Anaesthesia Clinical Services Accreditation (ACSA)
Accredited Departments

Central Manchester University Hospitals NHS Foundation Trust

Central Manchester University Hospitals NHS Foundation Trust March 2017

Dr Rhys Clayton quote (ACSA lead):
'The ACSA process has brought many benefits to our department. It has given us a chance to systematically review all areas of governance, and identify any areas that required improving. As well as highlighting areas requiring improvement, the ACSA process also allowed the department to reflect on the many things we do well, and encouraged us to consolidate on these areas of high achievement.

It has allowed us to homogenise systems and paperwork across the four sites that were accredited. This was particularly useful given that one of the sites only became part of the trust relatively recently.

We look forward to continued engagement with the ACSA process in the forthcoming years.'

Areas of good practice

The care pathway

Monitoring and use of early warning scores
All hospitals in the Trust use a system called 'Patientrack' to monitor patients against an appropriate early warning score (children and obstetrics have modified early warning scoring systems) [1.1.1.12]. It was noted that this had reduced their cardiac arrest rate. Nurses are responsible for inputting the data using a touchscreen by the patient's bedside. The system automatically calculates the early warning score and will flag up when observations have been delayed. Patients who show signs of deterioration are automatically flagged and this is linked through to a bleep system to an appropriate member of staff (senior nurse, core trainee, critical care etc.), who is required to attend. The rate at which observations are required to be taken will also be increased. Metrics are released weekly, and senior management are able to monitor and track response times and feed back to the teams involved [1.1.1.10; 1.5.0.4; 5.2.1.10]. The ACSA RT observed that wards had their 'scores' for observation delays on the 'ward accreditation' board in patient facing areas. There are plans in place to improve glucose control in diabetic patients by including blood glucose on the Patientrack system.

Enhanced recovery (ERAS+), including iCough, incentive spirometry
The iCough programme was piloted in patients going to critical care/ICU following surgery; patients were followed up and demonstrated a reduction from 18% to 9% complication rate, which has been sustained over time [1.2.1.2; 1.2.1.3].

A multidisciplinary team, led by Dr Moore, run a series of 'surgical schools' for patients receiving major surgery to improve optimisation and therefore outcomes. This includes information about how to improve diet and fitness before surgery, the importance of good oral hygiene, improving respiratory outcomes during the immediate postoperative period (including incentive spirometry), and exercise following surgery [1.2.1.2; 3.3.3.1]. The team had an opportunity to attend one of these sessions, and found it interesting and relevant.

Death in theatre policy
There is a good policy in place for death in theatre, which includes all of the salient points, and very good support network for clinicians following this type of event, particularly in obstetrics [1.1.1.17].

Intensive care programmes
While intensive care services were not part of the ACSA review, it was noted that the hospital had undertaken a number of initiatives to improve outcomes following a stay in the critical care department. These included musicians from the Royal Northern College of Music being invited to play classical music in the intensive care unit (ITU), patients being provided with exercises to do in bed, and after discharge (including an exercise video).

ACSA visit report (pg 5)
Author: Dr Emma Jane Hosking

Equipment, facilities and staffing

Point of care testing

The team noted that there was excellent access to point of care testing [1.3.5.1], which was available in the main theatre suite at MRI, St Mary's and also at Trafford General Hospital. This included thromboelastography (TEG) testing.

Hot dog pre-op in gynaecology

Obstetrics and gynaecology have access to a number of 'hot dog' mattresses that are used for managing patients preoperatively and intraoperatively to prevent hypothermia. Patients arriving for their surgery are instructed to sit on the hot dog while waiting for their surgery. This has improved surgical outcomes and temperature in post-operative patients [1.3.2.2].

Geographical configuration of theatres

The main site has been very well designed so that theatres are colocated in a sensible way. For example, the ophthalmic theatres that are used for children within the Manchester Royal Eye Hospital are immediately next to the children's hospital (which is accessed through a door), so paediatric colleagues can be called if required and patients can be wheeled back into the children's hospital [5.2.1.11]. Similarly obstetric theatres and maternal high dependency are close to the neonatal intensive care unit (which is in the Children's hospital) [1.5.0.9].

Retrieval service

Trafford General Hospital is a 'cold' site, and is staffed by an anaesthetic middle grade (usually a SAS doctor or clinical fellow) overnight. The ACSA RT found that there was a robust system in place for retrieval of patients who deteriorate overnight using the consultant led retrieval service. If this is required, a consultant (on a separate oncall rota) is called in from home to Trafford and transfers the patient to MRI for emergency surgery or critical care [1.1.1.14; 1.5.0.5]. The system was described to the team, who agreed that it appeared to be very safe and robust. The service is used two times per month on average.

ACSA visit report (pg 6)
Author: Dr Emma Jane Hosking

Patient experience

Interpretation services

The hospital recognised the importance of providing a full range of interpretation services, and provision in this area was excellent [3.3.2.2]. There is a service level agreement in place with an interpretation service for provision of face to face interpretation services within one hour. The ACSA RT were also shown the 'big word' telephones in the various areas of the hospital. Preassessment nurses commented that this was used regularly and was an improvement on their previous reliance on face-to-face interpretation, which could cause delays where patients were not flagged by GPs as requiring the service. All staff that the ACSA RT spoke to were aware of the services that were available, and feedback on the quality of the service from staff who had used the service was, in general, good. All levels of staff that the ACSA RT spoke to were aware of the hospital's policy that patients' relatives should not be used to provide translation services, and abided by this.

Creative use of patient information (Youtube)

A survey had been done by a trainee, supported by the consultants in St Mary's hospital, to find out how women wanted to receive information relating to labour and their options for childbirth. This found an almost 50-50% split in patients who wished to receive information in leaflet form, and those who preferred videos. The hospital has made a number of patient videos and put these onto YouTube for women delivering at St Mary's. The trainee also mentioned that she is looking into options for developing a mobile application [3.1.2.2].

Text message service for antenatal appointments

Staff at St Mary's Hospital identified a problem with women not turning up for their antenatal appointments. They introduced a text message reminder service, and this has improved attendance.

ACSA visit report (pgs 6 and 7)
Author: Dr Emma Jane Hosking

Clinical governance

Clinical governance structure

The leadership structure of the department was explained to the ACSA RT, and appeared very thoughtfully developed to ensure good clinical governance. The department is led by Jane Eddleston (division head). There is a deputy clinical director responsible for workforce, who is responsible for rotas, job planning and managing leave, a deputy clinical director who is responsible for the 'transforming theatres' and perioperative medicine workstream, and a deputy clinical director responsible for clinical effectiveness and audit, who manages the audit programme and organises the audit and clinical effectiveness (ACE) days (described below). There is a clinical lead for the Trafford site, who is responsible for both anaesthesia and critical care provision on that site. There is also a lead for MRI and emergency theatres. Certain specialty areas (pain, cardiothoracic, obstetrics/gynaecology) also each have a deputy clinical director responsible for each individual area and 'supergroups' associated with them. In addition to this, there are leads for particular workstreams in the perioperative group, and clinical effectiveness leads for the different hospitals/centres within the trust. The ACSA RT were impressed with the succession planning that was evident in this leadership structure [2.6.2.1].

This is supported by a structure of meetings, including monthly clinical governance meetings in subspecialty areas – these meetings examine all of the issues affecting their area of work, including critical incident and audit data, and the results of these discussions are taken to the ACE days which occur every three months [4.2.1.1; 4.3.1.1].

ACE days

As mentioned above, an ACE day is scheduled every three months. During this day, no elective surgery is scheduled so that staff can be available to attend. Staff that the ACSA RT spoke to were universally positive about these days, many saying that they 'would not miss it'. The agenda for each day includes consultant and trainee meetings (separately), multidisciplinary meetings in each of the individual specialist areas, research/national audit updates and training workshops on particular topics e.g. simulation and equipment training [4.5.1.1; 4.5.1.2].

Quick, robust feedback on critical incident reporting

Members of the department were happy with the level of feedback that they received following reporting a critical incident. Consultants indicated that any critical incident relevant to anaesthesia was discussed in so many forums that they were 'sick of hearing about it' by the time they had stopped talking about it. The ACSA RT felt that this showed an openness and willingness to learn from mistakes. There was also apparent open communication, and good support from the department for individuals involved [4.2.1.1].

Clinical excellence reporting

The department indicated that there was the facility within their critical incident reporting system to report 'excellent practice' that others could learn from. Where these were reported, positive incidents were discussed alongside critical incidents to allow for learning to take place.

Buy-in to NAP6 and NELA

The department as a whole showed a willingness to participate and, in some cases, lead national projects such as NAP6 and NELA and other multidisciplinary projects [4.5.1.1]. The ACSA RT were impressed by the department's apparent willingness to share good practice, and openness to improvements.

ACSA visit report (pgs 7 and 8)
Author: Dr Emma Jane Hosking