felt that the trusts approach to equality and diversity was under developed. Staff felt that there was still unconsciously biased attitudes and covert racism amongst their colleagues.

- Staff felt that there were limited opportunities to celebrate and embrace diversity and a lack of investment in support for all staff groups with protected characteristics.
- The trusts BME network was poorly attended as staff were not encouraged or given protected time in which to attend.
- The group felt the network lacked influence as meetings rarely resulted in actions by managers when issues were raised.

Fit and Proper Persons

- The trust had implemented systems and processes to meet the requirements of the Fit and Proper Persons regulation (FPPR). This regulation ensures that directors of NHS providers are fit and proper to carry out this important role.
- The trust policy on pre-employment checks covered criminal record, financial background, identity, employment history, professional registration and qualification checks.
- It was part of the trust's approach to conduct a check with any and all relevant professional bodies and undertake due diligence checks for all senior appointments.

Public engagement

- The trust patient experience strategy had been developed in 2015, with actions to be taken forward over 3 years. The strategy supported patient and public engagement; however many of the actions to support the strategy were still works in progress.
- Actions underway included; Supporting and establishing patient groups, Mapping engagement with third sector organisations, Mapping awareness campaigns to proactively respond to campaigns and align with Trust priorities and working with existing volunteers to establish a cohort of trained volunteers to gather patient stories for sharing and to embed patient voice within the organisation.

Staff engagement

- The trust had actively pursued improved staff engagement since the 2014 .This approach included the use of a number of engagement activities, including crowd sourcing, regular newsletters and updates from the CEO through the 'Monday Message' meetings and an open door policy. In addition the Trust invested heavily in engaging Staff to develop the 'Pride in Pennine' Framework and the 'Healthy, Happy, Here' plan that was approved in September 2015 Nursing and midwifery listening events also had been held to gain staff ideas and opinion

- Most staff were positive about these changes and felt it was a significant improvement on what was before. Staff felt that there was a better emphasis on safety and quality issues that could and would lead to service improvement.

NHS staff Survey results

- The survey was sent to a sample of 849 staff across different divisions, directorates and professions. The response rate was low at 29%, with only 243 staff completing the survey.
- The survey results indicated improvements in staff recommending the trust as a place to work or receive treatment. Staff motivation at work and staff satisfaction with level of responsibility and involvement as well as improvements in support from immediate line managers. Additional improvements in the percentage of staff reporting good communication between senior management and staff. The percentage of staff able to contribute towards improvements at work, the percentage of staff reporting errors, near misses and incidents witnessed in the last 12 months and the effective use of patient feedback.

However, there were a number of indicators where performance had deteriorated;

- These included the percentage of staff appraised in the last 12 months. The percentage of staff experiencing bullying, harassment or abuse from staff in the last 12 months. The percentage of staff reporting most recent experience of bullying, harassment or abuse. The percentage of staff experiencing discrimination at work in the last 12 months and the percentage staff witnessing potentially harmful errors and near misses.
- Sickness and absence rates were above the England average between June 12 and August 15 and although were reducing still required focussed management attention.
- Sickness rates in maternity services remained high at the time of our inspection.
- The staff survey results supported our finding in other areas highlighted in our Equality and Diversity section and in the section of the report relating to organisational culture. Although it is acknowledged that the number of staff participating in the survey was low.

Innovation, improvement and sustainability

Summary of findings

- We were concerned that there was a lack of awareness of potential risks to the quality and sustainability of services at board level as a consequence of poor governance and performance management systems.

Overview of ratings

Our ratings for North Manchester General Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Inadequate	Requires improvement	Good	Inadequate	Inadequate	Inadequate
Medical care	Inadequate	Requires improvement	Good	Requires improvement	Inadequate	Inadequate
Surgery	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Critical care	Good	Good	Good	Requires improvement	Good	Good
Maternity and gynaecology	Inadequate	Requires improvement	Good	Requires improvement	Inadequate	Inadequate
Services for children and young people	Inadequate	Requires improvement	Requires improvement	Requires improvement	Inadequate	Inadequate
End of life care	Good	Requires improvement	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	Good	Good
Overall	Inadequate	Requires improvement	Good	Requires improvement	Inadequate	Inadequate

Overview of ratings

Our ratings for Royal Oldham Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Medical care	Requires improvement	Requires improvement	Good	Requires improvement	Good	Requires improvement
Surgery	Requires improvement	Requires improvement	Good	Good	Good	Requires improvement
Critical care	Inadequate	Requires improvement	Good	Requires improvement	Inadequate	Inadequate
Maternity and gynaecology	Inadequate	Requires improvement	Good	Requires improvement	Inadequate	Inadequate
Services for children and young people	Inadequate	Requires improvement	Requires improvement	Requires improvement	Inadequate	Inadequate
End of life care	Good	Requires improvement	Good	Good	Requires improvement	Requires improvement
Outpatients and diagnostic imaging	Requires improvement	Not rated	Good	Good	Good	Good
Overall	Inadequate	Requires improvement	Good	Requires improvement	Inadequate	Inadequate

Our ratings for Rochdale Infirmary

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Requires improvement	Good	Good	Good	Requires improvement
Medical care	Good	Good	Good	Good	Good	Good
Surgery	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Overview of ratings

Our ratings for Fairfield General Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Medical care	Requires improvement	Requires improvement	Good	Requires improvement	Good	Requires improvement
Surgery	Requires improvement	Requires improvement	Good	Good	Good	Requires improvement
Critical care	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
End of life care	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	Good	Good
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Our ratings for Community End of Life

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	Good	Good	☆ Outstanding	Good	Good	Good

Our ratings for Community Children, Young People and Families

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	Good	Good	Good	Good	Good	Good

Overview of ratings

Our ratings for Community Adults

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	Good	Good	Good	Good	Good	Good

Our ratings for Community Inpatients

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	Good	Good	Good	Good	Good	Good

Our ratings for The Pennine Acute Hospitals NHS Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	Inadequate	Requires improvement	Good	Requires improvement	Inadequate	Inadequate

Notes

Outstanding practice and areas for improvement

Outstanding practice

Areas for improvement

Action the trust MUST take to improve

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the fundamental standards that were not being met. The provider must send CQC a report that says what action they are going to take to meet these fundamental standards.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 12. - (1) Care and treatment must be provided in a safe way for service users. (2) Without limiting paragraph (1), the things which as registered person must do to comply with that paragraph include - (a) assessing the risks to the health and safety of service users of receiving the care or treatment; (b) doing all that is reasonably practicable to mitigate any such risks; (c) ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely;

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance 17. - (1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part. (2) Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to - (a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services); (b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity;

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing 18. - (1) Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part. (2) Persons employed by the service provider in the provision of a regulated activity must - (a) receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform,

Regulated activity	Regulation
Maternity and midwifery services	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 12. - (1) Care and treatment must be provided in a safe way for service users. (2) Without limiting paragraph (1), the things which as registered person must do to comply with that paragraph include - (a) assessing the risks to the health and safety of service users of receiving the care or treatment; (b) doing all that is reasonably practicable to mitigate any such risks; (c) ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely;

Regulated activity	Regulation
Maternity and midwifery services	Regulation 18 HSCA (RA) Regulations 2014 Staffing 18. - (1) Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part. (2) Persons employed by the service provider in the provision of a regulated activity must -

This section is primarily information for the provider

Requirement notices

(a) receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform,

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the fundamental standards that were not being met. The provider must send CQC a report that says what action they are going to take to meet these fundamental standards.

This section is primarily information for the provider

Enforcement actions (s.29A Warning notice)

Action we have told the provider to take

The table below shows why there is a need for significant improvements in the quality of healthcare. The provider must send CQC a report that says what action they are going to take to make the significant improvements.

Why there is a need for significant improvements	Where these improvements need to happen
Start here...	Start here....