healthwatch Bury

Enter and View

A&E department

Fairfield General Hospital

26th November

1st December

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2 Introduction

2.1 Details of visit

Name of the service	A&E department, Fairfield General Hospital
Service provider	Northern Care Alliance
Date and time	Wednesday, 26th November 1-4pm Monday, 1st December 10am – 1pm
Authorised representative (s)	Alan Norton Sharon Allen (Alan Norton's PA) Florence Sokol Paulina Nehrebecka Andrea Wilson Annemari Poldkivi Alison Slater

2.2 Acknowledgements

Healthwatch Bury would like to thank the service provider, all emergency department staff, patients and their families for contributing to this Enter and View visit, notably for their helpfulness, hospitality, and courtesy. We would also like to say a big thank you to out Enter and View authorised representatives team for volunteering their time to carry out these visits.

2.3 How we gathered the data

This report is based on our observations and the experiences of the patients, relatives and staff we spoke to on the day of the visit.

3 What is Enter and View?

Part of the local Healthwatch programme is to carry out Enter and View visits. Local Healthwatch representatives carry out these visits to health and social care services to find out how they are being run and make recommendations where there are areas for improvement. The Health and Social Care Act allows local Healthwatch authorised representatives to observe service delivery and talk to service users, their families, and carers on premises such as hospitals, residential homes, GP practices, dental surgeries, optometrists, and pharmacies. Enter and View visits can happen if people tell us there is a problem with a service, but, equally, they can occur when services have a good reputation – so we can learn about and share examples of what they do well from the perspective of people who experience the service first-hand.

Healthwatch Enter and Views are not intended to identify safeguarding issues specifically. However, if safeguarding concerns arise during a visit, they are reported in accordance with Healthwatch safeguarding policies. If at any time an authorised representative observes anything that they feel uncomfortable about, they need to inform their lead, who will inform the service manager, ending the visit.

In addition, if any staff member wishes to raise a safeguarding issue about their employer, they will be directed to the Care Quality Commission, where they are protected by legislation if they raise a concern.

3.1 Purpose of visit

The Enter and View visit to Fairfield General Hospital A&E was conducted by Healthwatch Bury to provide an independent review of the quality and overall experience of care within the department. The visit aimed to gather feedback from patients and staff during a period of high demand, observe the environment, assess accessibility, communication and dignity in care and identify areas of good practice and opportunities for improvement for patient flow and waiting environments. This initiative supports transparency, promotes patient and public involvement in health services, and informs recommendations to improve care standards in line with statutory Healthwatch responsibilities.

3.2 Strategic drivers

Healthwatch Bury undertook this Enter and View visit to Fairfield General Hospital A&E following an invitation from the Northern Care Alliance. The decision to run this visit forms part of a wider programme aimed at strengthening patient and public involvement in health and social care services.

Enter and View visits are underpinned by statutory powers granted to local Healthwatch under the Local Government and Public Involvement in Health Act 2007 and the Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013. These powers enable authorised representatives to observe services and gather feedback directly from patients and staff, ensuring that local voices inform service improvement.

The rationale for this visit reflects several key drivers:

- Commitment to transparency and accountability in urgent and emergency care services.
- Recent changes and pressures in the health and care landscape, including increased demand on A&E departments and the need to maintain patient dignity and safety.
- Evidence based improvement, using real time experiences to identify good practice and highlight areas for development.

By conducting these visits, Healthwatch Bury aims to provide an independent perspective on the quality of care, support informed decision-making for patients, and contribute to continuous improvement within the Northern Care Alliance's services.

3.3 Background and context

Context for the Enter and View Visit

Fairfield General Hospital's Accident & Emergency (A&E) department operates 24/7 as part of the Northern Care Alliance NHS Foundation Trust, providing urgent and emergency care for Bury and surrounding areas and acting as a key gateway for hospital admissions. The department includes resuscitation bays, assessment areas, and an Urgent Treatment Centre (UTC) for less severe conditions. Following a recent reassessment of risk profiles, some patients, such as those with minor fractures, are now directed to the UTC. As the UTC does not operate on a fully 24-hour basis, patients meeting its criteria outside operating hours may wait overnight in A&E or return when the UTC reopens.

In light of these changes, Healthwatch Bury sought clarification from NCA regarding the operation of the UTC and the impact on A&E waiting times. NCA advised that UTC opening hours have been extended and that the service is staffed by experienced clinicians, with the intention of reducing pressure on A&E and supporting performance against national waiting time standards. While this represents a positive development, overall A&E performance remains below the national four hour target, and during the Enter and View visits it was not yet clear to what extent these recent changes had translated into sustained improvements in waiting times or patient experience. Healthwatch recognises that these developments were introduced shortly before or during the visit period and will continue to monitor their impact through future Enter and View activity.

Why This Visit Matters

National and regional A&E services are under serious pressure amid the ongoing winter surge. In the first half of 2025, NHS England recorded a historic increase, with 27.4 million A&E visits—up 7.1% year-on-year—and, during peak winter weeks, more than 5,400 patients per day were hospitalized with flu alongside high volumes of COVID-19 and norovirus cases.

As the season progresses, latest reports warn of a "double-whammy" flu-demic and NHS strikes. The average number of patients admitted daily with flu now exceeds 1,700, more than 10 times the levels seen at the same time in 2023 and over 50% higher than in 2024. NHS preparations—such as ramped-up flu-vaccination efforts and the expansion of urgent care pathways beyond A&E—are helping to manage rising demand, but pressures remain intense. [1]

[1] NHS England » NHS ready for double whammy of winter flu-demic and strikes

Activity at Fairfield General Hospital

While site specific monthly figures are not published in isolation, Northern Care Alliance hospitals (including Fairfield) collectively manage tens of thousands of attendances annually. Based on regional averages, Fairfield's A&E likely sees ~7,500 attendances per month, contributing to the Trust's overall emergency activity.

Fairfield General Hospital's Emergency Department is experiencing sustained pressure due to demand levels significantly higher than those it was originally intended to manage. Although no formal design-capacity figure has been published, the department was historically expected to serve the Bury borough population of around 190,000. A Type 1 A&E serving this population would typically receive 60,000–70,000 attendances per year.

Current activity far exceeds this. Fairfield now sees approximately 91,000 attendances annually[2]—around 250 patients per day—representing a 30–40% increase above the level expected for its original catchment. A major contributor to this rise is the closure of Rochdale Infirmary's A&E in 2011. With Rochdale's 223,000 residents now reliant on neighbouring hospitals, Fairfield receives an estimated 8,000–12,000 attendances per year from Rochdale postcodes.

This additional demand has created significant operational challenges. Fairfield faces increased waiting times, ambulance handover delays, and heightened pressure on inpatient beds due to higher emergency admissions. These pressures have driven the need for ongoing expansion of the A&E, including additional resuscitation bays, major injury cubicles, and enhanced rapid-assessment capacity.

Overall, the combination of historical design limitations, population growth, and the diversion of Rochdale emergency cases has placed Fairfield's A&E under considerable strain, with clear implications for service performance and the experience of both Bury and Rochdale residents.

Waiting Times and Performance

- At Fairfield General Hospital, around 53% of patients are seen within four hours, compared to the NHS target of 95%.
- Across Greater Manchester, performance is similarly challenged: most hospitals see fewer than two-thirds of patients within four hours, and one in five patients at some sites wait over 12 hours for admission.

[2] Emergency and Urgent Care - Welcome to the Emergency Department at Fairfield General Hospital :: Northern Care Alliance

- Nationally, in 2024/25 winter, 73% of patients were seen within four hours, far below the 95% standard, and 11% waited over 12 hours for a bed after a decision to admit.
- The average A&E wait time in England is now 5.2 hours, with some trusts exceeding 10 hours.

Comparison with Other Sites

- Northern Care Alliance hospitals (Salford, Oldham, Rochdale, Bury) report some of the lowest four-hour performance in Greater Manchester, with Bury around 66%, compared to the regional average of 69–72%.[3]
- England overall: 72.1% of attendances within four hours in 2023–24, continuing a decade-long decline from the 95% target. [4]

Impact of Winter Pressures

Winter exacerbates existing challenges:

- High bed occupancy and delayed discharges reduce patient flow.
- Corridor care and long waits have become common, raising safety and dignity concerns.
- Seasonal illnesses accounted for record hospital bed days in 2024/25, with flu admissions alone exceeding 315,000 bed days. [5]
- The Trust reports that escalation beds can be opened during periods of high pressure, subject to the availability of appropriate staffing and guided by a formal escalation plan. While this provides an important safety mechanism, it also highlights an inherent challenge: the ability to increase bed capacity is constrained by ongoing workforce pressures.
- It was not clear from the information provided how frequently escalation beds are opened in practice or how consistently they are available during peak demand. This uncertainty aligns with patient experiences of prolonged waits for inpatient beds during the visits.

[3] Third of patients spend more than four hours in Tameside A&E - Not Really Here Group - Tameside Radio, Tameside Reporter, Oldham Reporter, Glossop Chronicle

[4] Summary Report - NHS England Digital

[5] New analysis shows NHS faced record winter pressures in 2024/25

4 Overall summary

The Enter & View visits to Fairfield General Hospital A&E were conducted during periods of high operational pressure but presented contrasting experiences across different areas of the department.

Wednesday, 26th November: The department appeared calm and ordered, with visible leadership and amenities supporting both patient and staff experience. Care delivered in bays/cubicles was consistently described as professional, kind, and timely, with clean, private conditions and rapid diagnostics where clinically indicated. Staff interactions were positive, and the environment in clinical spaces met expectations for dignity and safety.

Monday, 1st December: Experiences in the main waiting area and corridor spaces were more variable. While some patients reported respectful triage and clear communication, others described long waits (up to 16–17 hours), limited updates, and privacy challenges during transitions. Comfort concerns were noted, including temperature control, seating adequacy, and refreshment access overnight. One patient reported feeling unsafe due to disruptive behaviour in the waiting room, highlighting the need for robust protocols to manage challenging situations.

Across both visits, overall satisfaction remained high for clinical care, but isolated negative experiences, particularly those involving extended pathways and perceived lack of support during prolonged waits, underscore the importance of system-level flow oversight and consistent communication standards. The visits identified:

- Access to GP services as a key driver of A&E attendance, with patients citing difficulty obtaining urgent GP appointments or being redirected by NHS 111.
- Operational pressures in acute care leading to corridor use for patient care and variability in patient experience.
- Opportunities to keep patients and families informed without them having to ask. Including Regular waiting-time updates, explaining delays. clear communication about next steps and checking in on people who look worried or confused.
- Protecting patients' dignity and personal information (Speaking quietly when discussing personal details, using private spaces for sensitive conversations, ensuring curtains are fully closed and being mindful of visibility)

- Comfort measures such as offering water, blankets, or pillows to those waiting for long periods, providing clear signage, ensuring seating is clean and accessible and checking on vulnerable patients.
- Fast triage for urgent symptoms such as chest pain, breathing difficulties, or stroke signs, clear systems for alerting senior clinicians when a patient's condition changes. Regular monitoring of high-risk patients while they wait and ensuring no one deteriorates unnoticed.

The visits demonstrate strong staff commitment and leadership presence but reveal systemic challenges across the urgent care pathway. Addressing primary care access, flow constraints (timely access to an appropriate inpatient bed), and communication gaps will be critical to improving patient experience and safeguarding dignity during peak demand.

The Trust has advised that a number of initiatives aimed at improving patient flow and experience were introduced in December 2025, including changes to urgent care pathways, stroke flow workstreams, and extended service hours. These developments represent a positive commitment to addressing some of the pressures observed during the Enter and View visits. As several of these initiatives were either newly introduced or still embedding at the time of the visits, their full impact was not consistently visible to patients during our observations. Healthwatch will seek to explore the efficiency and sustainability of these changes during future visits.

5 Methodology

The visit was prearranged with respect to timing, and an overview explanation of the purpose was also provided.

The Authorised Representatives (ARs) arrived at the A&E on Wednesday, 26th November at 1pm and actively engaged with patients between 1pm and 3pm. They left at 3.30pm.

On arrival, the AR(s) introduced themselves to the Lead Nurse for Emergency Department, Julie Newton, and Patient Experience Lead, Tracy Shaw, and the visit details were discussed and agreed. Healthwatch team had already met with the Emergency Department staff prior to the visit to agree and finalise the details. Tracy Shaw shared her contact details for any unexpected queries or challenges.

The ARs checked with the provider whether any individuals should not be approached or were unable to give informed consent. The Lead Nurse for Emergency Department provided the ARs with a thorough tour of the A&E department and introduced them to staff along the way. The ARs were subsequently afforded access to all parts of the department for the duration of the visit.

The ARs used a semi-structured conversation approach in meeting patients on a one-to-one basis, mainly in the main waiting area, bays and urgent care centre waiting area. The checklist of conversation topics was based on the pre-agreed themes for the emergency department visits. Additionally, the ARs spent time observing routine activity. The ARs recorded the conversations and observations via hand-written notes.

Patients were approached and asked if they would be willing to discuss their experiences. It was made clear to patients that they could withdraw from the conversation at any time.

A total of fifteen patients and three staff members took part in these conversations. 5 of those patients were in the Urgent Care Centre waiting area.

In respect of demographics:

- 8 patients were male and 6 females; one patient did not want us to report back on their gender.
- One patient was under 30 years old. Most patients (6) we spoke to were over 65

At the end of the visit, the Patient Experience Lead was verbally briefed on the overall outcome.

For the second visit

The Authorised Representatives (ARs) arrived at the A&E for the second visit on Monday, 1st December at 10am and actively engaged with patients between 10am and 11.30am. They left at 11.45am.

On arrival, the AR(s) introduced themselves to the Patient Experience Lead, Jemma Holt, and the visit details were discussed and agreed. Healthwatch team had already met with the Emergency Department staff prior to the visit to agree and finalise the details. Jemma Holt shared her contact details for any unexpected queries or challenges.

The ARs checked with the provider whether any individuals should not be approached or were unable to give informed consent. The Lead Nurse for Emergency Department provided the ARs with a thorough tour of the A&E department and introduced them to staff along the way. The ARs were subsequently afforded access to all parts of the department for the duration of the visit.

The ARs used a semi-structured conversation approach in meeting patients on a one-to-one basis, mainly in the main waiting area, bays and urgent care centre waiting area. The checklist of conversation topics was based on the pre-agreed themes for the emergency department visits. Additionally, the ARs spent time observing routine activity. The ARs recorded the conversations and observations via hand-written notes. At the outset, the team was advised which areas and bays were restricted due to infection risks relating to flu and COVID.

Patients were approached and invited to share their experiences, with reassurance that they could withdraw from the conversation at any point.

In total, thirteen patients participated: seven in the main waiting room, six in the corridor, and one in a bay. Demographic details included:

- 10 female patients and 3 male patients
- The largest age group represented was 70–90 years old (five patients)

At the conclusion of the visit, the Manager received a verbal summary of the overall findings. The Enter and View team also had the opportunity to ask further questions, enabling a deeper understanding of the day-to-day operations within the A&E department.

6 Summary of findings

6.1 Pre-Visit Questionnaire Summary

Prior to the Enter and View visit, a pre-visit questionnaire was sent to the Lead Nurse of the Emergency Department at Fairfield General Hospital. The purpose was to gain insight into departmental processes, patient support mechanisms, and collaborative practices before the site visit. Key findings from the questionnaire are outlined below:

Patient Feedback and Concerns:

The department promotes feedback through visible information on electronic screens and posters, including the NCA Experience Plan and "Open and Honest" boards. Patients can raise concerns via Patient Advice and Liaison Service[6] and a dedicated help phone system. Friends and Family Test[7] feedback is reviewed monthly.

Patient Support and Communication:

Named nurses are allocated to patients in majors and resus areas, ensuring hourly contact. Waiting room patients are supported by assessment nurses, reception staff, and volunteers. Daily walk rounds by senior nurses and information screens help keep patients informed. Interpreters (including BSL), loop systems, and links to specialist teams are available for those with additional needs.

Managing Distress and Challenging Behaviours:

Distraction aids, quieter areas, and sensory equipment are used to support distressed patients. Individualised care plans can be uploaded to the ED system. A specialist nurse works with safeguarding teams, mental health liaison, and police. A violence and aggression reduction team and dedicated police officer have recently been introduced.

Frequent Attenders and Alternative Care Options:

Processes exist to redirect patients to Urgent Treatment Centre, Same Day Emergency Care, GP, pharmacy, or self-care. A non-clinical navigator supports redirection when A&E is not appropriate. Plans are underway to introduce care by appointment for minor injuries.

Partnership Working:

[6] Patient Advice and Liaison Service (PALS)

[7] Patient Feedback :: Northern Care Alliance

The department collaborates with mental health liaison teams, falls specialists, tissue viability, learning disability and safeguarding teams, and private providers for mental health care. Mental health practitioners have a base within the Emergency Department and complete mental health passports for patients awaiting admission.

Incident Management and Safety:

Incidents are reported via DATIX[8] ,(A web-based system for incident reporting widely used by providers of NHS healthcare as part of local incident management arrangements. In NHS trusts this system links to the National Reporting and Learning System (NRLS)). followed by medical and senior nurse reviews and learning reviews under The Patient Safety Incident Response Framework (PSIRF). Safety huddles occur at the start of each shift, with risk assessments completed for all patients. Preventative measures include bedside handovers, end-of-shift huddles, and visual aids for fall risks.

Recent Improvements:

Introduction of a 24-hour housekeeper to support nutrition and hydration needs. Waiting times are now displayed electronically. Processes are in place to maintain dignity for patients cared for in temporary escalation areas such as corridors.

Staff Training and Development:

Mandatory training includes core and Emergency Department specific competencies, supported by a dedicated practice educator. Staff access internal and external courses, team days, and regular updates from senior clinicians.

Identified Needs for Improvement:

- Direct access from Emergency Department to mental health services in a quieter, dedicated space.
- Faster transport for patients requiring specialist care not available at Fairfield.

6.2 Overview

Fairfield General Hospital, located on Rochdale Old Road in Bury, Greater Manchester, is part of the Northern Care Alliance NHS Foundation Trust. The Accident & Emergency (A&E) department offers 24/7 urgent and emergency care to the community. [9]

CQC Registration & Department Capacity

The hospital is registered with the Care Quality Commission (CQC)[10]. The Urgent and Emergency Services at Fairfield are currently rated as Requires Improvement

[8] Screening incident glossary - GOV.UK

[9] Fairfield General Hospital :: Northern Care Alliance

[10] Fairfield General Hospital - Care Quality Commission

as of the last inspection in August 2022[11]. The A&E is classified as a Type 1 department, handling both resuscitation bays (5) and assessment bays/rooms (17), in addition to 3 rapid assessment bays and a dedicated mental health room.

Historical figures show the department was originally built for around 45,000 annual attendances, but by 2012 it was treating over 65,000 patients per year due to increased demand. A recent expansion plan aims to further enhance capacity to serve approximately 30,000 urgent care patients annually, suggesting significant throughput.[12]

Patient Activity

• While exact daily or weekly attendance figures for the visit date weren't available, national-level data is published monthly and annually by NHS England and NHS Digital.[13][14]

• The A&E is part of the Type 1 & 2 category, which includes data from September 2023 onwards, demonstrating a structured reporting system. [15]

Location & Site Characteristics

Situated in a semi-residential area approximately 2 miles from Bury town centre and 10.5 miles north of Manchester, the hospital is accessed via a main thoroughfare (Rochdale Old Road) and is well served by local bus routes.

The facility comprises an expanded campus with buildings from different eras, including:

- Origins as the Bury Union Workhouse Infirmary (1905),
- NHS conversion in 1948,
- Major modernisation during the 1970s,
- Post-2007 expansion after Bury General Hospital's closure.
- A significant multi-million-pound A&E extension was granted planning permission in December 2023. This phase includes a new resuscitation unit, care testing rooms, mental health suite, and modular treatment bays, reflecting continuous infrastructure investment.

Leadership & Departmental Management

The Lead Nurse for the Emergency Department oversees clinical operations and staff development.

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[11] Trust - RM3 Northern Care Alliance NHS Foundation Trust (22/12/2022) INS2-13377901931

[12] Fairfield Hospital A&E expansion takes another step forward | Bury Times

[13] Number of attendances and people by total time spent in emergency care, England: March 2021 to April 2022 - Office for National Statistics

[14] A&E attendances and emergency admissions for March 2025 and Quarterly report (Q4) - GOV.UK

[15] Statistics » A&E Attendances and Emergency Admissions

6.3 Key Findings

Limitations: Visitors' reflections are observational and time bounded; patient accounts are a small sample; findings should be interpreted as indicative signals rather than definitive performance metrics.

Bay Experience

- Care in bays/cubicles was consistently professional, compassionate, and timely, with rapid diagnostics (e.g., scans on arrival).
- Clinical spaces were clean, private, and quieter, supporting dignity and safety.
- Visible leadership culture focused on improvement; staff described as calm, courteous, and proactive.
- Occasional privacy vulnerabilities noted (e.g., doors left open).

Waiting area/Corridor Variability

- Proactive communication with patients and relatives was not consistent. Several patients reported long periods without any updates about their care or expected waiting times. This lack of information caused significant stress for relatives, who were worried that their loved one's condition might deteriorate without timely access to specialist treatment. This concern was particularly evident on 1 December, when five stroke patients were waiting to be admitted to the stroke unit and their families felt unsure about what was happening or when specialist care would begin. Corridor care was safe but uncomfortable, with privacy and comfort requiring attention during transitions.
- Patients advised that they felt more vulnerable and more concerned for their personal safety when in an open space with other patients and staff passing them.

Flow & Access

- Day-to-day variability observed: quicker movement on 26th November, but extended pathways for some patients.
- Corridor →bay transitions occurred under pressure; dignity safeguards needed.
- Parking and downstream bottlenecks beyond ED warrant system-level review.
- Due to the need for treatment in a private area, patients were frequently moved from a cubicle to a corridor at any time which caused further anxiety
- We asked if there was a strategic plan for areas of speciality which indicated more ward capacity was required, in this case for stroke patients

Communication

- Clear and reassuring in bays, but limited updates for waiting/corridor patients, especially overnight.
- Need to standardise pre-bay updates (expected wait, clinician changes) and clarify referral pathway messaging (GP/111/UTC/ED).

Environment & Amenities

- Cleanliness generally acceptable; positive amenities noted (free hot drinks, staff pamper box).
- Comfort concerns: temperature control, seating adequacy, and privacy protocols need reinforcement.
- Waiting areas described as stuffy, with requests for better layout, signage, and more seating.
- Although a housekeeper is available 24/7 patients advised they had only received a sandwich /toast and no substantial meal even though they had been waiting for an extended period. Several patients had food and beverages brought in for them by relatives however not every patient may have a relative or friend who can do this for them. The Trust has explained that a vacancy within the housekeeping service contributed to gaps in food and refreshment provision, and that recruitment is underway to support a 24-hour service. While this provides helpful context, patient feedback gathered during the visits highlighted that some individuals waiting for extended periods, particularly overnight, received limited food or refreshment.
- From a patient experience perspective, it is reasonable to question whether short term mitigation, such as overtime or bank staffing, could have been more consistently utilised during periods of high demand. Ensuring reliable access to food and drink remains an important comfort and dignity issue for patients facing long waits.

Urgent Care Centre

- Observations in the Urgent Treatment Centre (UTC) highlighted several practical challenges for patients and staff. Older people and those with mobility difficulties often struggled when asked to move from the Emergency Department to the UTC without support, particularly in bad weather. During the visit, two patients in their 80s were directed to use the external route: the woman had a broken ankle, and her husband had to push her wheelchair across an icy path to reach the UTC.
- Although an internal route between the two areas exists, it appears to be rarely used, meaning many patients still have to go outside. The Trust has advised that, where possible, patients are now being transferred internally within the department to support dignity and improve flow. This was not observed during the Enter and View visits, when corridor care and movement between areas were still evident.

It is possible that this change reflects learning from issues raised during the visits or has been implemented more consistently since. Healthwatch identifies this as a specific area for follow-up during future Enter and View activity to assess how frequently and effectively internal transfers are now being used in practice.

- The UTC itself now sees a broader range of patients following recent changes to its role, but the physical space has not expanded to match this increased demand, leading to a cramped waiting environment.
- Some patients reported waiting up to five hours without being seen or spoken to, and many expressed frustrations about the lack of communication regarding their wait.
- During the visit, questions were raised about whether additional staff have been allocated to the UTC and whether there are plans to improve or enlarge the waiting area. It was also unclear whether free hot drinks, which are available in the Emergency Department, are provided in the UTC as well.
- The Trust reports that, as part of winter planning, the Urgent Treatment Centre (UTC) and Same Day Emergency Care (SDEC) services have extended their opening hours, with UTC now operating until midnight and SDEC until 02:00, seven days a week, supported by experienced clinical staff. This extension is a positive step in supporting patient flow and reducing pressure on the main Emergency Department.
- During the Enter and View visits, however, capacity and physical space constraints within the UTC remained evident, and not all patients were able to access the service via an internal route. As a result, some patients, particularly those with mobility difficulties, continued to experience challenges when being directed to the UTC. The extent to which extended hours translate into improved patient experience will require ongoing monitoring.

Overall Satisfaction

- Predominantly positive for clinical care and staff interactions.
- Outliers (long journeys, unsupported feelings during extended waits) highlight improvement needs in communication and comfort as patients complained of feeling cold.

Systemic Issues Identified

- Primary care access barriers: Patients reported difficulty obtaining timely GP appointments or being redirected to A&E (e.g., "GP refused to give me antibiotics"; six-month struggle for catheter-related care).
- Prolonged waiting and delays: Cases include ~17 hours for suspected stroke, ~16 hours for possible sepsis, and ~17 hours in the main waiting room awaiting imaging/review.
- Communication and dignity challenges: Despite praise for staff, patients cited limited updates, audible personal information, and practical

concerns (belongings, changing clothes, support going to the toilet and personal hygiene).

- Environment and safety: Disruptive behaviour observed in waiting areas by patients we spoke to; noise and lighting issues noted.
- Feedback signals a whole-pathway challenge—constrained GP access, urgent care demand, and acute bed/flow pressures combine to create long waits and corridor/delays, impacting privacy, dignity, and safety, especially for time-critical conditions (stroke, sepsis).
- As the Trust moves forward with plans for the Fairfield General Hospital A&E extension, it will be important to consider how these developments align with the wider service improvements discussed during our visit. In response to questions from Healthwatch, NCA advised that a range of specialist services already provide in reach to the Emergency Department, including mental health support delivered by the Pennine Care NHS Foundation Trust. As part of the A&E expansion, a larger, dedicated area for mental health assessment is planned, intended to improve the environment for patients presenting with acute mental health needs.

Enter and View Visitors' reflections

- manager presence/enthusiasm, amenities (free hot drinks),
- staff demeanour, cleanliness, staff welfare (pamper box),
- "Constant review and adapt" culture (e.g., paediatrics),
- Phase 3 expansion, throughput observations (quieter/ordered compared with August; quicker movement from initial waiting), and one case arriving by taxi due to ambulance wait (non-Cat 1/2).

"They are constantly reviewing how things are working… a new area (Phase 3) is going to be built, staff were excited."

"Three patients in bays were happy with their journey, feeling they were seen and treated within a reasonable time."

6.3 Arrival and Check In

Positives:

- Visible leadership and managerial presence: Observers noted "a good number of managers or leads" who were "enthusiastic," reinforcing a culture of oversight and responsiveness. This aligns with patient reports of orderly handovers and huddles
- Professional and reassuring staff demeanour: Patients and visitors consistently described staff as "really nice," "amazing," "polite/helpful," and "professional/kind." Nurses appeared calm and approachable, contributing to a sense of safety and confidence.
- Positive bay experience: Patients in clinical bays reported being "happy with their journey," feeling they were seen and treated within a reasonable time, supported by rapid diagnostics and clear communication.

Areas to Strengthen:

- Waiting area experience: While visitors found the department "quiet and ordered," patient accounts still highlight variable proactive engagement and comfort (temperature/seating/layout).
- Ambulance wait decisions: One person "came by taxi because of the ambulance wait (not Cat 1/2)." This underscores the need to support patients who self-present due to ambulance triage categories, ensuring safe, timely navigation on arrival.
- Extended waits (e.g., suspected stroke patient waiting ~17 hours before a bed became available) highlight the importance of early escalation and communication standards during arrival and check-in.

"Had a scan as soon as arrived… staff were all amazing; brought refreshments for my wife and the accompanying staff member."

"Not spoke to anyone whilst waiting… too warm in A&E."

"Better layout, more signage, more explanation about the process." *Patients (waiting area)*

6.4 Waiting Times and Communication

Positives

- Rapid triage and movement on 26th November: Observers noted that patients were "moving through from the initial waiting area quite quickly," supported by patient reports of fast triage and scans-on-arrival in bays, indicating efficient throughput during the first visit.
- Clear communication in bays: Patients described interactions in clinical spaces as reassuring and professional, with staff providing explanations during diagnostics and treatment.
- Respect and safety at triage: Several patients in the second visit felt safe and respected while awaiting results, reflecting positive staff engagement despite operational pressures.

Areas to Strengthen

- Prolonged waits and variability on 1st Dec: Evidence shows extreme delays, including ~17 hours for a suspected stroke patient, ~16 hours for possible sepsis, and ~17 hours in the main waiting room awaiting imaging and review for a stroke bed. Other cases reported waits of 30 minutes to four hours, highlighting significant variability driven by acuity and capacity constraints. Provider data shared with Healthwatch indicates that average waiting times for stroke patients to be admitted from the Emergency Department are, overall, lower than those observed during the second Enter and View visit. This suggests that the day of the visit may have been particularly challenging.

  The Trust has described a dedicated multidisciplinary workstream, commenced in December, aimed at improving stroke flow, including the use of escalation beds and capacity reviews.
- Limited updates during extended waits: Patients praised staff but reported uncertainty and minimal communication, particularly overnight (e.g., "under observation… don't know yet"; no overnight updates)
- Corridor-to-bay transitions under pressure: Movement from waiting areas to bays often occurred in challenging conditions, requiring stronger privacy and dignity safeguards.
- Refreshment and comfort gaps: Accounts noted limited food and drink provision during prolonged waits (e.g., one sandwich at 6pm; no tea/coffee overnight) and concerns about personal belongings security in corridor care. However, several other patients had previously reported that they had been offered refreshments throughout their wait.
- Environment and safety concerns: Reports of audible personal information, difficulty changing clothes, and disruptive behaviour in waiting areas contributed to reduced perceived safety and comfort.

"Nine hours overall… CT scan… absolutely not (would not return)."

"17 hours in a bed on a corridor — very upsetting." — *Patient (male, 80+, suspected stroke)*

6.5 Staff interaction and quality of care

Positives

- Professionalism and compassion: Patients consistently described staff as "brilliant," "very good," "polite/helpful," and "professional/kind," reinforcing confidence in clinical care.
- Visible leadership and teamwork: Observers noted strong managerial presence and a "constant review and adapt" culture, with staff appearing calm and collaborative during both visits.
- Quality of care in bays: Patients reported feeling reassured and supported, with rapid diagnostics and timely interventions where clinically indicated.
- Respect and dignity: Several patients highlighted respectful interactions at triage and during treatment, even under high operational pressure.

Areas to Strengthen

- Communication consistency: While communication in bays was clear, patients in waiting areas and corridors reported limited updates, particularly during prolonged waits and overnight periods.
- Escalation during extended waits: Critical cases (e.g., suspected stroke patient waiting ~17 hours before a bed became available- please note the patient had been triaged and treated as they arrived at the hospital) underscore the need for time-bound senior review triggers and proactive engagement during delays.
- Privacy during transitions: Corridor-to-bay movements occurred under pressure, with occasional privacy vulnerabilities (e.g., audible personal information, doors left open).
- Support during surge conditions: Staff compassion was evident, but capacity constraints limited opportunities for reassurance and comfort measures during peak demand.

6.6. Environment and Facilities

Positives

- Cleanliness and hygiene: Both visits confirmed that clinical areas, bays, and toilets were generally clean and well-maintained, with visible sanitation routines.
- Amenities supporting comfort: Observations noted free hot drinks in the waiting area and staff welfare measures (e.g., pamper box), which were positively received by patients and visitors.
- Orderly environment during first visit: On 26th November, the department appeared calm and organised, with staff maintaining a professional atmosphere despite operational pressures.

Areas to Strengthen

- Comfort and seating: Patients reported discomfort during prolonged waits, citing limited seating capacity and stuffy conditions in waiting areas.
- Temperature control: Feedback highlighted inconsistent temperature regulation, particularly in crowded spaces, requiring routine monitoring and adjustment.
- Privacy protocols: Corridor care and transitions occasionally compromised privacy (e.g., doors left open, audible conversations), underscoring the need for reinforced standards.

- Safety and behaviour management: Disruptive behaviour in the waiting area during the second visit contributed to reduced perceived safety, indicating a need for visible protocols and staff presence to manage challenging situations.
- Layout and signage: Several patients suggested improvements to wayfinding and spatial layout to reduce crowding and confusion, enhancing overall patient experience.

> "Free coffee, tea and water offered in the waiting room to everyone."
>
> "Nurses seemed quite happy and calm… toilets were clean… staff toilets had a pamper box."
>
> "Better layout, more signage, more explanation about the process."

6.7 Overall Experience and Suggestions

Positives

- Confidence and satisfaction in clinical care: Patients interviewed in bays and cubicles consistently expressed high levels of confidence, describing their experience as "very good," "wonderful," and praising staff for being "professional," "kind," and efficient. Rapid diagnostics and timely interventions were noted as strengths.
- Visible leadership and calm environment

Areas to Strengthen

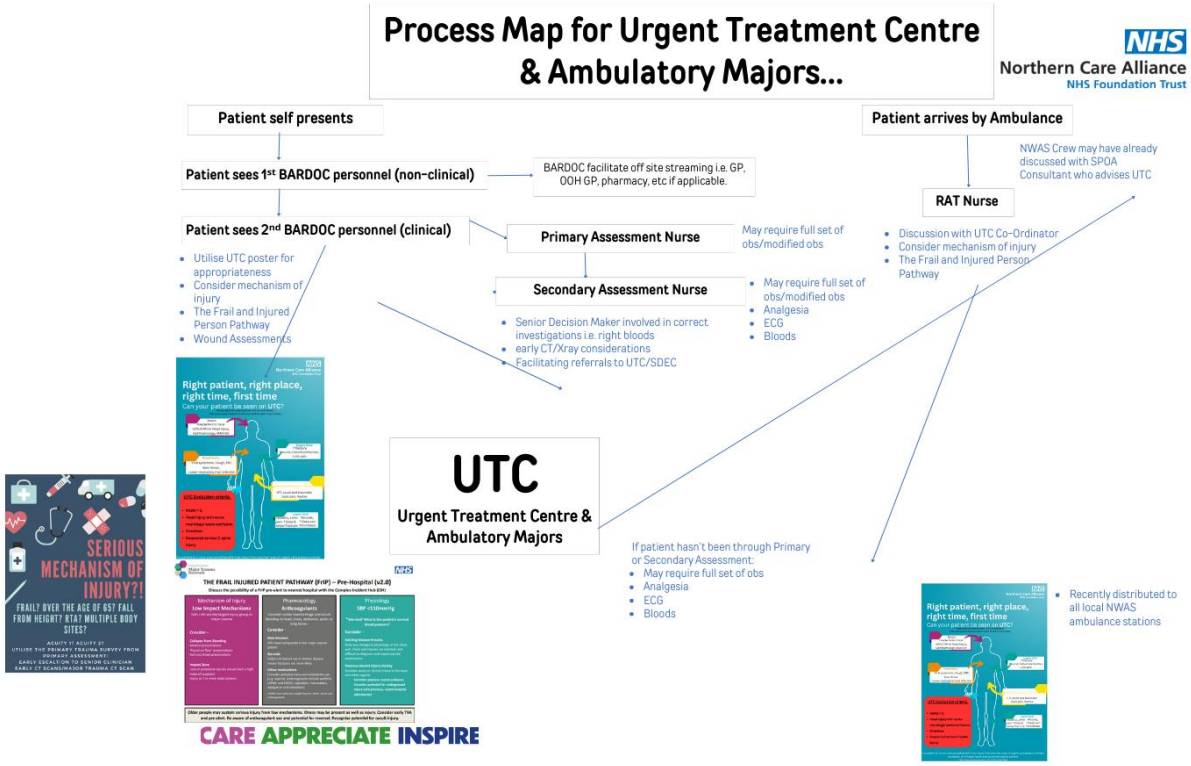
- Variability in waiting experience: While some patients moved quickly through initial triage and into bays, others reported prolonged waits—up to 17 hours for suspected stroke, 16 hours for possible sepsis, and extended periods in the main waiting room awaiting imaging and review. These delays were compounded by inconsistent communication, particularly overnight.
- Communication gaps during long waits: Patients praised staff but described feeling unsupported during extended waits, citing limited updates and uncertainty about next steps. This was especially evident in critical cases where escalation and reassurance were essential.
- Comfort and dignity concerns: Feedback highlighted challenges with seating, temperature control, and privacy during corridor care and transitions. Some patients reported audible personal information and difficulty maintaining dignity while changing clothes.
- Safety and behaviour management: Disruptive behaviour in waiting areas during the second visit contributed to reduced perceived safety, underscoring the need for visible protocols and staff presence to manage challenging situations.
- As the Trust moves forward with plans for the FGH A&E extension, it will be important to consider how these developments align with the wider improvements discussed during our visit. In particular, reference was made to an enhanced mental health service that is expected to support patients presenting with acute mental health needs.

Service standards

- **Urgent primary care standards**[16] emphasise same-day access and clear navigation across GP, NHS 111, UTCs, and ED to minimise avoidable ED attendances and ensure timely assessment for time-critical conditions (e.g., stroke, sepsis).
- **Emergency Department care standards** [17][18] include rapid triage, escalation, privacy/dignity, and regular communication on waits and next steps.

Operational pressures evidenced by this dataset:

- Primary care access & navigation gaps: Antibiotic refusal, prolonged difficulty contacting GP, and 111 redirection indicate front-door constraints that displace demand to Emergency Department.
- Flow/bed constraints in acute care: Multiple 16–17 hour waits and corridor/overflow care point to ongoing capacity problems (beds, discharge flow, specialty availability).
- Communication: During pressures, staff compassion coexists with limited update frequency, affecting perceived responsiveness and dignity.
- Environment/safety: Observed amenity strengths (free hot drinks) alongside disruptive behaviours and stuffy conditions in waiting areas suggest variable experience contingent on demand peaks.



[16] NHS England » Urgent treatment centres – principles and standards
[17] NHS England » Guidance for emergency departments: initial assessment
[18] NCA Policy Hub

6.8 Staff feedback

Three staff questionnaires were analysed. Please see the key points below:

• Working environment was reported to be busy, challenging; good teamwork; pressured by Northwest Ambulance Service/site team; waiting room not big enough; corridor care occurs every shift.

• Staffing: Long days/nights with ~15 Registered Nurses and 4–5 Healthcare Assistants; escalation Registered Nurse for corridor care; Urgent Treatment Centre has separate nursing team.

• Training: Induction/preceptorship; core/mandatory Emergency Department training; monthly updates; access to external courses; practice educator support.

• Patient communication: Screens for waiting times; tannoy announcements overnight; triage nurse to inform patients; staff go to patients to update them directly.

• Safeguarding: Online forms; duty team referrals; safeguarding link nurse; adult vulnerable/MH re-attender nurse support; Mental Health liaison presence.

• Feedback systems: Friends and Family Test reviewed monthly by unit manager; patient experience meetings each month; staff survey/Datix/open door policy.

Datix is a widely used web-based incident reporting and risk management system in NHS organisations. It allows staff to:

- ✓ Report patient safety incidents (e.g., falls, medication errors, delays in care).
- ✓ Record near misses, complaints, and safeguarding concerns.
- ✓ Support compliance with the Patient Safety Incident Response Framework (PSIRF) by enabling structured reviews and learning.
- ✓ Provide data for governance, audits, and quality improvement.

- Improvement ideas: Reduce corridor care; expand areas; optimise streaming to Urgent Treatment Centre/Same Day Emergency Care; maintain senior presence and huddles.

7 Recommendations

System wide recommendations:

1. Access & Navigation (Primary Care / 111 / UTC)

- Strengthen NHS 111 and Urgent Treatment Centre direct booking into rapid-access slots for common urgent presentations (e.g., abdominal pain, chest symptoms, catheter problems, suspected infection).
- Unified patient signposting across GP websites, telephony, 111, and hospital materials: clear criteria for Emergency Department vs Urgent Treatment Centre/GP, what to expect, and how to escalate; publish indicative wait ranges for both ED and UTC to set expectations.

NCA recommendations:

2. Emergency Department Safety, Escalation & Communication

- A safety process is needed for patients with stroke or sepsis when there are long waits. This should include clear time limits for when a senior doctor must review them, regular checks of their vital signs, and simple guidance for patients and families on what to look out for if the person's condition starts to get worse.
- Standardise communication cadence (e.g., hourly or milestone-based updates) supported by visible digital boards showing estimated waits, bed status, and escalation routes.
- Privacy and belongings support: deploy mobile privacy screens, reduce use of full names in open areas, provide secure belongings storage, and facilitate clothing changes with portable screens. Provide assistance in personal care as required.

3. Patient Flow & Capacity

- Improve how beds are managed by giving patients a reliable expected discharge date, using the discharge lounge more actively to free up beds, and making sure specialist teams review patients on the wards every day. These steps help reduce the amount of time patients have to wait in the Emergency Department for an available bed.
- Increase the number of senior clinicians involved in early assessment so patients can be seen and decisions made more quickly. Make fuller use of Same Day Emergency Care (SDEC) so that people who don't need to stay overnight can be treated and sent home safely. These steps help reduce delays and prevent unnecessary hospital admissions.
- Comfort measures during surges: maintain hydration/snack/meal rounds, family seating, lighting moderation, temperature monitoring in waiting/children's areas, provision of blankets if required, and ensure

overnight refreshment access (building on the 24-hour housekeeper and free hot drink offer).

-

4. Governance, Learning & Equity

- MAY ALREADY EXIST! Establish a joint Primary/Urgent/Acute review group (with Healthwatch input) to monitor demand, access, flow, and experience metrics, report regularly to ICS quality boards. Based on the findings from this Enter and View visit, Healthwatch considers that greater involvement in this aspect of system-wide oversight would support shared learning, transparency, and sustained improvement across the urgent and emergency care pathway. Continuous experience capture via QR micro-surveys at registration/discharge and "You said, we did" cycles.
- Apply an inequalities lens: assess impacts on older adults, carers, and those with mobility or sensory needs exposed to corridor/waiting room care; tailor mitigations (e.g., seating proximity, toileting support, wayfinding assistance).

7.1 Examples of Best Practice

Examples of Best Practice

- Daily/safety huddles and bedside handovers with standardised tools.
- Use of waiting room screens and tannoy announcements to keep patients informed.
- Safeguarding link nurses and Mental Health liaison co located with Emergency Department, Communication Needs passports and dementia support materials.
- Urgent Treatment Centre/Same Day Emergency Care pathways supporting streaming and same day decisions.
- Monthly Friends and Family Test review and patient experience meetings led by unit managers.

Healthwatch understands that several improvement initiatives described by the Trust are currently underway. In some cases, timescales for full implementation and measurable impact were not yet clear at the time of reporting. Healthwatch welcomes the direction of travel and will continue to monitor progress, including through future Enter and View visits, to assess whether these changes lead to sustained improvements in patient experience and flow.

8 Service provider response

Response was received on Tuesday, 10th March 2026

The Bury Executives have reviewed the draft report and are happy that it is a fair representation of the service reviewed.

Thank you again to your team for their thorough and consistent approach and for giving their time to help us to improve our services for patients and their families.

9. Appendix 1

Information Request from Healthwatch Bury to support Enter and View Report for Bury A&E (Jan 2026)

No	Query	Response	Additional documents
1.	What was the original A&E design capacity when it was built? (patients per year)	Around 50,000 patient per annum	Detail obtained from C&D undertaken as part of new ED build
2.	How many patients are attending the department annually now? (most recent 12 months)	In the last 12 months we have assessed and treated 85,894 patients	Obtained from BI
3.	How many HMR patients are attending each year? (% of total)	31% (data attached at Q4)	As below

4.	How many HMR patients go to Oldham (% of total)	18% as shown in adjacent tables

Bury ED Arrivals

Arrival Date	ED Arrivals	HMRCCG_Flag	%
2024	**81587**	**25362**	**31%**
Jan	6912	2243	32%
Feb	6318	1926	30%
Mar	6798	2023	30%
Apr	6528	2060	32%
May	7199	2285	32%
Jun	6846	2048	30%
Jul	6951	2092	30%
Aug	6465	2016	31%
Sep	6581	2028	31%
Oct	7000	2233	32%
Nov	6882	2147	31%
Dec	7107	2261	32%
2025	**85159**	**26862**	**32%**
Jan	6836	2122	31%
Feb	6373	2023	32%
Mar	7160	2232	31%
Apr	6992	2196	31%
May	7333	2281	31%
Jun	7133	2291	32%
Jul	7379	2309	31%
Aug	7076	2252	32%
Sep	7300	2314	32%
Oct	7489	2383	32%
Nov	7198	2274	32%
Dec	6890	2185	32%
Grand Total	**166746**	**52224**	**31%**

Oldham ED Arrivals

Arrival Date	ED Arrivals	HMRCCG_Flag	%
2024	**123221**	**22048**	**18%**
Jan	9393	1670	18%
Feb	9426	1726	18%
Mar	10650	1828	17%
Apr	9951	1703	17%
May	10748	1910	18%
Jun	10252	1793	17%
Jul	10804	1928	18%
Aug	9368	1659	18%
Sep	10119	1855	18%
Oct	11033	1964	18%
Nov	10863	2023	19%
Dec	10614	1989	19%
2025	**123272**	**22999**	**19%**
Jan	9812	1745	18%
Feb	9244	1697	18%
Mar	10442	1981	19%
Apr	10144	1928	19%
May	10669	1910	18%
Jun	10469	1872	18%
Jul	10796	1975	18%
Aug	9763	1817	19%
Sep	10287	1905	19%
Oct	10726	2009	19%
Nov	10919	2127	19%
Dec	10001	2033	20%
Grand Total	**246493**	**45047**	**18%**

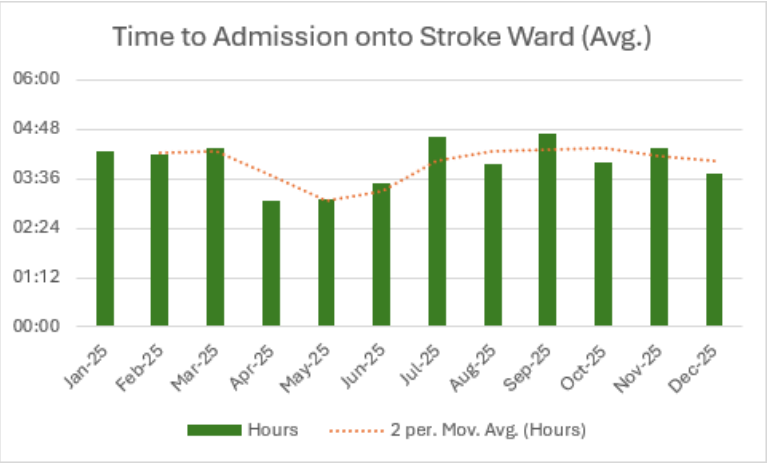
5.	Is there a direct pathway from A&E to UTC entirely indoors? Or do patients have to go around the outside of the hospital?	Patients streamed to UTC by BARDOC (who provide pre-ED streaming) will be redirected to enter UTC via the main entrance of the hospital. This requires the patient to go outside. If a patient is directed to UTC from initial or secondary assessment in ED, an escort will walk/ transfer the patient via x-ray. The ED Team have requested designated signage to support better orientation.
6.	The departme nt is	The new build improvement work will generate a

	currently undergoing improvement work to improve capacity; how will this work improve patient experience?	custom-built ED to meet the needs of our population, not only increasing the resuscitation room capacity, cubicle area and dedicated mental health assessment rooms but will provide improved access to immediate investigations such as point of care testing. Improved facilities enhance patient experience, reducing stress and anxiety with a better organised environment, with improved clinician efficiency, care and safety. Increased cubicle capacity reduces corridor care, provides more privacy and therefore improved communication and the upgraded ventilation helps reduce the spread of infection.	
7.	Will the expansion include access to specialist services in A&E? For example, mental health specialist teams to manage own	Numerous specialist services provide in-reach to the Emergency Department where required, in line with internal professional standards. The specialities include: respiratory, endocrinology general medicine, stroke, frailty, ENT	

	patients and is the additional resource funded?	and mental health (provided by PCFT). Specialist services assess and provide treatment; patients remain under the care of ED and will receive joint care from ED and the speciality until an appropriate bed is sourced. There is no additional resource or funding required. As part of the ED build there will be a larger area for patients requiring mental health assessments, where the mental health liaison team will be based, this does not require additional funding.	
8.	What is the expected impact of winter pressure on service delivery and patient care?	The impact of winter pressure is assessed on previous year's attendance and trend data at local level; national and international intelligence such as influenza statistics in the Southern Hemisphere, help to guide our preparedness. This year we recognised 'flu was emerging earlier and was more transmissible therefore, there was an early focus on flu plans. In winter we already recognise there can be an increase on acuity of illness and an increase in	

		attendances. To meet this demand service provision is reviewed, increased resources and staffing are provided and the expansion of services as explained in Q9.	
9.	What additional hospital capacity is planned for winter pressure? Is there staffing resource for this?	The potential for increased capacity is based on previous years data. This year the Urgent Treatment Centre (UTC) and Same Day Emergency Care (SDEC) have extended opening times, the UTC until midnight and SDEC until 02:00, over 7 days. This has required staffing resource which in this case has come via NHSP. The hospital has the ability to open escalation beds if they can be appropriately staffed. A full escalation plan is available to guide a stepped approach to escalation. The Clinical Site Management team who are operational 27/7 on site, provide live site position information to facilitate safe and timely decision making in collaboration with a) Divisional Triumvirates/ Director	

		of Nursing/Medical Director in hours or b)out of hours, decision making sits with the Clinical Site Manager and Director on Call.	
10.	UTC has expanded massively to reduce risk in A&E. Has staffing increased to support this? Is this every day on every shift?	The UTC has expanded to enable the ED to meet the needs of our patient population, working with NWAS on direct pathways, avoiding the main ED, ambulatory pathways from initial assessment and investing in staff recruitment, retention and skills. Staffing has increased to support this, and UTC is open 7 days (08:00-02:00) providing the same service each day, with Emergency Nurse Practitioners (ENP) and Advanced Clinical Practitioners (ACP) and medical staff.	
11.	Does UTC have a wait target?	Yes, the UTC is aligned to the national 4 hour standards	

1 2.	Several stroke patients gave feedback during the visit and they & their relatives were visibly upset re the long waits (all over 12 hours for a bed). Although care and treatment was maintained, A&E is clearly not the place to wait. Is there an option to move these patients to another hospital with capacity?	We acknowledge these long waits in the ED department are not those we would wish for our patients. Stroke inpatient capacity across GM in totality is pressured which contributes to delays in admission, unfortunately. We monitor our length of stay from ED to ward (see run chart). We ensure that while awaiting admission patients do receive specialist stroke care and management but ideally would be admitted within the nationally agreed timeframe for Stroke. Hyper acute stroke provision is only available at Fairfield, Salford and Stepping Hill Hospitals. At Fairfield we have stroke in reach within ED at FGH from 07:00 - 23:00. Outside these hours all stroke conveyances via NWAS go direct to Salford Royal as ~~and~~ per the commissioned pathway. Actions we have commenced to improve flow of patients into the stroke ward include a dedicated workstream (commenced in December) which consists of an MDT	

		task group to review opportunities and facilitation. To date the actions include: spot commissioning of IMC beds, commencement of capacity and demand exercise to quantify any deficit and opening of stroke escalation beds. Progress on this work is reviewed through the divisional assurance framework.	
13.	What is the catering provision for those waiting for long periods in the department?	The ED is currently recruiting to provide a 24-hour housekeeper service. The ED is able to provide sandwiches, soup, biscuits and refreshments 24 hours. Individual needs will be supported on a case by case basis.	
14.	From an organizational perspective, is there a rising demand on site for specialist beds? Is stroke capacity adequate and what are the long term plans to improve capacity if not?	Advances in stroke treatment (thrombectomy and extended indications for thrombolysis) is allowing ever more patients access to acute reperfusion, which is good news for stroke patients. With a greater proportion of patients surviving stroke there is also an associated increase on those patients living with morbidity and rehabilitation agendas. It is important for us, as a provider, to ensure our inpatient bed	

		base aligns with the demands of stroke patient inpatient care. We are therefore evaluating demand & capacity whilst also assessing the transformation required to ensure those patients on our stroke rehab pathway do not experience a long length of stay in hospital which does not support their rehabilitation needs and impacts on acute stroke bed availability. This will inform a case for the stroke service will work in the future. Work is under way and prioritised for Q4 (25/26) and Q1 (26/27).	

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