Countess of Chester Hospital NHS Foundation Trust

Inspection report

Executive Suite, Countess Of Chester Health Park
Liverpool Road
Chester
CH2 1UL
Tel: 01244365000
www.coch.nhs.uk

Date of inspection visit: 15 February 2022 to 17 March 2022
Date of publication: 15/06/2022

Ratings

Overall trust quality rating	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Requires Improvement**
Are services caring?	**Good**
Are services responsive?	**Requires Improvement**
Are services well-led?	**Inadequate**

Our findings

Our reports

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

Overall summary

What we found

Overall trust

We carried out an unannounced inspection of acute services provided by Countess of Chester NHS Trust as part of our continual checks on the safety and quality of healthcare services.

The Countess of Chester Hospital NHS Foundation Trust consists of a 600 bedded large district General Hospital, which provides its services on the Countess of Chester Health Park and a 64 bedded Intermediate Care Service at Ellesmere Port Hospital. It also hosts and delivers an integrated care partnership. The Trust has over 5,100 staff and provides a range of health services to more than 445,000 people per year from an area covering Western Cheshire, Ellesmere Port, Neston and North Wales.

The Trust is the main trust serving Western Cheshire and also provides services to approximately 30% of the population covered by Betsi Cadwaladr University Local Health Board in Wales. Welsh patients represent one fifth of the workload of the trust. At the time of the inspection the trust was arranged into three clinical divisions: urgent care, planned care and diagnostics and pharmacy division, plus support services.

The Countess of Chester Hospital provides a full range of acute and a number of specialist services including urgent and emergency care, general and specialist medicine, general and specialist vascular surgery and full consultant led obstetric and paediatric services for women, children and babies. At Ellesmere Port Hospital the trust provides medical care services, outpatients, rehabilitation and intermediate care to patients over 65 years age. It has 64 beds over three wards.

At our last inspection we rated the trust overall requires improvement because we had concerns about the quality of services. Prior to our 2022 inspection we received information giving us concerns about the safety and quality of the services.

Our findings

We visited the Countess of Chester Hospital as part of our inspection during 15 to 18 February 2022. Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity. We visited urgent and emergency care services, surgical services, maternity and medicines core services as part of the inspection. We also looked at those parts of these services that did not meet regulatory requirements following the 2018 inspection.

In addition, we inspected the well-led key question for the trust overall. The Well Led inspection took place on the 15, 16, 17 March 2022.

We did not inspect all the core services provided by the trust as this was a risk-based inspection. We continue to monitor all services as part of our ongoing engagement and will re-inspect them as appropriate.

Our rating of services stayed the same. We rated them as requires improvement because:

- We rated the trust as requires improvement overall. We rated safe effective, responsive and well-led as requires improvement and caring as good. In rating the trust, we took into account the current ratings of critical care, services for children and young people, end of life care and outpatient services which were not inspected this time.
- The well led provider rating for the trust was inadequate.
- During our inspection of the trust's leadership and governance in December 2019, we asked the trust to ensure that action was taken to improve the quality and safety of care patients were receiving on the inpatient wards. Our return visit found that the trust had not made significant improvement in some of the areas of concern identified in our 2019 inspection which resulted in continued breaches of several regulations.
- The trust did not have suitable governance systems and processes to effectively manage patient referral to treatment waiting times performance. We were not assured that senior leaders had ensured a sufficient pace of change or timely implementation of an effective recovery plan for planned care and treatment.
- Due to the implementation of the new Electronic Patient Record system, staff were not always able to assess risks to patients. Care records were not always up to date, contemporaneous or easily accessible.
- The trust did not always manage safety incidents well, actions and learning following incidents was not always robust.
- Senior and executive leaders did not always operate effective governance systems to manage risks and issues within the service. Not all staff felt respected, supported and valued.
- The trust did not always engage well with staff, patients and the community to plan and manage services effectively.

However:

- Staff understood how to protect patients from abuse.
- Staff treated patients with compassion and kindness.

How we carried out the inspection

We carried out this unannounced inspection of some of the acute services at Countess of Chester Hospitals NHS Foundation Trust as part of our continual checks on the safety and quality of healthcare services. At our last inspection we rated the trust overall as requires improvement. Our inspection was prompted by concerns about the quality and safety of some services. We also inspected the well-led key question for the trust overall.

Our findings

We inspected urgent and emergency care, medicine, surgery and maternity services at the Countess of Chester Hospital. At this inspection we found the core service ratings for urgent and emergency care, medicine, surgery had stayed the same and maternity services had deteriorated since our previous inspection in 2018.

As part of the inspection, we spoke with 142 staff across all disciplines, looked at 69 patient records and spoke with 41 patients.

Further concerns were found in maternity services and trust-wide governance processes, which meant we served the trust with two warning notices under Section 29A of the Health and Social Care Act 2008. The warning notices told the trust that they needed to make significant improvements in the quality and safety of healthcare provided in maternity services and significant improvements in governance systems relating to referral to treatment processes, implementation of the electronic patient record system and around the management of incidents, complaints and patient deaths.

You can find further information about how we carry out our inspections on our website: www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve:

We told the trust that it must take action to bring services into line with 34 legal requirements. This action related to the overall trust and the urgent and emergency care, surgery, maternity and medical care services.

Trust wide

- The trust must ensure it has effective systems and processes to manage patient referral to treatment waiting times performance. (Regulation 17(1)).
- The trust must implement quality improvement systems and processes such as regular audits of the service's provided and must assess, monitor and improve the quality and safety of services. (Regulation 17 (1)(2)(a)).
- The trust must ensure that significant improvement in assessing the risk to patients, because there is a potential risk of patient harm due to patient assessments not being completed effectively or due to medicine prescribing or administration errors resulting from staff inappropriately trained in the use of the Electronic Patient Record system. (Regulation 12 (1)(2)(a)(b)(c)(g)).
- The trust must ensure that patients receive care in a timely way and work towards improving performance against national standards such as the time from arrival to treatment and median total time in the Urgent and Emergency Care department. (Regulation12 (2)(a)).
- The trust must ensure that significant improvement is made in relation to effective governance systems and processes relating to the timely identification, investigation and learning from incidents, complaints and patient death reviews. (Regulation 17 (1)(2)(a)(b)(e)).

Our findings

- The trust must ensure that staff are suitably trained on the electronic patient record system so that completed risk assessments can be accessed and patient safety is not put at risk. (Regulation 18 (2)(a)).
- The trust must ensure that the electronic prescribing system has restricted access to prescribing functions to prescribers. (Regulation 17(1)(2)(c)).

Countess of Chester Hospital core service:

Medicine including older people

- The service must ensure that oxygen therapy is prescribed as per national safety alert and record of its administration maintained. (Regulation 17(1)(2)(c)).
- The service must ensure that fire exits are clear from obstruction and well maintained. (Regulation 12(1)(2)(d)).
- The service must ensure that policies and procedures are reviewed and follow national guidance. (Regulation 17(1)(2)(a)).
- The service must ensure patient records are complete and contemporaneous. (Regulation 17(1)(2)(c)).
- The service must ensure patient records and details are kept secure and confidential. (Regulation 17 (1)(2)(d)).
- The service must ensure staff receive training in mandatory training modules (Regulation 18(1)(2)(a)).
- The service must ensure staff receive appropriate safeguarding training. (Regulation 18 (1)(2)(a)).
- The service must ensure all areas are kept clean. (Regulation 12(1)(2)(h)).

Surgery

- The service must ensure that staff training is sufficient to meet the needs of all patients and completed in accordance with their schedule. Regulation 18(2)(a)).
- The service must ensure premises and equipment are maintained and used in a manner which mitigates risk in the event of a fire. (Regulation 12(2)(d)).
- The service must ensure patient records are complete and easily accessible to staff. (Regulation 17(1)(2)(c)).
- The service must ensure safe systems are operated in relation to medicines management. (Regulation 17(1)(2)(c)).

Maternity

- The service must ensure that patients receive care in a timely way and work towards improving performance against national standards, such as from the Royal College of Obstetricians and Gynaecologists. (Regulation 12(2)(a)).
- The service must ensure that policies and procedures are reviewed and follow national guidance. (Regulation 17(1)(2)(a)).
- The service must ensure that a robust system is in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users. (Regulation 17(1)(2)(b)).
- The service must ensure patient records are complete and contemporaneous. (Regulation 17(1)(2)(c)).
- The service must ensure that staff training is sufficient to meet the needs of all patients and completed in accordance with their schedule. (Regulation 18(1)(2)(a)).

Our findings

- The service must ensure that incidents are investigated promptly, and in line with national guidance. Any shared learning and improvements must be implemented in a timely manner. (Regulation 17(1)(2)(e)).
- The service must deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff to make sure that they can meet people's care and treatment needs. (Regulation 18(1)).
- The service must ensure that all premises used by the service are safe to use for their intended purpose and are used in a safe way. (Regulation 12(2)(d)).
- The service must ensure that all equipment is appropriately located for the purpose for which it is used. (Regulation 15(1)(f)).

Urgent and emergency care

- The trust must ensure that the electronic prescribing system has restricted access to prescribing functions to prescribers. (Regulation 17(1)(2)(c)).
- The service must ensure that oxygen therapy is prescribed as per national safety alert and record of its administration maintained. (Regulation 17(1)(2)(c)).
- The trust must improve the completion rates for numbers of staff who have received basic life support training for adults and children in order to meet trust compliance rates. (Regulation 18(2)(a)).
- The service must be able to evidence that areas in the department have been cleaned in line with available cleaning schedules. (Regulation 15(1)(a)).
- The service must ensure that there is enough staff with the right qualifications, skills, training and experience to provide care and treatment, specifically in relation to medical staffing including taking into account national guidance for the care of children and specifically paediatric emergency medicine consultant cover – This in line with the Royal College of Paediatrics and Child Health “Facing the Future – standards for children and young people in emergency care settings”. (Regulation 18(1)).
- The service must ensure that patients receive care in a timely way and work towards improving performance against national standards. (Regulation12(2)(a)).

Action the trust SHOULD take to improve:

Trust wide

- The trust should consider the full implementation of national guidelines such as the Equality Delivery System for the NHS [EDS2]. Regulation (17).
- The trust should ensure that there are effective systems in place to respond to staff when concerns are escalated. Regulation (17).
- The Trust should consider ensuring that a board lead with accountability for Equality and Diversity is identified. Regulation (17).
- The trust should ensure that audit outcomes are actioned and appropriately supervised to ensure timely improvement. Regulation (17).

Countess of Chester Hospital core service:

Medicine including older people

Our findings

- The service should ensure that processes to check temperature monitoring of areas storing medicines are appropriate to maintain safe storage including fridges and the wider environment. (Regulation 17).
- The service should consider developing a vision and strategy. (Regulation 17).
- The service should consider further development of data collection methods within the electronic patient record system to allow for easier analysis and review. (Regulation 17).

Surgery

- The service should ensure that the use of resources, for example theatre time, is planned effectively to reduce delays in treatment. (Regulation 17).
- The service should review systems to ensure they record the completion of essential cleaning in appropriate detail. (Regulation 12).
- The service should ensure complaints are responded to in accordance with policy and best-practice. (Regulation 17).

Maternity

- The service should ensure that all clinical areas (such as the central labour suite) are secure to prevent anyone leaving the area unsupervised. (Regulation 12).
- The service should comply with guidance around daily multidisciplinary safety huddles. (Regulation 12).
- The service should consider ensuring that black and ethnic minority women are encouraged to take the appropriate vitamin supplements. (Regulation 12).
- The service should ensure that an effective risk stratification is used to ensure that similar incidents have consistent risk ratings. (Regulation 17).

Urgent and emergency care

- The trust should review arrangements in the ambulatory majors waiting area to minimise the length stay of patients in there without access to a bed. (Regulation 12).
- The service should indicate on policies the date it was last updated and when it is next due to be updated so that staff can see that they are working with the latest version of the document. (Regulation 17).
- The service should ensure that findings from clinical audits are properly analysed and reviewed by appropriately trained staff.. When required, results should be escalated, and appropriate actions taken to improve patient outcomes. (Regulation 17
- The service should consider how health promotion and information can be reintroduced in the department at the earliest opportunity. (Regulation 12).
- The service should consider what adjustments can be made to the department to meet the needs of patients living with dementia and learning disabilities and those whose first language is not English. (Regulation 9).
- The service should consider including associate specialist doctors on the General Medical Council specialist register. (Regulation 18).
- The service should improve compliance in staff competencies, such as for fluid balance, tracheostomy and catheter line management. (Regulation 18).

Our findings

Is this organisation well-led?

Our rating of well-led went down. We rated it as inadequate.

Leadership

Senior leaders demonstrated the necessary knowledge and skills. However, there were several new appointments to the board and the plans the board had developed had not yet had time to evidence their impact or sustainability. Not all senior leaders were visible or approachable in the organisation. Leaders were not always fully sighted on risk within the trust or acted upon it in a timely way.

Following our previous inspection in November and December 2018 there had been several changes in the executive leadership. The chief executive (CE) joined the trust on 1 August 2018 as the then medical director (MD) before becoming acting CE in October 2018 and substantive CE in April 2019. The MD joined the trust in April 2018 and became the MD full time in 2019. The MD was leaving the trust in June 2022, and at the time of the inspection, there was a recruitment process underway for a replacement. The director of nursing and governance joined the trust in May 2021 in an interim role and was made substantive in October 2021. The trust had also recently recruited a new chief operating officer (COO) and Director of Human Resources (HR), both commenced employment in March 2022. The previous HR director and COO had both worked at the trust in an interim capacity.

The Trust has an experienced NHS director of finance who had been in post for several years. They were supported by a capable finance team. The finance team had recently been re-accredited at Level 2 on the finance staff development (FSD) strategy (national programmes designed to engage staff in improving NHS Finance), and there were some good examples of best practice within the department, for example, their approach to equality and diversity.

A new trust chairman was appointed in September 2021 and several non-executive directors (NEDs) had also been recently appointed. The chairs of the Audit Committee and Finance and Performance Committee were experienced NEDs and demonstrate a good grasp of their subject areas, and insight as to how they intended to gain assurance.

The diversity of the board was limited. Of the executive board members none were from a British minority ethnic group (BME).

While some executive areas of responsibility had been designated to specific executive leads, for example the executive Director for Infection Prevention and Control [DIPC]. We found that at the time of inspection there was no identified board lead with accountability for Equality and Diversity.

There were limited leadership roles in areas such as learning disabilities, dementia and mental health. An appointment had recently been made for a role for complex care. However, they would also be the lead for safeguarding so capacity would be limited.

The company secretary had recently taken up post, after a significant period without this role being filled substantively. They told us that the intention was to carry out a full review of governance processes and effectiveness.

The council of governors (CoG) were aligned to the board and involved in various activities. The use of virtual technology during the pandemic had provided some opportunities for governors to attend meetings. However, visiting restrictions had meant they were unable to visit patients on wards as they had done prior to the pandemic, Governors told us that plans were being put in place to restart the visits when pandemic restrictions were completely lifted.

Our findings

Fit and proper persons requirement

We found that the trust's policy for fit and proper persons requirement (FPPR) was in date and met the requirements of the regulation, however, it did not detail how often disclosure and barring service (DBS) checks would be repeated for directors. We noted that all files we reviewed contained DBS certificates.

We reviewed three non-executive director and three executive director FPPR files. We found no inconsistency in the information held in them. All the files reviewed held clear information on occupational health checks and professional body checks.

Vision and Strategy

The trust had a set of existing values and a vision and organisational strategy in place with some underpinning strategies. Staff were not always aware of, did not understand the vision and values or had not been fully involved in developing them.

The trust had recently developed its vision and overarching five-year strategy 2021-2026. The vision was "*we will improve the lives of our community and provide excellence in healthcare, through partnership and innovation*". The strategy was approved by the board in May 2021. It was based on the trust's existing clinical strategy. We were told that 138 staff and external stakeholders had been involved in the development of the strategy.

The trust values of safe, kind and effective were retained.

The trust had also developed four underpinning strategies:

- People strategy 2021-2026
- Clinical Strategy 2019-2024
- Digital and Data Strategy 2021-2026
- Green Plan 2022-2025

At the time of the inspection no other new supporting strategies had been developed to support the overarching five-year strategy.

There was not an up to date financial strategy, to support the overall organisation's strategy, that demonstrated a clear understanding of the drivers of the underlying financial position, in the context of the changing NHS financial regime and the trust's own environment.

We were told the trust was in the process of developing, but had not yet implemented, supporting strategies for key areas such as mental health, equality and diversity and estates and facilities. The trust submitted the freedom to speak up strategy 2019-2021 as part of our post-inspection data requests; however, we noted that this had expired and had not been updated at the time of inspection.

Some operational staff we spoke with could not articulate what the trust vision was or whether there was in fact a current trust vision in place.

Our findings

Culture

There was a mixed response from staff in relation to the senior leadership culture. In the core services we inspected, we found most staff felt respected, supported and valued, especially by their local leadership, however, this was not universal. Staff, in the main, were focused on the needs of patients receiving care despite the significant challenges in some services. The trust was working towards an open culture where patients, their families and staff could raise concerns without fear, however, this was not yet embedded.

Some staff groups described a negative culture within parts of the trust and reported that low morale was a result of poor support and engagement by the trust leadership. Some staff we spoke with identified a culture of bullying and discrimination.

These concerns were similar to concerns raised by staff during our previous inspection in 2018. Staff groups we spoke with in 2018, reported their concerns were either not listened to, or dismissed by senior leaders. Similar feedback was received from staff during this inspection, relating to senior leaders dismissing concerns or not engaging or providing any information on remedial actions to staff raising concerns. These issues where raised across all core service areas inspected.

During our inspection we observed many examples of how staff continued to work with a caring approach, often under demanding and challenging circumstances. However, despite staff working hard to deliver care to patients there were times when staff told us that the culture was not in line with the trust values.

The NHS Staff Survey 2021 showed that the trust was worse than the national average in all nine key areas of the survey. There was a decline in staff morale within the trust since our last inspection in 2018 and since the trust's staff survey of 2020. The results showed the trust scored the lowest nationally for staff morale. The NHS staff survey 2021, also highlighted that staff engagement had declined to well below the national average. However, the senior leaders told us they recognised that staff wellbeing was an important factor to consider especially during and after a global pandemic.

Trust data for February 2022 showed an overall staff appraisal completion rate of 79.8%. This was below the trust internal target of 90%.

Freedom to speak up (FTSU)

There was limited provision of the Freedom to Speak Up service. Although, most staff we spoke with were aware there was a FTSU guardian in place and knew how to report concerns.

The trust had a freedom to speak up guardian who worked part time, two days per week. They reported to the CE although formal meetings had been intermittent. There were no FTSU champions in place to support the work of the FTSU guardian. We were told expressions of interest for FTSU guardians, to start in June 2022, had been advertised.

The FTSU guardian told us that they sent twice-yearly a report to board. The most recent report (January 2022) only showed basic information such as number of concerns / key themes. We noted that there was no data reported on progress / open / closed incidents. The FTSU guardian told us that they did not hold a database of all incidents raised as this was held by the HR team. We were not able to get clear answers on what progress had been made in relation to concerns raised by staff.

Our findings

Staff focus groups were held during the well led inspection and some staff told us that colleagues were afraid to raise issues with the senior leadership of the trust. We were told this was due to a combination of fear of retribution and that staff did not feel that speaking up would make any difference.

The guardian of safe working

The guardian for safe working supported junior doctors in their role and facilitated meetings to discuss support and concerns with good representation from all relevant areas in the hospital.

The guardian worked closely with the medical director and had support from human resources with the reporting requirements. The guardian also submitted an annual report to the trust board and had not reported any significant concerns around safe working hours during the current year.

The guardian reported there had been 187 exception reports raised during the past year; of which 120 related to late finishes and 20 related to early starts. The guardian reported all exception reports had been resolved and there had been no fines issued during the past year.

Equality and Diversity.

The trust did not have an effective equality and diversity strategy in place.

The people strategy 2021-26 made limited reference to equality and diversity for staff. There was no detailed strategy relating to patients attending the trust's hospitals.

The equality and diversity lead told us that they attended regular BME, disability and LGBT+ network group meetings. However, engagement with staff during the pandemic had primarily been focused on completion of Covid-19 risk assessments. There was limited information about any other engagement with these groups from the Equality Diversity and Inclusion [EDI] lead or trust senior leadership.

The EDI lead and HR director were unable to clearly explain how the trust implemented national guidelines such as the Equality Delivery System for the NHS [EDS2].

Staff we spoke with told us that there was no effective system in place to support staff with protected characteristics to develop within their careers. Throughout the inspection period, we were approached by staff who wanted to share their experience within the trust. We spoke with 22 members of staff who all stated that they felt there was a lack of inclusion and no real focus on equality or diversity by the trust board.

The NHS Staff Survey 2021 showed an increase in staff experiencing discrimination on the grounds of their ethnic background within the trust. Whilst it had risen to 35.1%, from 28% in the last survey in 2020, the trust was still better than the national average.

The trust Workforce Race Equality Standard Annual report to the board [2021], highlighted that in line with the 2020 staff survey results, fewer BME staff compared to white staff believed that the trust provided equal opportunities for career progression or promotion.

We noted that at the time of inspection the trust board has no BME representation.

Our findings

Governance

There were arrangements for governance, however these were not always operated effectively or completed in a timely manner. External support had been obtained to review and improve governance processes throughout the trust.

Whilst governance arrangements were in place, we found a number of areas where further improvement was required. Directors had also identified areas where governance could be improved, particularly the risk management strategy and the Board Assurance Framework (BAF), where reviews were underway. Our review of the BAF identified that there was a lack of mitigating actions identified for some risks and for some actions the timescale for completion had expired and had not been updated. This meant that the board could not be assured that the trust was effectively mitigating the risks to the delivery of the trust's five-year strategy. This was corroborated by the 2021/22 Head of Internal Audit Opinion which was for Moderate Assurance on the overall control environment, with the design and use of the BAF being an area for improvement.

The company secretary had recently taken up post, after a significant period without this role being filled substantively; they intended to carry out a full review of governance processes and effectiveness. In addition, in 2021, the trust had undertaken a procurement exercise to source a company to undertake a Well-Led review. This review was due to take place during February and March 2022; the outcome of this was not available at the time of the inspection.

Following the concerns identified at our previous inspection in 2018 the trust had carried out a governance review. Some actions from the governance review and its development plan were still in the process of being implemented at the time of the 2022 inspection. A governance handbook had been published in September 2019; however, training had not commenced until September 2021. We were told this was because of the Covid-19 pandemic. In September 2021 a governance academy and leadership programme had commenced. Implementation of some of the identified improvements had been slow, for example, strengthening the board's committee reporting structures. The trust had plans to separate the finance and performance committee into two separate functions from April 2022. There was also a Quality and Safety board committee. There were plans for a new People and Organisational Development Committee, as part of reducing the work within the Finance and Performance Committee.

Under its new chair, the audit committee work plan had broadened out its consideration of risks beyond finance. There were a number of "limited" assurance audit reports that sat outside finance which the committee needed to address; these would require appropriate support by all members of the executive. There were also a significant number of outstanding audit recommendations from earlier years that required action.

Board committees meet bi-monthly which, given the scale of change programmes (EPR, major capital investment, etc) and operational challenges, may not have provided enough "air time" for board members to deal with the salient issues and gain an appropriate level of assurance. Committee reporting arrangements to Board were in place with points of escalation identified.

Whist the Board committees had conducted self-assessment effectiveness reviews, we were told there have been low response rates which limited their usefulness.

We found that key information regarding quality of service and emerging risks was not always clearly and effectively communicated for the trust board to be able to respond to with robust actions. From some leaders we spoke with there was a focus on improving the processes to gain assurance and the role of a unitary board within this. However, they were not always able to articulate an understanding of the concerns/risks identified within services and what the trust was doing to address them.

Our findings

At senior level, there was a reliance on reassurance rather than assurance in board level processes. We found that the trust's governance structure made the trust executive leadership group the primary forum for accountability, assurance and for reporting and escalation to the trust's board of directors. For example, the trust governors told us they relied on information from senior leaders around key performance and risks. They had been reassured by senior leaders that the key issues around the implementation of the electronic patient record system had been addressed.

The requirement for working groups to be accountable to the trust's executive group and to assure the trust's board committees meant that it was not clear whether the trust's systems for internal control and management of risk were effectively overseen by the trust's committees.

Whilst the trust had a process for reviewing policies and procedures it was not always managed effectively; in some services there were numerous policies that appeared to be out of date, the most significant numbers were in maternity. In addition, not all policies / procedures clearly stated the effective date and version history, which could lead to staff using superseded / out of date policies.

Management of risk, issues and performance

Risks, issues and poor performance were not always dealt with appropriately or quickly enough. There were systems to manage performance, however, these were not robust or used efficiently. A risk management approach was applied inconsistently and was not linked effectively into planning processes. Significant risks were not always identified or escalated appropriately and there were insufficient processes to identify actions to reduce their impact. During the inspection we found that the trust was not safely and effectively managing the risk to some service users.

Whilst there were some systems in place to manage risks, there was a lack of operational oversight and timely action at board and senior levels in the trust to effectively manage concerns and reduce the risks.

Some of the risks which we identified at inspection, were not being effectively managed by the organisation. Examples included staff not being able to use the EPR system effectively, concerns re incident reporting and management, and action plans not being effectively monitored. A number of staff we spoke with were unable to effectively access information relating to such things as patient risk assessments from the EPR. Whilst senior leaders had taken some actions, there were significant concerns that the actions taken had not reduced the risks.

Whilst there was a trust-wide risk register in place there were over 100 risk that scored 15 or above. Not all risks had effective controls in place or mitigations. Over 19 of these risks related to the new electronic patient record. There were also significant clinical risks such as cancer performance times.

We were not assured the trust has effective systems and processes in relation to the timely reporting and investigation of serious incidents. In maternity services we found concerns in relation to managing the risks of Post-Partum Haemorrhage (PPH) and unplanned hysterectomy. Between April 2021 and November 2021 inclusive, five service users had experienced a major PPH (greater than two litres of blood loss) resulting in an unplanned hysterectomy in each case. Not all of these were reported as serious incidents and where there was learning identified, action plans were not being completed in a timely way.

The trust integrated performance report (IPR) was recorded at trust level. It captured data for a range of metrics such as performance against national standards, incidents, bed moves, HSMR, cancer and IPC. However, due to the

inconsistencies in reporting, partly in relation to the new EPR system, there was a lack of assurance that the trust had up to date, effective oversight and accurate data included in the performance report. External reporting for RTT and DM01 was suspended in August 2021 following the EPR implementation. The trust started externally submitting RTT data in November 2021 and DM01 data in December 2021.

Referral to Treatment

The trust did not have suitable governance systems and processes to effectively manage patient referral to treatment waiting times performance. We were not assured that senior leaders had ensured a sufficient pace of change or timely implementation of an effective recovery plan for planned care and treatment.

NHS England data showed the total number of patients on the referral to treatment (RTT) waiting list at the trust had increased from 25,051 patients in July 2021 to 39,427 patients in January 2022.

The monthly average proportion of patients waiting less than 18 weeks from referral to treatment was 46% in January 2020, 57% in July 2021 and 44% in January 2022. During this period, the trust had consistently performed worse for the 18-week waiting time standard when compared with national averages and to other trusts in the Cheshire and Mersey region.

Performance in relation to cancer care between April and December 2021 was below target in all areas except one. The 14-day standard for cancer treatments for the proportion of patients seen by a specialist within two weeks of an urgent GP referral, was significantly below the national target of 93%. Data from the trust indicated that the lowest performance was just above 50% in September 2021 increasing to just over 60% in the January 2022 performance report. The 14-day standard for referral for symptomatic breast cancer measured 13% against a target of 93%.

The previous recovery plans developed during 2020 / 2021 had not led to sufficient improvement in referral to treatment waiting times. An external consultant was appointed by the trust in November 2021, as recovery director, and a new framework for elective recovery had been developed and launched in March 2022. Whilst the framework provided a structured approach to managing elective recovery, the main focus was on reducing 104-week waits from over 800 patients to zero by the end of June 2022. As part of the framework for elective recovery, a weekly report of 104-week waiting list performance has been introduced in March 2022. This included performance against planned trajectories. The weekly 104-week reporting data showed the trust had 813 patients on the 104-week waiting list on 11 March 2022. The weekly 104-week waiting list report for 18 March 2022 showed this had increased to 858 patients. The weekly 104-week waiting list report for 24 March 2022 showed the trust had 848 patients. The trust had 60% of Cheshire and Mersey region's 104-week waits. The weekly data showed there had not been any immediate improvements in 104-week waiting list performance.

Trust data showed clinical validation of patients on the referral to treatment pathway waiting lists was still on-going across a number of specialties; including general surgery, orthopaedics and ear, nose and throat (ENT) surgery. The clinical validation was planned for completion during March and April 2022. This meant that not all patients on the waiting list had been assessed to determine any risk factors associated with the extended waiting times for their treatment.

We had concerns around the lack of cleaning schedules or cleaning checklists (records) in place across the core services we inspected; whilst the areas were visibly clean, there was a lack of clear process / documentation to indicate this. The trust could therefore not be assured that infection, prevention and control IPC processes were being effectively implemented.

Our findings

The standing up of the process to drive cost reduction, efficiency and productivity was at a very early stage and presented a significant risk to the 2022/23 position and beyond. Given the challenges faced by the Trust in delivering waiting list targets and the impact of restoring elective capacity on the financial plan, there was a lack of strong alignment between finance and the elective restoration programme and regular reporting to the finance and performance committee.

Following our inspection, we formally wrote to the trust under our Regulation 29A powers to share our concerns about our inspection findings. We asked the trust to take immediate action to improve the quality and safety of maternity services and governance systems around referral to treatment processes, implementation of the electronic patient record system and around the management of incidents, complaints and patient deaths.

Information Management

The trust did not have effective systems and processes to identify, assess and mitigate key risks associated with the implementation of a new electronic patient record (EPR) system. The trust did not always collect reliable data, analyse and use it to make improvements. Staff accessed data on multiple electronic and paper platforms. This meant that, for some services, information was difficult to access promptly and may provide limited assurance.

Our inspection identified significant concerns following the implementation of a new electronic patient record (EPR) system which had been launched in July 2021.

We saw evidence staff underwent e-learning training in the use of the EPR system prior to its launch; however, this training had only been completed by 83% of staff, with a further 10% of staff in training at time of launch. Feedback from ward staff during our inspection identified there was an inconsistent approach in the level of training and additional support available to staff during and after the EPR system launch and not all staff were confident in using the EPR system effectively. Some staff commented that it was e-learning of less than an hour.

We identified concerns around staff lack of training or understanding of the EPR system in order to effectively complete patient records, including care plans and patient risk assessments (such as for falls or pressure care). We looked at 10 patient records across the medical and surgical wards on 24 February 2022 and found seven of these records did not have complete and up to date patient risk assessments or care plans; such as for patient fall risks, mobility or pressure care.

We also identified risks around medicines management, such as lack of controls or restrictions within the EPR system meant that all nursing staff and pharmacy staff had access to prescribing within the EPR system. This posed a potential risk of patient harm if medicines were prescribed or administered incorrectly. We also found inconsistencies in staff understanding around how to check the EPR system if prescribed medicines had been administered. The trust reported this was a known issue and a standard operating procedure had been developed to provide guidance for staff. However there was a reliance on individual staff vigilance and reporting of any EPR system constraints and issues in relation to medicines management, which posed a risk to patient safety as without proper oversight there was the potential for individuals to manipulate the system. The trust reported following the inspection that a technical fix was being developed and tested to prevent inappropriate prescribing by staff.

We found senior managers had adopted a reactive and retrospective approach to managing key issues or risks following the EPR implementation. We found some risks relating to the implementation of the EPR had been logged as key risks in

trust-wide and divisional or departmental risk registers. However, we are not assured formal risk assessments have been completed to assess key risks including mitigations and controls in relation to staff training in the EPR system, incomplete patient records (such as falls, pressure care risk assessments) and around medicines management risks identified during our inspection

The EPR implementation had encountered a number of difficulties, which the trust was still working through regarding training, hardware and immediate functionality issues. Three external reviews have been carried out into the issues associated with this project between October 2021 and December 2021. The trust reported the combined recommendations from these reviews formed the basis of stabilisation plans that were presented to the trust Board in January 2022. There was a lack of clarity as to how these reports were scoped to address board members concerns and how they have been processed by the Trust's governance arrangements. At the time of the inspection, the audit committee had requested that these reports be brought together into a holistic set of actions which would potentially improve board overview.

Since the implementation of the new system in July 2021 the trust had been unable to consistently provide accurate and timely reports such as for waiting list management, including to external commissioners and regulators. The trust was not meeting the mandatory requirement to submit this data.

At the time of the inspection this was starting to improve. The trust shared a basic maternity dashboard and from interviews it was apparent that time-limited external project support had been sourced to oversee the validation and improvement of the accuracy of the waiting list data. The lack of consistent robust data may also have affected future modelling of services and the development of improvements going forward as this required robust data that was validated and accurate.

During the core service inspection, we identified policies and clinical guidelines were out of date or in the process being updated in the maternity services. We found that all policies were available on the trust intranet site. A sample of the 55 policies (such as complaints policy and mandatory training policy) were reviewed during the inspection. However, we found that 26 of these did not have key information such as version history, author, effective date or review by date clearly shown on the policy document. This meant that there was a risk of staff using superseded or out of date policies.

Our review of the trust Strategic Executive Information System (STEIS) data from March 2021 to February 2022 identified 66 incidents had been reported and 39 (59%) of these had been reported within 30 days. However, 27 (41%) of these incidents had taken longer than 31 days to report. The time taken to report 17 (26%) of these incidents was more than 61 days. This demonstrated that serious incidents are not always reported to STEIS in a prompt and timely manner.

Engagement

We found there was minimal engagement with people who used services, staff, and the public. Staff told us that feedback was not always reported or acted upon in a timely way. Leaders told us that they engaged with patients, staff, equality groups, and the public, however, we frequently heard from staff that senior leaders were not visible.

Senior leaders did not consistently engage with patients, staff, equality groups, the wider public and local organisations to plan and manage services. For example, we found there was limited evidence of women or their families being involved investigations relating to postpartum haemorrhage (PPH) incidents reported in the maternity services.

Our findings

We noted that trust governors had a limited role in talking to the public during the pandemic, whereas prior to the pandemic they were involved in ward visits and were openly invited to observe board and subcommittees of the board. We spoke with governors who stated they felt very engaged with the trust and the executive team during the pandemic, and they were given opportunity to ask questions following meetings they attended to gain a greater context of the discussion.

We did observe some collaboration with partner organisations to help improve services for women and babies within the maternity department, such as the Cheshire and Mersey Gold Command Maternity Services Escalation Meeting.

Trust executives such as the chief executive officer, director of nursing and medical director were also routinely involved in engagement meetings within the local integrated care system. This included routine meetings with local mental health providers, clinical commissioning groups and local maternity system meetings to discuss areas such as key performance, elective recovery and Covid-19 response and vaccination processes.

The trust scored worse than national averages for staff engagement in the 2021 NHS trust staff survey (6.4 against the national average of 6.8). The trust also scored below national average for a number of indicators; such as working flexibly, team working and staff morale, At the time of the inspection the trust reported that the findings of the 2021 survey were being analysed and action plans to improve the services had not yet been developed.

Actions had been identified to support staff during the COVID-19 pandemic, with an emphasis on staff well-being. Staff were encouraged to access a range of available support, including occupational health services, risk assessments, counselling for staff. There was a workforce wellbeing steering group.

The director of finance engaged regularly with the whole finance team and held a monthly finance working group meeting with divisional directors. People we spoke with indicated that morale amongst the finance team was good. The finance department actively engaged in One NHS Finance programme and, in particular, the equality and diversity agenda.

The trust was part of the Merseyside and Cheshire Integrated Care System (ICS) which consisted of organisations across primary care, community services, social care, mental health, acute and specialist services. We saw evidence the trust was trying to engage with system partners to support patients who did not meet the criteria to reside and had some processes in place to do this.

Learning, continuous improvement and innovation

The trust did not have effective systems and processes to ensure incidents, complaints and patient death reviews were managed and investigated appropriately in a timely way which delayed any required improvements to patient care. However, staff were committed to continually learning and improving services. They used quality improvement methods and had the skills to use them.

Incident Reporting

We were not assured the trust has effective systems and processes in relation to the timely reporting and investigation of serious incidents.

Our findings

Our review of your Strategic Executive Information System (STEIS) data from March 2021 to February 2022 identified 66 incidents had been reported and 39 (59%) of these had been reported within 30 days. However, 27 (41%) of these incidents had taken longer than 31 days to report. The time taken to report 17 (26%) of these incidents was more than 61 days. This demonstrates serious incidents are not always reported to STEIS in a prompt and timely manner.

Trust data from January 2021 to March 2022 showed there have been 91 serious incidents (SIs) reported by the trust; of which 16 (17%) have been closed. The remaining 77 (83%) serious incidents were still open and 39 (50% of open incidents) had been open for longer than 60 days. This demonstrated a significant number of serious incidents have not been fully investigated and closed in a timely manner.

The quality governance group papers (February 2022) state that as of January 2022, there were 1711 open actions from the management of incidents; 607 of which were overdue. We noted that a significant number of the overdue actions related to Infectious Diseases (Covid and C. Difficile) and skin integrity incidents. An audit undertaken in Urgent Care demonstrated that 87% of overdue actions fell into these two categories. Senior leaders told us that a plan to reduce those numbers was being formulated at the time of inspection.

Managers did not consistently investigate incidents. Whilst the trust completed an SBAR (Situation, background, assessment, recommendation) rapid incident report shortly after incidents were identified, they were then not always categorised accurately, which meant that some serious incidents were not fully investigated using root cause analysis methodology. This was especially so within maternity. For example, incidents of post-partum (PPH) haemorrhage were not always graded correctly; of 20 PPH incidents identified as major or above, 10 incidents were classified as no harm, one classified as low harm, seven were classified as moderate harm and one classified as severe harm. And, incidents where five women required an unplanned hysterectomy, one was classified as severe harm, two classified as moderate harm and two were classified as no harm in relation. The trust could not be assured that it recognised and addressed incidents that were significant in relation to PPH and Hysterectomies.

Women and their families were not involved in these investigations. We reviewed five of the trust's SBAR reports regarding incidents relating to an unplanned hysterectomy following a PPH. There was no evidence of women or their families being involved in these investigations. Learning from one of these cases in August 2021 included implementation of the All-Wales Pathway (a guideline of how to manage PPH effectively). This had not been fully implemented at the time of our inspection. CQC received an action plan on 29 November 2021, one action was to implement the All Wales Pathway by 15 December 2021. We received an updated action plan on 07 March 2022, this stated implementation of the All Wales Pathway on the same date of 15 December 2021. This action was rated as amber, no new implementation or update was available in the trust action plan.

There was minimal evidence of learning from incidents. The majority of staff we spoke with at the unannounced inspection were unable to tell us about learning which occurred from incidents.

Mortality reviews

We are not assured there is an effective and consistent approach to undertaking patient death reviews using the structured judgement review methodology. The mortality review process was clearly work in progress, with developments made since the last inspection.

Our findings

A new post of deputy medical director had been created in December 2021 for quality and safety and this included all learning from deaths. The trust had not yet implemented the national database for managing death reviews. The process was paper based. However, the trust had purchased an electronic system but there had been delays in its implementation.

We were told that there were mortality and morbidity meetings in place across the trust and a learning from deaths group. There was a non-executive board lead for learning from deaths.

The role of the medical examiner (ME) was introduced to the trust in January 2021 with the expectation that they would review all deaths by April 2022 and make recommendations for which ones required an SJR. There was 0.7 whole time equivalent ME in post with a plan for one WTE going forward.

There was a structured judgement review (SJR) process in place. This is where trained clinical reviewers look at the medical record in a critical manner and comment on specific phases of clinical care. There were about 35 clinicians trained within the trust with a plan to train five more. Structured judgement reviews were completed by completed by the trust; 30% were completed in 2020/21 and 405 in 2021/22.

Our review of 10 structured judgement review (SJR) patient death records identified that there were inconsistencies in the review records. There was considerable variation in the level of detail and information recorded in the SJR reviews, which meant it was not always clear how improvements and learning could be identified and shared.

There are two main mortality measures used nationally: the hospital standardised mortality ratio (HSMR) and the summary hospital level mortality indicator (SHMI). The HSMR is worked out according to observed deaths divided by expected deaths, multiplied by 100. A score of 100 means that the number of deaths is similar to what would be expected. A higher score means more deaths; a lower score, means fewer.

The trust reviewed both mortality measures and we were given an example of a specific outlier for fractured neck of femur which the local clinicians were addressing by the orthopaedic and ortho-geriatricians working together.

For the 12-month period from Oct 20 - Sep 21, HSMR was higher than expected with a value of 117.88 (compared to 100 for England) and 870 deaths compared to an expected 738 deaths. NHS Data confirmed that HSMR had remained within the 'higher than expected' banding since 2019. The integrated performance report dated January 2022 indicated some improvement to 111.

For the 12-month period from Oct 20 - Sep 21, SHMI was within expected range with a value of 1.01 (compared to 1.0 for England) and 1,185 deaths compared to an expected 1,175 deaths.

Complaints

The trust did not have effective governance systems and processes relating to the management of complaints.

We were not assured complaints were always acknowledged or responded to within the timelines stated in the trust's policy for listening and responding to concerns and complaints.

We reviewed the trust complaints policy and noted that the policy stated complaints would be acknowledged within three days and responded to within 25 days for low level complaints, within 40 days for medium level complaints and within 60 days for complex complaints. Trust data for the period March 2021 to February 2022 shows the overall average

compliance rate for acknowledgment of complaints was 68%. The monthly average ranged between 38% and 93% during this period. Trust data for the period March 2021 to February 2022 shows the overall average compliance rate for responding to complaints within 65 days was 68%. The monthly average ranged between 23% and 90% during this period.

We reviewed 17 complaints records as part of our inspection and identified that ten of these complaints had not been acknowledged within three working days. Eight of the records we reviewed did not include any details of complaint responses. Five records indicated on-going correspondence between the central complaint's teams and individual ward or department the complaint related to, only four of the 17 complaints records included clear complaint outcomes with response letters present on file.

This meant that we could not be assured that there was an effective and consistent approach to managing complaints in line with trust policy.

A continuous improvement strategy was in place for 2020-2025. The trust was developing a culture of improvement, with over 700 staff having been trained in "lean" continuous improvement methodology.

The finance team had recently been re-accredited at level two on the finance staff development strategy and there is a plan in place to move this on to level three in the next financial year. Appraisal rates for the finance team were satisfactory and individuals spoke positively about their experience of formal reviews with their manager. Patient level costing appeared to have lost momentum during the pandemic, despite investing in a well-regarded costing system.

Key to tables

Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	➔➔	↑	↑↑	↓	↓↓

Month Year = Date last rating published

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires Improvement ➔➔ Jun 2022	Requires Improvement ➔➔ Jun 2022	Good ➔➔ Jun 2022	Requires Improvement ➔➔ Jun 2022	Inadequate ↓ Jun 2022	Requires Improvement ➔➔ Jun 2022

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Ratings for a combined trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute locations	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement
Ambulance	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
Adult social	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
Mental health	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
Community	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
Primary medical	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
Overall trust	Requires Improvement →← Jun 2022	Requires Improvement →← Jun 2022	Good →← Jun 2022	Requires Improvement →← Jun 2022	Inadequate ↓ Jun 2022	Requires Improvement →← Jun 2022

The rating for the well-led key question is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions take into account the ratings for different types of service. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
The Countess of Chester Hospital	Requires Improvement →← Jun 2022	Requires Improvement →← Jun 2022	Good →← Jun 2022	Requires Improvement →← Jun 2022	Requires Improvement →← Jun 2022	Requires Improvement →← Jun 2022
Ellesmere Port Hospital	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016
Overall trust	Requires Improvement →← Jun 2022	Requires Improvement →← Jun 2022	Good →← Jun 2022	Requires Improvement →← Jun 2022	Inadequate ↓ Jun 2022	Requires Improvement →← Jun 2022

Ratings for the trust are from combining ratings for hospitals. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for The Countess of Chester Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Requires Improvement ➔➔ Jun 2022	Requires Improvement ➔ Jun 2022	Good ➔➔ Jun 2022	Requires Improvement ➔➔ Jun 2022	Requires Improvement ➔➔ Jun 2022	Requires Improvement ➔➔ Jun 2022
Services for children & young people	Requires improvement Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016
Critical care	Good Jun 2016	Good Jun 2016	Good Jun 2016	Requires improvement Jun 2016	Good Jun 2016	Good Jun 2016
End of life care	Good Jun 2016	Requires improvement Jun 2016	Good Jun 2016	Requires improvement Jun 2016	Requires improvement Jun 2016	Requires improvement Jun 2016
Outpatients and diagnostic imaging	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016
Surgery	Requires Improvement ➔➔ Jun 2022	Requires Improvement ➔➔ Jun 2022	Good ➔➔ Jun 2022	Requires Improvement ➔ Jun 2022	Requires Improvement ➔➔ Jun 2022	Requires Improvement ➔➔ Jun 2022
Urgent and emergency services	Requires Improvement ➔➔ Jun 2022	Good ➔➔ Jun 2022	Good ➔➔ Jun 2022	Requires Improvement ➔➔ Jun 2022	Requires Improvement ➔➔ Jun 2022	Requires Improvement ➔➔ Jun 2022
Maternity	Inadequate Jun 2022	Requires Improvement Jun 2022	Good Jun 2022	Requires Improvement Jun 2022	Inadequate Jun 2022	Inadequate Jun 2022
Overall	Requires Improvement ➔➔ Jun 2022	Requires Improvement ➔➔ Jun 2022	Good ➔➔ Jun 2022	Requires Improvement ➔➔ Jun 2022	Requires Improvement ➔➔ Jun 2022	Requires Improvement ➔➔ Jun 2022

Rating for Ellesmere Port Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016
Outpatients and diagnostic imaging	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
Overall	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016

The Countess of Chester Hospital

Executive Suite, Countess Of Chester Health Park
Liverpool Road
Chester
CH2 1UL
Tel: 01244365289
www.coch.org

Description of this hospital

The Countess of Chester Hospital NHS Foundation Trust consists of a 600 bedded large district General Hospital, which provides its services on the Countess of Chester Health Park, and a 64 bedded Intermediate Care Service at Ellesmere Port Hospital.

The Countess of Chester Hospital is a 600 bedded large district General Hospital that provides a full range of acute services. This includes acute and specialist services including an urgent and emergency care, general and specialist medicine, general and specialist vascular surgery and full consultant led maternity, obstetric and paediatric hospital services for women, children and babies.

The emergency department at the hospital operates 24 hours a day, seven days a week. There had been 72,035 urgent and emergency care attendances between December 2020 and November 2021.

The hospital provides midwifery and consultant led maternity care across 52 maternity beds. Between July 2020 and June 2021 there were 2,295 babies birthed under the care of this service.

The medical care services at the hospital form part of the urgent care division and provide non-elective care services. The hospital has 310 acute beds across 11 wards that provide a range of specialities including the cardiology unit, respiratory, acute stroke service, gastroenterology, endoscopy, general medical wards including care of the elderly wards and modular Covid build.

The surgical service is part of the planned care division that provides elective and non-elective care for a range of specialities including gynaecology, orthopaedics, vascular, urology, eye and general surgery. The hospital has 109 surgical beds across five inpatient wards at the Countess of Chester Hospital. Additional services are also provided through a surgical assessment unit, a day-case unit and a specialist eye care unit.

Our previous inspection of the Countess of Chester Hospital was undertaken on 13-15 November 2018 and 11-13 December 2018. The report was published on 17 May 2019. We inspected urgent and emergency care, surgery and medical care services as part of that inspection. The trust was rated as requires improvement overall, with a rating of requires improvement for safe, effective, response and well-led, and a rating of good for caring. There were 18 regulatory breaches identified in total, relating to four regulations; Regulation 10: Dignity and respect, Regulation 12: Safe care and treatment, Regulation 17: Good governance and Regulation 18: Staffing.

Our findings

We previously inspected the maternity services at this hospital in 2016 alongside their gynaecology service. Therefore, we are unable to compare our current ratings with the previous ratings following the 2016 inspection.

We rated the maternity services at The Countess of Chester Hospital as inadequate because:

- We rated safe and well led as inadequate, effective and responsive as requires improvement and caring as good.
- The service did not have enough staff to care for women and keep them safe. Staff did not always have training in key skills and did not manage safety well. Staff did not consistently assess risks to women to keep them safe. The service did not manage safety incidents well or learnt lessons from them. Shift changes and handovers did not include all necessary key information to keep women and babies safe.
- The design of the environment did not always follow current national guidance or provide environments for the delivery of safe and timely care.
- The service did not have enough suitable equipment to help them to safely care for women and babies.
- The service did not have robust system is in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users.
- Patient records were not always complete and contemporaneous.
- Not all premises used by the service were safe to use for their intended purpose nor used in a consistently safe way.
- Not all equipment was appropriately located for the purpose for which it was used.
- Managers did not consistently monitor the effectiveness of the service or make sure staff were competent. Staff did not always provide good care and treatment.
- The service did not consistently plan care to meet the needs of local people or take account of women's individual needs. People could not always access the service when they needed it and the service was not auditing how long women were waiting to be seen or treated.
- Leaders did not run services well, use reliable information systems or consistently support staff to develop their skills. Staff were unaware of the service's vision and values. Not all staff felt respected, supported and valued.
- The service had not fully implemented all national recommendations aimed at keeping women and babies safe.
- The service did not engage well with women and the community to plan and manage services. Not all staff were committed to improving services continually.
- Staff told us they reported all incidents and we noted that the service had processes and procedure in place.

However:

- The service controlled infection risk and managed medicines well.
- Staff gave women enough to eat and drink and gave them pain relief when they needed it. Staff mostly worked well together for the benefit of women and supported them to make decisions about their care.
- Key services were available seven days a week.
- Staff treated women with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to women, families and carers.

Our findings

- The service made it easy for people to give feedback.
- Staff were focused on the needs of women receiving care.

We rated the urgent and emergency care services at The Countess of Chester Hospital as requires improvement because:

- The service did not evidence control of infection risk well as cleaning schedules were not in use and stickers to indicate when areas had been cleaned were available but rarely used. Staff assessed risks to patients, but it was difficult for them to access them on the electronic patient records system due to a lack of effective training.
- There were not always enough staff with the right qualifications, skills, training and experience to provide care and treatment to children and rota staffing of children's nurses was not in line with national guidance.
- Staff did not always follow systems and processes when administering and recording medicines.
- Staff did not effectively advise patients on how to lead healthier lives as there was a lack of available literature and information in the department.
- Although people could access the service when they needed it waiting times for treatment were not within national targets.
- Not all staff had received all the expected mandatory training.
- There was no local strategy for the department or division so we could not be assured that there were effective plans for the department or division to make improvements going forward, based on sustainability of services and aligned to local plans within the wider health economy.

However:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback.
- Local leaders ran services well using information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

We rated the medical care services at The Countess of Chester Hospital as requires improvement because:

Our findings

- For training in key skills, compliance levels were below the trusts target of 90% for mandatory and safeguarding training. For infection, prevention and control the trust reported the infection of Clostridium difficile above their trajectory and in compliance audits eight of the wards were assessed as partially compliant. We observed that fire doors were either obstructed or in need of maintenance. The electronic system was not embedded and staff did not navigate consistently. We were not assured that risk assessments were completed appropriately. The electronic prescribing system did not have a mechanism to prevent non-prescribers from prescribing and we observed that oxygen was not prescribed. Temperatures of medicine fridges were not consistently monitored.
- Policies were available for staff to follow, however; some were passed their date of review. Managers monitored the effectiveness of the service, however; audits had been paused since the introduction of the electronic system and we did not receive outcome data to review.
- Due to the Covid pandemic, patients were initially screened and allocated to either red or green wards. This meant there could be outliers on other wards. Some patients needed to move wards according to hospital capacity. There were patients who did not meet the criteria to reside and needed to stay in hospital longer than necessary. Patient experience information was limited on ward areas.
- There was no vision or strategy for the service or division. Staff told us senior leaders were not visible. The electronic patient record system was not embedded and not being utilised fully.

However:

- The service had enough staff to care for patients. Staff we spoke with understood how to protect patients from abuse. Monitoring equipment was well maintained and daily checks of resuscitation equipment were generally completed. Staff were encouraged to report incidents and these were investigated.
- Staff provided good care and treatment, gave patients enough to eat and drink and gave them pain relief when they needed it. Staff who worked on speciality wards received training according to the competency requirements. Staff worked well together for the benefit of patients, supported them to make decisions about their care. Key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- Patients identified as outliers were reviewed appropriately. The service took into account patients individual needs, where possible.
- Senior leaders had skills to manage the service and supported others to develop their skills. Staff felt supported and valued by their immediate managers. Leaders were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

We rated the surgery services at The Countess of Chester Hospital as requires improvement because:

- Mandatory training was basic and did not meet the needs of all patients and staff. Completion rates for planned care were below the target of 90% in a number of areas. Staff did not always use personal protective equipment and control measures correctly to protect patients, themselves and others from infection. The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff did not always complete and review risk assessments for each patient. There was limited assurance that risk was assessed and regularly reviewed provided by the electronic patient record (EPR).Patient notes were comprehensive, but not all staff could access them

easily because the EPR system was difficult for some staff to navigate. Staff maintained some paper records and had developed different ways to store and retrieve information from the EPR. Staff followed systems and processes to prescribe and administer medicines safely. However, they identified issues with the EPR in relation to medicines' recording which caused risk.

- Managers did not always plan and organise services so they met the needs of the local population. Theatre time was not used efficiently to maximise the number of procedures. Not all facilities and premises were appropriate for the services being delivered. Staff did not always support patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. People could not always access the service when they needed it and did not always receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards.
- Communication in response to concerns being raised was not always effective. The majority of staff we spoke with were positive about the culture within the surgical division. They told us they felt supported and could raise concerns freely. However, 15 of the 19 staff we spoke with expressed concern about the manner in which the new EPR was introduced and the impact this had on their ability to complete work efficiently and effectively. Leaders and teams did not always use systems to manage performance effectively. They did not routinely identify and escalate relevant risks and issues and identify actions to reduce their impact.

However:

- The service had enough staff to care for patients and keep them safe. Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service.
- The service provided care and treatment based on national guidance and evidence-based practice. Staff gave patients enough food and drink to meet their needs and improve their health. Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care. Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff gained consent from patients for their care and treatment in line with legislation and guidance.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers. Each of the patients we spoke with was complimentary about the staff and the way they were treated.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.
- Leaders supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

How we carried out the inspection

Our findings

We carried out an inspection of The Countess of Chester Hospital during 15 to 18 February 2022. Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity. We visited urgent and emergency care services, surgical services, maternity and medical care core services as part of this inspection.

We only visited wards identified as not having an outbreak, due to Covid restrictions in place at the time of inspection. We inspected the urgent and emergency care department, the maternity day unit, fetal medicine department, antenatal clinic, the antenatal and postnatal ward, the central labour suite and maternity theatres.

We also inspected four surgical wards and nine medical wards, including the acute medical units (AMU / AMAC), endoscopy, cardiology, ward 45 (gastroenterology), ward 42 (acute stroke unit), wards 50 and 51 (care of the elderly) and the discharge lounge. Due to Covid restrictions we only visited wards identified as not having an outbreak at the time of inspection.

We spoke with 142 staff across all disciplines, looked at 69 patient records and spoke with 41 patients as part of the inspection. We also observed nursing handovers, ward rounds and bed meetings.

Urgent and emergency services

Requires Improvement ➔➔

Is the service safe?

Requires Improvement ➔➔

Our rating of safe stayed the same. We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills including life support training to staff and monitored completion levels. However, completion levels were lower than the expected compliance rate set by the trust in several key courses.

Not all staff had received all the expected mandatory training. The expected compliance rate was 90%. The trust had undergone challenges to delivering mandatory training as courses were generally face to face. These had been paused during a period of the pandemic and when they had resumed, social distancing had been a challenge to allowing staff to catch up with training. In the eight weeks prior to our inspection, increased pressures in the emergency department meant that training had been cancelled due to departmental pressures.

We reviewed the mandatory training figures on site for nursing staff in the department and saw that, in several courses, less than 90% of nursing staff had completed the training. Data showed that 76% of nursing staff had completed Adult Basic Life Saving [BSL] 70% had completed Paediatric Life Saving [PBSL] 62% had completed fire safety; 7% had completed information governance training; 85% had completed equality and diversity training and 58% had completed mental health training.

Other mandatory training courses within this range were equality, diversity and human rights; fire safety; infection prevention and control level two; information governance and data security and moving and handling level two.

The divisional level data showed that medical staff completion rates for mandatory training were only 54.81% and 54.07% for adult basic life support and paediatric basic life support respectively. Compliance rates were also below 60% for information governance and data security training. Other mandatory training courses for medical staff ranged from 63.7% for moving and handling and 80% for equality, diversity and human rights.

Across the division, mandatory training was below the 90% target completion rate for all courses for nursing and medical staff.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia.

Local managers monitored mandatory training and alerted staff when they needed to update their training.

Staff in the department undertook life support training. Basic life support for both adults and children training was part of mandatory training. Records showed that 75% of nurses had completed basic life support training for adults and 74% had completed basic life support training for children. Managers told us that there was a plan in place to increase these figures. However, we did not see any action to implement this plan during our inspection.

Urgent and emergency services

We made several requests for the training compliance rates for staff trained in advanced life support training, advanced paediatric life support training and advanced trauma life support training . Data provided by the trust confirmed that nursing staff have completion rates of but we have not received this. We were told that all registered children's nurses had advanced paediatric life support training and a large number of the sisters in the department. We were told that it was difficult to put staff through this training as it only ran twice yearly. The matron advised that they ensured that there were a number of staff on each shift with advanced life support training. However, we have not received confirmation of what we were told from the trust, this meant that we cannot be fully assured that mandatory training in key areas such as Advanced Life Support [ALS] were being monitored effectively.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Nursing and medical staff received training specific for their role on how to recognise and report abuse. Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. The patient record system prompted staff to consider the risk of safeguarding vulnerability and provided instructions should the risk be present. The patient record system alerted staff if an attending child was on the child protection register.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. An initial safeguarding review was completed for each patient at triage and if safeguarding risks were identified a referral to the multi-agency safeguarding and support hub (MASSH) was made.

Training included PREVENT which is a is part of the government's overall counter-terrorism strategy to reduce the threat from terrorism by stopping people becoming terrorists or supporting terrorism and 90% of staff had completed this training.

Training also included elements on female genital mutilation (FGM) and child sexual exploitation. We reviewed the completion rates for nursing and medical staff for level two and level three children's and adults safeguarding courses. We saw that 95% of staff had completed training in level two adult's safeguarding and 98.2% had completed level two children's safeguarding. Level three safeguarding for adults and children had been completed by 91.9% of staff.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They did not always keep equipment and the premises visibly clean and did not have documentation to indicate which areas had been cleaned and the frequency.

All areas were not always visibly clean. The department had suitable furnishings which were well-maintained. We found that there were no cleaning schedules in the department available for domestic staff to sign off the areas that had been cleaned or to evidence what needed to be cleaned and how often. This was an issue that had been highlighted during our last inspections in 2016 and 2019 but had still not been resolved.

Staff told us that there were green stickers in the department for use to show when items and areas had been cleaned with the date and time of cleaning, but they were rarely used. We saw no evidence of stickers being used in the department.

The lack of use of cleaning schedules and stickers was raised with the facilities manager during the inspection but when we returned to the department the following week, there remained no evidence of cleaning schedules or clean indicator stickers being used in the department.

We returned to the department again on 14 March 2022 and saw that areas looked dirty and there was clinical waste and vomit on the floor. In addition, we were told and saw that, at that time there was only one cleaner on duty to service the whole department.

Staff followed infection control principles including the use of personal protective equipment (PPE) and were bare below the elbow.

Staff cleaned equipment and washed their hands after patient contact.

Measures to control and protect patients from infection, particularly from Covid-19 were in place in the department. The trust had reopened an isolation majors area for patients with confirmed Covid-19 or suspected Covid-19. This area was separated from the rest of the department with closed doors and cubicles had fixed screens between them, rather than curtains. There were13 cubicles in this “red” majors area and one resus cubicle. However, we had some concerns about measures to control and protect patients from Covid-19 in the ambulatory majors waiting area. There were 12 chairs in the room, eight of which were armchairs with no social distancing between them.

We returned to the department again on 14 March 2022 and saw that the Covid-19 majors area was no longer an isolation area though there had been over 50 patients in the department that day who were Covid-19 positive.

The service had generally performed well for cleanliness in the Patient-led assessment of the care environment (PLACE) audit, however, the last available scores were from 2019.

The trust had a programme of audits for infection prevention and control for 2021-2022. The audit programme showed that the main emergency department had not yet been audited. The paediatric area in the emergency department had received an audit in April 2021 and achieved an overall score of 95% compliance. The areas audited and compliance scores achieved for this area were as follows: ward environment (85% compliance); departmental waste (95% compliance); management of patient equipment (97% compliance); safe handling and disposal of sharps (90% compliance); hand hygiene (97% compliance); personal protective equipment (100% compliance) and isolation precautions (100% compliance).

The trust provided an infection prevention and control (IPC) monthly governance pack for each directorate. The pack provided each department with relevant information pertaining to infection prevention and control, including: healthcare associated infection surveillance; audit reports and action plans; training compliance; learning from risk reviews and investigations and to highlight risks and issues. It also identified the IPC champions in each department. The emergency department had two IPC champions.

The emergency department had no outbreaks of healthcare acquired infections in the last 12 months before our inspection.

Urgent and emergency services

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

Patients could reach call bells and staff responded quickly when called.

Staff carried out daily safety checks of specialist equipment and there was evidence that equipment had been serviced.

The service had suitable facilities to meet the needs of patients' families. The paediatric emergency department was appropriate for the care and treatment of children and young people. It was separate from the main emergency department and there was a safe and secure waiting area for children and their families that had sufficient seating. This was an improvement from our last inspection.

There were three treatment rooms in the paediatric area, along with two triage rooms. One of the treatment rooms was equipped to be used as a resus room, should this be required.

Since our last inspection, the main waiting room for the department had been enlarged and could now seat around 75 people. We saw that there was enough seating in the room for people to be able to spread out and socially distance.

The ambulance handover area had improved since our last inspection and had moved to a larger area next to the blue (non-Covid) majors area with three assessment cubicles in use, each with a call bell.

The designated mental health assessment room within the department was appropriately furnished, lit and decorated. Since our last inspection, the furniture in the room had been replaced with heavy furniture that could not be picked up or thrown. The room was comfortably furnished with a sofa and two armchairs. There was a panic alarm and call bell in the room. It was in line with the psychiatric liaison accreditation network guidelines.

The service had enough suitable equipment to help them to safely care for patients.

Needle sharps bins were stored correctly, and none were seen to be overfilled during our inspection.

Equipment used such as dressings and syringes were found to be stored appropriately and were all seen to be in date. However, we checked the major incident stores and saw that there was out of date equipment, such as airway tubes, bandages and dressings. We did not see any tabards in the cupboard to identify staff roles during a major incident, nor did we see any equipment checklists. The major incident plan held in the store was dated 2016.

Following our inspection, we raised our concerns with the trust. The trust moved the major incident store during the week of our inspection and re-stocked the resus and catastrophic haemorrhage boxes. They also provided the most up to date major incident plan that was ratified in 2019 and due to be updated again in April 2022.

Assessing and responding to patient risk

Staff completed risk assessments for each patient, however, it was difficult for staff to review and update the risk assessments as many staff did not know how to access the completed risk assessments on the electronic patient records system. Staff identified and quickly acted upon patients at risk of deterioration.

Urgent and emergency services

We saw that patients who arrived and were confirmed as Covid-19 positive or suspected Covid-19 positive were streamed to the red majors area for assessment where they could be isolated from other patients. Bays in this area had solid screens between them rather than curtains.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. The department used a national early warning score (NEWS2) system for adults and a paediatric early warning score (PEWS) system for children to identify deteriorating patients. These systems scored a set of observations and prompted an appropriate response dependent on the score or whether the score was increasing.

Staff completed risk assessments for each patient on arrival, using recognised tools, however, we were not assured that risk assessments were readily available for staff to view and update on the electronic patient record system as staff struggled to find completed risk assessments on the system. We saw that the risk assessments were on the system but only a limited number of staff knew how to access them.

We had some concerns about the safety of patients in the ambulatory majors waiting area. This was a glass-walled room in the ambulatory majors area where patents waited to be assessed in a cubicle or to be admitted to the hospital when that decision had been made. We saw that patients often experienced long waits sitting in a chair. There was a concern that patients in this area had an increased risk of pressure ulcers or deep vein thrombosis.

Data showed that from August 2021 to February 2022, 35.5% of patients in that area had a wait of over four hours from the decision to admit them and 3.6% had a wait of more than 12 hours.

We sought reassurance from the trust about these patients, especially those who may be in the waiting area overnight. We were told that beds were provided within the department for those patients in that area whose wait extended into the evening so that they could get some sleep. We were told that, it was only with exception, when the department was under severe pressure, that bed spaces would only be found for the most vulnerable patients in the ambulatory majors waiting area to ensure that their comfort needs were met.

The service had 24-hour access to mental health liaison and specialist mental health support. (if staff were concerned about a patient's mental health). An initial mental health assessment was made by the triage nurse using a mental health triage pathway.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide.

Staff shared key information to keep patients safe when handing over their care to others.

Ambulance handover records showed that patients were being handed over and clinically assessed within around 15 minutes of arrival and ambulances were able to clear the department to attend another call within around 30 minutes.

Ambulance crews told us that there were few delays in handing over patients when they arrived at the department and they did not have to hold patients in ambulances outside the department.

Urgent and emergency services

We saw limited corridor care on 15 and 16 February. When patients needed to be moved to the corridor, at times of high demand, this was escalated to the lead nurse and an assessment made regarding which patients would have the lowest risk. However, we visited the department again on 14 March and saw that the department was in escalation and both the corridor and the urgent treatment centre were being used to accommodate patients but there were not the expected number of staff working to meet the escalation plan requirements.

Shift changes and handovers included all necessary key information to keep patients safe. There were around four to five clinical safety huddles a day. These were attended by the assistant service manager; consultant of the day; nurses in charge and the matron. We saw that the huddles were organised, proactive and appeared to be attended by the right people.

There was always a nurse in the department with advanced paediatric life support training. There was always a consultant in the hospital with advanced paediatric life support training who was either in the department or on call where this was not available.

We saw that, when a trauma patient was brought into the resus area that there was a scribe as part of the medical team so that all clinical decisions and actions were written down and accurately reflected on the patient record.

Nurse staffing

There were gaps in nurse staffing but there was ongoing recruitment to ensure that there were enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Local managers regularly reviewed staffing levels and skill mix, and gave bank and agency staff a full induction.

We requested the numbers of planned whole time equivalent (WTE) nursing and care support worker staff of different grades in the department against the actual number employed but did not receive this.

We received the planned registered nurses and unregistered staff (care support workers) hours for January 2022 against the actual hours. These showed that, for registered nurses, actual hours against planned hours worked for day shifts was at 119%; day shifts for unregistered staff were at 102%; night shifts for registered nurses was at 107% and night shifts for unregistered staff was at 140%.

Managers calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance.

The department manager could adjust staffing levels daily according to the needs of patients. Since January 2020, at times of pressure in the department, managers had authority to increase the nursing establishment per shift from 13 or 14 registered nurses and three to five care support workers to 17 registered nurses and seven care support workers.

Staffing in the children's emergency department had improved since our last inspection. There were six registered children's nurses and a band six children's nurse to oversee the area. Three new children's nurses had just been recruited and were awaiting start dates and there was an advertisement out for a further two children's nurses.

We were told that there were two children's nurses on shift in the paediatric department from 8am until 10pm and then one nurse overnight from 10pm until 8 am with an identified support nurse from the main emergency department who was familiar with working in the paediatric emergency department. However, the paediatric nursing roster from 31/01/2022 until 27/02/2022 indicated that the planned staffing level of two children's nurses was only met on three shifts. On two days in January 2022 there had been no qualified registered children's nurses on any shift.

The newly recruited children's nurses would allow staffing in the children's emergency department to be in line with the workforce standards in the Royal College of Paediatrics and Child Health's guidance document, "Facing the Future: Standards for children in emergency healthcare settings." which require every emergency department treating children to be staffed with two registered children's nurses.

There were 18 care support workers in post at the time of inspection.

There was one practice development nurse in post.

The service had low vacancy rates. There were vacancies for one whole time equivalent (WTE) band six nurse; one WTE band six emergency nurse practitioner that had been advertised; three WTE band five nurses that had been recruited and were awaiting start dates and three WTE registered children's nurses that been recruited and were awaiting start dates. There was also an advertisement out for a further two registered children's nurses. There was a rolling recruitment programme for nurses in the department.

The service had low and/or reducing turnover rates. We requested the turnover rates for nursing staff for the emergency department but only received this at divisional level. This showed that the average staff turnover rate for the urgent car division at February 2022 for nursing staff was 8.23%

We requested the sickness absence rates for the emergency department but only received this at divisional level. This showed that the average sickness rate for nursing staff had slightly increased from a 12 month average of 5.42% per month during the previous 12 months to 6.2% in February 2022.

The service had low rates of bank nurses and we were told did not use agency nurses. However, we visited the department again on 14 March and found that there were agency nurses working who were unfamiliar with the department and had no access to the patient record system though the manager had tried to ensure that there was at least one substantive member of staff in each area to assist these staff..

Medical staffing

There were gaps in medical staffing and the planned number of consultants did not meet the Royal College of Emergency Medicine guidelines on consultant workforce. There was ongoing recruitment of lower grade doctors. Local Managers reviewed staffing levels and skill mix and gave locum staff a full induction. Associate specialist doctors were not on the General Medical Council specialist register.

The department had a planned number of nine whole time equivalent (WTE) substantive consultants and three associate specialist (senior middle-grade) doctors. The trust reported that the associate specialist doctors formed part of the senior emergency department (ED) team and supported the rota alongside the consultants. Associate specialists all had a named emergency medicine (EM) consultant on-call if they were ever on shift without a resident EM consultant. The trust informed us that associate specialists had a minimum of five years of senior emergency medicine experience, however, they were not on the General Medical Council (GMC) specialist register.

Urgent and emergency services

Managers told us that the department met the Royal College of Emergency Medicine standard of having at least one consultant in the department for 16 hours a day. However, a minimum of ten consultants are generally required to staff a rota at this level. In addition, the Royal College of Emergency Medicine guidelines on consultant workforce 2019 states that 18-25 whole time equivalent consultants and a minimum of 30 whole time equivalent senior decision-making doctors should be employed in a medium sized emergency department. This meant consultant staffing was not fully in line with Royal College of Emergency Medicine guidelines.

Consultants worked in the department from 8am until midnight seven days a week. The service had a consultant on call during evenings and weekends.

There were no paediatric emergency medicine consultants in the department although they were available to call from the women and children's division. This was not in line with the Royal College of Paediatrics and Child Health "Facing the Future – standards for children and young people in emergency care settings".

The medical staff did not match the planned number for speciality doctors. The budget was for six WTE senior clinical fellows. At the time of our inspection 3.2 were in post. The budget was for four ST1/2 trainee doctors with 3.4 in post and for six ST1/2 doctors with 5.16 in post. However, middle grade ST3 and above middle grade doctors were over established by 0.6 WTE staff.

The total planned medical staffing was for 37 staff with 33.36 in post.

We visited the department again on 14 March 2022 and saw that the twilight shift was short staffed by one consultant and one junior doctor.

We found that the service had low and/or reducing vacancy rates for medical staff although we could not be assured that the planned medical staffing was sufficient in total for a medium sized emergency department. The service had low and/or reducing turnover rates for medical staff. We found that sickness rates for medical staff were low and/or reducing.

The service had low and/or reducing rates of bank and locum staff. Managers could access locums when they needed additional medical staff.

Managers made sure locums had a full induction to the service before they started work. The service had a good skill mix of medical staff on each shift and reviewed this.

Records

Staff did not consistently keep detailed records of patients' care and treatment. Records were clear and stored securely but were not easily available to all staff providing care.

The department used an electronic patient records system that had been introduced within the last year. We saw that there appeared to be training gaps in staff knowledge of how to use the system to keep patients safe and access all the required information about a patient easily. This was especially evident when we asked staff to show the risks assessments that were indicated as having been completed for a patient and they were unable to locate them on the system. Staff often had to ask other staff to help them use the system.

Urgent and emergency services

We reviewed 14 sets of adult patient notes and found these were generally well-completed with risk assessments and allergies recorded. Five of these records were looked at in detail. We saw that in two of the five records, an hourly safety checklist had not been carried out every hour. In three out of the five records looked at in detail we saw that the patient did not receive an initial clinical assessment within 15 minutes.

We reviewed four sets of paediatric notes and saw that they were well completed with appropriate risk assessments in place. None of the patients had received an initial clinical assessment within 15 minutes of arrival. Times ranged between 22 minutes and 58 minutes.

When patients transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely.

Medicines

Staff did not always follow systems and processes when administering and recording medicines. However, the service used an electronic system to prescribe, administer and record medicines for patients. The system did not have a way to restrict prescribing ability to only those staff with appropriate prescribing qualifications.

We found that when patients were administered oxygen this was not always prescribed or recorded as administered on the system. This was an issue that had been highlighted at our last inspection.

Information from the trust following the inspection showed the electronic patient record system had the functionality for recording oxygen prescribing and administration. However, the majority of staff we spoke with during the inspection did not have a clear understanding of this. They were either not aware of or had not accessed the oxygen prescribing functionality within the electronic patient record system.

The patient record system had a red flag system that indicated when a medicine dose had not been given. However, it also flagged red when the dose had been given but was late. It was sometimes necessary to delay the dose being given if the previous dose had not been given on time, to ensure that the correct time interval between doses was adhered to. The system flagging red for a missed dose and a late dose presented a risk that a dose could be given twice or not at all. Managers were aware of the risk and it was on the risk register until the system could be changed

Antibiotics were prescribed as per national guidelines; however, they were not always administered within one hour of being added to the sepsis pathway.

Although there was no clinical pharmacy support to the department; staff we spoke to were aware of how to contact the pharmacy department for advice if required.

Staff stored and managed all medicines and prescribing documents safely. The department had an automated medicine dispensing cabinet that was in a secure area and access by fingerprints and a secure code.

Where medicines were stored in fridges, we saw that fridge temperatures were checked daily and were within a safe range.

Staff learned from safety alerts and incidents to improve practice.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines.

Urgent and emergency services

Incidents

The service managed patient safety incidents. Staff recognised and reported incidents and near misses to local leaders. Managers investigated incidents and shared lessons learned with the whole team and the wider service but we had limited assurance that serious incidents were investigated appropriately as we were not able to review investigation reports. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

The department used an electronic incident reporting system. Staff knew what incidents to report and how to report them.

Staff raised concerns and reported incidents and near misses in line with trust policy.

The service analysed incidents and trends reported. From February 2021 to January 2022 the service reported 996 incidents, an average of 83 per month. Of these, the highest reported incident category was related to security with 170 incidents (17% of the total), followed by bed management at 130 incidents (13%) and emergency medicine at 99 incidents (9.9%).

From February 2021 to January 2022, the service had reported two serious incidents, in September and November 2021. We requested root cause analysis reports and action plans for these incidents but did not receive them. This meant we had limited assurance that incidents were investigated appropriately.

The service reported no never events in the previous 12 months leading up to our inspection. Never events are serious, largely preventable safety incidents that should not occur if the available preventative measures are implemented.

Managers shared learning with their staff about serious incidents and never events that happened elsewhere.

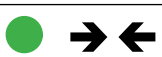
Staff reported serious incidents clearly and in line with trust policy. A trust serious incident panel met weekly and departments presented details of any serious incidents that had occurred.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong.

Staff received feedback from investigation of incidents. Managers discussed recent incidents and lessons learned at staff safety huddles and information was also disseminated to staff by the corporate risk and safety team.

Managers debriefed and supported staff after any serious incident.

Is the service effective?

Good 

Our rating of effective stayed the same. We rated it as good.

Urgent and emergency services

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice although we could not be assured that all policies in use were the most up to date version. Local managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed policies to plan and deliver high quality care according to best practice and national guidance, however, we saw that not all policies in use were the most up to date version.

Pathways and policies were based on guidelines and standards set by organisations such as the National Institute of Health and Care Excellence (NICE) and the Royal College of Emergency Medicine (RCEM). The documents were easily accessible to all staff (including bank and agency staff) on the intranet.

Policies and procedures in the document library had been reviewed and were in date. However, we saw from the major incident policy that, when the document was opened, there was no indication on the policy as to when it was last updated or version control number and the footer of each page defaulted to today's date as the date it was printed.

Staff were advised on policies that if they were printed, they should be disposed of after use although we could not be assured that this happened.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. We saw that patients were given regular meals and those with extended waits were given hot food.

Staff fully and accurately completed patients' fluid and nutrition charts where needed.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition but staff could not easily access these risk assessments.

Specialist support from staff such as dietitians and speech and language therapists was available for patients who needed it.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice.

Patients received pain relief soon after it was identified they needed it or they requested it. Patients told us that pain relief was offered regularly or given to them when they requested it.

Staff prescribed, administered and recorded pain relief accurately.

Patient outcomes

Staff monitored the effectiveness of care and treatment. Local managers did not always use the findings to make improvements and achieve good outcomes for patients.

The service participated in relevant national clinical audits. There was a lead consultant for audits in the department. Submission to national audits had been halted during the COVID-19 pandemic.

The service had participated in some of the Royal College of Emergency Medicine (RCEM) audits. We reviewed the summary of the audit results for the RCEM 2020 audit on care of children in the emergency department that was completed in March 2020.

The trust met the fundamental standards for a review of notes by a senior clinician when an infant, child or adolescent left or was removed from the department without being seen; for having a system in place to identify children and young people who attended frequently and for having a policy in place to identify and review children at high risk for potential safeguarding.

For the standard on infants at high risk of potential safeguarding presentations being reviewed by a senior clinician in the emergency department, only 46% of children attending the department, had a senior review against a national average of 78%. For the standard on whether there was a policy in place to review cases where an infant, child or adolescent left or absconded from the department unexpectedly or when they did not attend a planned follow up, nationally, 94.3% of emergency departments had these policies in place but although the service had a policy for patients not attending planned follow-up there was no policy in place for patients who left or absconded.

Managers had not used the results to improve patients' outcomes. Although the audit results had been summarised and reviewed at the emergency department governance meeting, the decision had been made not to carry out any follow-up actions to improve outcomes.

Managers and staff did not carry out a programme of repeated audits to check improvement over time however and we were unable to gain assurance on how the trust was monitoring improvements following audits.

Managers shared and made sure staff understood information from the audits.

The service had a lower than expected risk of re-attendance than the England average.

Competent staff

The service made sure staff were competent for their roles. However, there were low staff compliance in specific competencies, such as for fluid balance, tracheostomy and catheter line management competencies. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.

Urgent and emergency services

Managers gave all new staff a full induction tailored to their role before they started work. All new staff received an induction pack which included uniforms, details about breaks, shifts, door codes and so on. There was a general induction checklist for all new staff. International nurses underwent a separate induction.

Newly qualified or international nurses spent the first week on an induction course and the first two weeks on duty on day shifts, Monday to Friday plus six weeks on a supernumerary period.

Experienced nurses who were new to the trust spent one week on day shifts and three weeks on a supernumerary period. Qualified nurses were also invited to carry out the induction course.

Newly qualified nurses in the department also underwent a 12-month preceptorship and met with the practice-based educator at month three, six, nine, eleven and twelve.

Nurses and paediatric nurses had their competencies assessed using a comprehensive competency document adapted from the Royal College of Nursing competencies. Competencies were assessed over a year. Information received from the trust confirmed that the Emergency Department competency framework, had been completed by all Band 7 nurses and the process has now begun to roll out with the junior team. Data received from the trust showed that completion rates ranged from 100% compliance with core competencies such as NEWS/PEWS, blood glucose, oxygen administration and sepsis were at 100%. However, compliance with fluid balance competency was 50%. The trust informed us that they had developed a business case to strengthen departmental clinical educator capacity, with specific focus on improving training compliance.

Nursing staff within the department also received extended clinical skills, which were to be completed within six months post induction. Data received from the trust showed that nursing staff had completed training in topics such as female catheterisation [89%], non-invasive ventilation [83%], tracheostomy [69%], PICC/Line Management [69%], and IV Opiate/IV medications [91.5%]. This showed that most staff had completed extended clinical skills competency-based training.

Managers supported nursing staff to develop through regular, constructive clinical supervision of their work. We saw that 80% of nursing staff had received an appraisal at the time of our inspection.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Junior doctors received teaching every Friday from 2pm.

The practice based educator supported the learning and development needs of staff. They reviewed interests and learning needs and were able to support staff to become link nurses for areas in which they had a special interest.

Managers made sure staff attended team meetings or had access to full notes when they could not attend.

Managers identified any additional training needs for their staff had and gave them the time and opportunity to develop their skills and knowledge.

Managers made sure staff received any specialist training for their role. Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. There were three nurses on a university emergency nursing course and two emergency nurse practitioners were undertaking a non-medical prescribing course.

Urgent and emergency services

Th trust was working with the local university to develop specific courses in emergency department nursing.

Managers identified poor staff performance promptly and supported staff to improve.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Handovers took place with nursing and medical staff three times a day to share information about the status of the department and address any issues. Staff were allocated to different areas of the department but supported each other and moved if one area was particularly busy.

Staff worked across health care disciplines and with other agencies when required to care for patients. There was in reach from speciality teams to support patients entering the emergency department at the earliest opportunity. Medical staff told us that the rapid response team were available to assess patients when needed and a consultant physician came to the department to assess frail patients. Dietitians attended the department upon request.

Staff referred patients for mental health assessments when they showed signs of mental ill health or depression. Doctors told us that the psychiatric liaison team and alcohol liaison team were very approachable and responsive. The trust had a trial underway whereby registered mental health nurses working elsewhere in the hospital could be used to support patients in the emergency department where there were no specialist mental health nurses when there were a number of mental health patients in the department who may have long waits for further support or admission to a mental health bed in another location.

Seven-day services

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

Staff could call for support from doctors and other disciplines and diagnostic services, including mental health services, 24 hours a day, seven days a week.

Radiology services were available 24 hours a day, seven days a week.

Pharmacy services were available seven days a week but there was no pharmacist working specifically within the emergency department.

Health Promotion

We saw no evidence that the service gave patients practical support and advice to lead healthier lives.

The service had removed all health promotion and information leaflets and booklets from display areas during the Covid-19 pandemic.

Staff told us that the information was still kept in the department but there was an expectation for patients to ask for any information on health promotion and we saw no evidence that patients were offered health promotion information.

Urgent and emergency services

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.

Staff gained consent from patients for their care and treatment in line with legislation and guidance.

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

Staff made sure patients consented to treatment based on all the information available.

Staff clearly recorded consent in the patients' records.

Staff understood Gillick Competence and Fraser Guidelines and supported children who wished to make decisions about their treatment.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good.

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way.

Patients said staff treated them well and with kindness.

Staff followed policy to keep patient care and treatment confidential.

Urgent and emergency services

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

Staff made sure patients living with mental health problems received the necessary care to meet their needs. We saw that mental health patients, although they may experience lengthy waits in the department, were treated with kindness and compassion and that staff, including security staff, tried to make them feel at ease

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Emotional support

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

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

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment.

Staff talked to patients in a way they could understand, using communication aids where necessary.

We spoke to 12 patients who told us that staff treated them with dignity and respect and they had been given pain relief in a timely way. Patients told us that they were well-informed about their care plan and what was happening.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this.

Staff supported patients to make advanced decisions about their care.

The feedback from the Emergency department survey for 2021 was positive. The trust scored about the same as other trusts for all areas in the survey that took account of arrival in the department; waiting times; how doctors and nurses treated them; care and treatment received; tests received; hospital environment and facilities; leaving A and E; respect and dignity and overall experience.

The service scored highly (a score of nine or above out of 10) for doctors and nurses acknowledging patients; privacy when examined or treated; communication; feeling safe; cleanliness; clear explanations about medication purpose and being treated with respect and dignity.

Urgent and emergency services

Is the service responsive?

Requires Improvement 

Our rating of responsive stayed the same. We rated it as requires improvement.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services so they met the needs of the local population. The service had a plan in place to relieve pressure on other departments when they could treat patients in a day. A new same day emergency care (SDEC) building was being constructed at the front of the emergency department and was due to open later in 2022.

The department was adequately signposted so that patients could easily find it from outside or within the hospital.

Facilities and premises were appropriate for the services being delivered. The main waiting area of the department had sufficient seating and there were vending machines available for the use of people in this area.

Staff could access emergency mental health support 24 hours a day, 7 days a week for patients with mental health problems. They had access to the psychiatric liaison team but there was no on call psychiatric consultant.

The service had systems to help care for patients in need of additional support or specialist intervention.

Meeting people's individual needs

The service did not always take account of patients' individual needs and preferences. Staff made some reasonable adjustments to help patients access services. They coordinated care with other services and providers.

The department was not designed to meet the needs of patients living with dementia. We did not see any dementia friendly adjustments in the department, such as signage, orientation boards, clocks or anything to occupy patients living with dementia or learning disabilities.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss.

The service did not have information leaflets available in languages spoken by the patients and local community. All patient information leaflets had been temporarily removed from the department as an infection control precaution, so we were unable to see what information was generally available to patients.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or British Sign Language (BSL) interpreters when needed.

Patients were given a choice of food and drink to meet their cultural and religious preferences.

Urgent and emergency services

Access and flow

Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not always in line with national standards. The service was not meeting national standards to admit, treat, transfer or discharge patients within four hours. However, people could access the service when they needed it.

The Department of Health's standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the A&E. The trust achieved 69.8% compliance rate at the time of our inspection against an England average of 73.4%. For Type one A and E attendances this figure was 67.2% against an England average of 64.2%.

During the same month in 2021 the trust performance for all types of attendances was 92.1% against an England average of 83.9% so this showed a declining picture. However, number of monthly attendances had risen by around 2000 attendances per month since February 2021. The decline was similar to the regional trend.

The trust had reported no 12-hour breaches (waiting more than 12 hours from decision to admit to admission) from January 2020 until August 2021. The trust reported six 12-hour breaches in September 2021, 100 in October 2021, 162 in November 2021 and 202 breaches in December 2022. The trust reported 425 12-hour breaches in January 2022 and 461 breaches during February 2022. There had been a worsening trend in performance since October 2021.

We reviewed the data for patients in the ambulatory majors area from August 2021 to February 2022, from 1 August 2021 to 24 February 2022 there were 2964 patients treated in the ambulatory majors area. Of these 35.5% (776 patients) waited more than four hours in the area after a decision had been made to admit them and 3.6 % (78) patients waited more than 12 hours in that area after a decision had been made to admit them.

The trust had not submitted the percentage of type one attendances treated within 60 minutes of arrival into the department since July 2021 at the time of our inspection.

We saw that the service had a consistently higher number of attendances who were resus patients than the England average. They had a consistently lower number of patients who were majors patients than the England average and a consistently higher number of minors patients than the England average.

Data showed that the service consistently treated less type one attendances that were children than the England average.

There was a target for mental health patients to receive a mental health assessment by the psychiatry liaison team within one hour of arrival in the department. Trust records showed that from May 2021 to October 2021 there were 430 referrals to the psychiatry liaison team. Of these, 382 were classed as emergency referrals and 48 were normal, routine or urgent/serious. Of the emergency referrals 43.5% were seen within one hour and of all referrals, 43.6% were seen within one hour.

The trust was unable to provide any data on mental health assessments from November 2021 onwards as the change to the new electronic patient record system meant there was no interface between the trust system and that of the local mental health trust who carried out the assessments.

Managers and staff worked to make sure patients did not stay longer than they needed to. We saw that there was constant monitoring of the patient dashboard, showing the number of patients in each part of the department so that concerns about increasing numbers of patients could be escalated at the earliest opportunity.

Urgent and emergency services

The trust operated a teletracking system to aid admission of patients into the hospital from the emergency department. The teletracking system indicated to other departments within the hospital where a bed area was being cleaned or was the next to be cleaned. This aided in preparing a patient to be moved to a bed and starting to move the patient at the earliest opportunity. The system had brought down the time from a bed being cleaned to the next patient occupying the bed from up to one hour to an average of 35 mins.

There were several bed meetings each day. We observed one bed meeting and saw that there were clear messages about capacity within the hospital and the numbers of patients that needed to be admitted from the emergency department. There were clear messages about when patients would be discharged and good communication between departments so that there was a clear picture of the overall situation. At the time of our inspection, bed capacity was at around 95% and this was a steady situation. Despite, this, we saw that patients were moved out of the emergency department and admitted as soon as a bed became available, although some patients had a considerable wait before the bed becoming available.

The increased size of the ambulance handover area since our last inspection, had made a difference to the times for ambulance handovers and minimised patients being held on a corridor awaiting assessment. Patients brought in by ambulance could be assessed within a relatively short period of time before being moved into the main emergency department area. Patients arriving by ambulance were very rarely held on a corridor because there was no capacity.

There were plans in place to convert part of the existing red majors area into a rapid assessment and treatment area for patients brought in by ambulance when the need for a Covid-19 isolation area was stood down. This had the aim of reducing ambulance handover times even further

The service operated a reverse queueing system when reduced capacity meant that patients had to be held on a corridor as a last resort. A maximum of five patients could be held on the corridor and these were patients who were stable with a NEWS2 score of one or below or ready for discharge or awaiting admission. There was a standard operating procedure in place and for the reverse queueing system and an escalation plan if the maximum of five patients on the corridor was reached. We saw that there were no more than three patients on the corridor during our inspection.

Since our last inspection the trust had introduced a service known as see, treat, assess and refer (STAR) to the emergency department. This was staffed by GPs who were employed by the trust. Patients triaged to this area were generally those patients who could have been seen in a primary care setting, rather than an emergency department. Managers told us that many patients attended the department as they could not get a timely appointment with their GP.

The STAR area had five assessment cubicles and a third triage room for the department. On one day during our inspection, there were four GPs working in the area, in addition to a triage nurse. Patients presenting complaints were reviewed by the STAR team and those with complaints which appeared suitable for streaming to the STAR team were triaged by a member of the team and then by a doctor who would treat the patient and discharge them, stream them elsewhere in the emergency department or to a speciality location within the hospital. There was a target of the process to be complete within an hour of the patient registration. Managers told us that the STAR area was successful in treating and discharging less unwell patients in the shortest possible times.

The service had an emergency multidisciplinary unit (EMU) that enabled frail patients who may have had falls to be quickly assessed and, if necessary moved to the acute frailty unit to ensure that they got access to services that could support their health and help them to stay in their own homes. There were around four chairs in this area, as opposed to trolleys. Patients had to be fit enough to sit. Patients attending the EMU were generally discharged within a day.

Urgent and emergency services

The number of patients leaving the service before being seen for treatments was low.

Managers and staff started planning each patient's discharge as early as possible.

Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs.

Staff supported patients when they were referred or transferred between services.

Managers monitored patient transfers and followed national standards.

The service moved patients only when there was a clear medical reason or in their best interest.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. We were not assured that the service treated concerns and complaints seriously, investigated them in a timely way and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns.

The service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them.

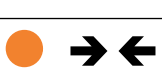
Managers investigated complaints and identified themes. Medical complaints were handled by the lead consultant and nursing complaints were investigated and dealt with by the matron. However, trust data showed that complaints were not always acknowledged or responded to within the timelines stated in the trust's policy for listening and responding to concerns and complaints. Trust data for the period from March 20211 to February 2022 showed that the average compliance rate for acknowledgement of complaints was 68%. The overall average compliance rate for responding to complaints within 65 days was also 68%.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service.

Staff could give examples of how they used patient feedback to improve daily practice.

Is the service well-led?

Requires Improvement 

Our rating of well-led stayed the same. We rated it as requires improvement.

Urgent and emergency services

Leadership

Local leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The emergency department was part of the urgent care division in the trust. This included urgent and emergency care and all medical wards and services.

There was a triumvirate leadership team for the urgent care division comprising nursing, operational and medical leadership. The division was led by a divisional director of nursing, divisional director and clinical lead.

Leadership programmes were available for senior staff, matrons and lead nurses.

Staff told us that senior leaders were not visible in the department but felt supported by departmental leaders and they felt comfortable to raise concerns with them.

We saw that lead nurses supported staff in the department when needed.

Vision and Strategy

The service did not have a vision for what it wanted to achieve or a strategy to turn it into action, developed with all relevant stakeholders.

The trust vision was “we will improve the lives of our community and provide excellence in health and care, through partnership and innovation.”

The trust values were a commitment to be safe, kind and effective.

We requested departmental or divisional strategies for the emergency department but did not receive these so we could not be assured that there was a strategy for the department or division to make improvements going forward, based on sustainability of services and aligned to local plans within the wider health economy.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff told us that they felt supported and valued by the local departmental leaders. There was a commitment from managers to seek feedback from staff on how they felt working in the department and take suggestions for improvements.

The matron was committed to receiving feedback on staff mental health and wellbeing and had an open-door policy.

We saw staff of all disciplines working well together and supporting each other within the department.

The department promoted some equality and diversity. There were trust-wide staff networks for LGBTQ+, disability and ethnic groups. The trust had an equality and diversity lead

Urgent and emergency services

Senior leaders expressed their pride in the staff and the hard work they had carried out. They reported good relationship between all medical, nursing and operational staff with them being flexible across departments and divisions particularly during the Covid-19 pandemic delivering safe and quality care.

Governance

Within the service, local leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There was a clear governance framework in place at a local level that enabled key messages to be communicated from the department to the board and vice versa. For assurance and oversight the division presented quarterly to the Executive team.

The emergency department had a formal governance framework that fed into the wider trust governance framework.

Governance committee and divisional committee meetings were scheduled monthly, however; these were stood down if staff were unable to attend due to operational pressures. Action plans showed that items were actioned and closed on completion.

Speciality meetings were held departmentally. We reviewed a sample of meeting minutes. Meetings were held monthly, bimonthly or quarterly with some regular agenda items and some variations in agenda items. This included capacity, staffing, the electronic system, performance, restoration, national updates and audits.

Quality governance meetings were held that included the trusts ward accreditation scheme.

There were daily system overview meetings, trust wide. These monitored live information such as the number of patients awaiting admission from the emergency department and any staffing issues.

Management of risk, issues and performance

Leaders and teams used systems to manage performance. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The division had a risk register that was reviewed monthly. Actions were discussed in the senior team meeting, divisional committee and governance meetings and escalation was made at the quality governance group. We were told that the risk management group is to be re-instated in April 2022 with a plan to oversee risk registers across the trust.

Risks were divided into local and divisional risks (those scoring as moderate and above).

Senior leaders shared the top risks for the division. These included 12 hour waits in the emergency department, falls and mandatory training for nursing staff.

There were nine risks on the register for the emergency department. Four of the risks were rated as moderate, such as having two paediatric nurses on duty for each shift; medicines management risks due to delays in moving patients to inpatient areas; a lack of middle grade doctors and a risk of delays to initial triage due to the electronic patient record system. Two risks were rated as high. These were an increasing number of 12-hour trolley wait breaches and patient and service demand outweighing the capacity of the emergency department.

We saw that the risk register contained details of controls in place to mitigate the risk to the lowest possible level and a next review date. Risks were reviewed regularly.

Departmental managers in the emergency department were aware of the risks in their own areas.

There was a standard operating procedure in place for escalation when the department was reaching full capacity.

Information Management

The service collected data, however, staff could not always find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. Data or notifications were not consistently submitted to external organisations as required. The information systems were integrated and secure.

Data was collected using a performance dashboard to measure performance. Included in this were the time from arrival to treatment, overall time in the unit and outcome such as discharge, transferred or left without being seen. However, the trust had not submitted the percentage of type one attendances treated within 60 minutes of arrival into the department since July 2021 at the time of our inspection.

Staff in the department were unable to readily access patient risk assessments on the electronic patient record system and this presented a risk to patient safety.

We saw that mandatory training compliance rates for information governance were very low in the department.

The department had an electronic dashboard showing daily performance data. This showed how many people were in the department in each area, waiting to be seen and how long each patient had been in the department.

There was a secure electronic incident reporting system in place that could be used to analyse themes and trends in reported incidents to enable reviews and appropriate mitigating actions to be taken.

Staff had access to policies and procedures via the trust secure intranet, although when accessed, it was not always clear when the policy or procedure had last been updated.

Patient records were stored securely on an electronic patient record system. Patient safety checklists were also held electronically, which gave a more robust method of tracking the completion of safety checklists and the timescales in which they had been conducted.

The trust operated a teletracking system that allowed staff across the hospital to see bed spaces that were vacant and in the process of being cleaned. In addition, the system tracked patient positions within the hospital and grounds. Each patient was given a wristband upon entry to the emergency department and the system tracked their whereabouts within the hospital so staff could see where each patient was, for example if they had gone for a scan or x-ray or had left the hospital.

Engagement

Local leaders and staff actively and openly engaged with patients and staff. They collaborated with partner organisations to help manage services for patients.

Patient feedback was actively sought using friends and family surveys although the friends and family cards had been removed during the pandemic. Patients were now sent a text survey to complete and that had reduced response rates.

The patient experience group were available to support patients with any feedback. Staff aimed to meet families face to face to address any emerging concerns. There was a recognition that patient voice was important.

Senior staff participated in 'drop ins' for staff and there had been forums for staff that had been working from home, such as administrative support.

Staff participated in ward meetings.

There was a weekly trust wide bulletin for staff.

Quality improvement projects were recognised and shared at a celebration event for staff.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Local leaders encouraged innovation and participation in research.

The trust had a continuous improvement strategy for 2020 to 2025 which had the aim of creating a culture where staff came to work to "do their work" and "improve their work" through strong leadership, governance, capability, projects, engagement and learning.

There was support from the executive level of the organisation to drive improvements and empower managers to make decisions to deliver quality improvements.

We saw limited examples of continuous improvement and innovation specific to the emergency department however staff were committed to delivering a restructure of the service to improve access and flow and ensure that patients were treated at the right time by the right people. Managers and staff were cited on how the build of the new same day emergency care unit and the conversion of part of the existing red majors area into a rapid assessment and treatment area would improve access and flow of patients through the department.

Surgery

Requires Improvement ● ➔➔

Is the service safe?

Requires Improvement ● ➔➔

Our rating of safe stayed the same. We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills to all staff. However, completion rates fell below the Trust's target in a number of areas.

Mandatory training was basic and did not meet the needs of all patients and staff. For example, training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia was not required for clinical staff. This meant staff may not have the necessary skills, knowledge and experience to provide care and treatment to patients with complex needs.

Training data for the surgery division was not presented in a way which allowed for specific analysis, but it was clear completion rates for planned care were below the target of 90% in a number of areas. For example, overall training completion for medical and nursing staff in planned care was 77.18%. Adult Basic Life Support training for medics and nurses had a completion rate of 60.09% and 75.68% respectively.

Managers monitored mandatory training and alerted staff when they needed to update their training. However, at the time of the inspection this had not resulted in compliance with the trust's targets for completion. Managers and staff told us restrictions on face to face training imposed during the pandemic and staff absence had a negative impact on training completion. Managers used an electronic system to monitor and record staff mandatory training module compliance rates. Managers alerted staff when training module compliance had lapsed or when training was due, and they booked training modules and assigned time for staff to complete mandatory training.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training specific for their role on how to recognise and report abuse. Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Training completion in safeguarding within planned care was variable but fell below the target of 90% for all staff groups. Level two training was completed by 83.03% of medics and 88.44% of nurses, while Level 3 training was completed by 53.57% of medics and 67.26% of nurses. All staff were supported by a named safeguarding lead officer who was trained to level four.

Cleanliness, infection control and hygiene

Staff kept equipment and the premises visibly clean. The service used systems to identify and prevent surgical site infections. However, staff did not always use equipment and control measures correctly to protect patients, themselves and others from infection.

Surgery

Ward areas were visibly clean and had suitable furnishings which appeared to be clean and well-maintained. Staff cleaned equipment after patient contact but did not routinely label equipment to show when it was last cleaned. Disposable curtains were not always dated to show when they should be replaced.

The service completed their own checks which indicated they performed well for cleanliness, but cleaning schedules were not routinely displayed as required. Records were not always completed which meant it was difficult to establish if cleaning had been completed in accordance with the schedule and safe-practice. There was no guidance for the completion of deep cleaning. We observed practice in relation to deep cleaning which placed patients and staff at avoidable risk of harm. For example, curtains and bed linen from a high-risk area were removed while two patients lay in bed.

Staff did not always follow infection control principles including the use of personal protective equipment (PPE). We saw staff on two wards wearing their masks below the nose. We also saw staff removing their used aprons in a manner which did not following safe-practice guidelines for donning and doffing.

Staff worked effectively to prevent, identify and treat surgical site infections. Staff used records to identify how well the service prevented infections. Performance was equal to, or better than the national average for the previous 12 months.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff were trained to use them but did not always do this in accordance with safe practice. Staff managed clinical waste in accordance with the relevant guidance.

The design of the environment did not comply with current national guidance. For example, three of the four wards we visited where patients were admitted overnight did not have bathroom facilities within the bays. One of these wards did not have sufficient ventilation to maintain a comfortable temperature or to ensure regular changes of air.

Areas of the main building had been put into alternative use which compromised patient and staff safety. The surgical assessment unit was temporarily re-located to an area which did not allow for social distancing. In the same area we saw fire doors which were not being used safely. One door was held open with a wedge. While another had a side-panel which was not locked in position as required. We checked again on the second day of the inspection and found the wedge was in use again.

The service had enough suitable equipment to help them to safely care for patients. Staff carried out daily safety checks of specialist equipment and reported issues for resolution. Patients could reach call bells and staff responded quickly when called.

At our last inspection the trust was in breach of regulation because substances hazardous to health were not always stored safely. As part of this inspection we checked storage and found substances such as cleaning materials were stored safely in accordance with the relevant guidance. Staff disposed of clinical waste safely.

Assessing and responding to patient risk

Staff did not always complete and update risk assessments for each patient. Staff identified and quickly acted upon patients at risk of deterioration

Surgery

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Staff used national early warning score systems (NEWS2) and carried out routine monitoring based on patients' individual needs to ensure any changes to their medical condition could be promptly identified. Compliance with NEWS2 was subject to regular auditing.

Staff did not always complete and review risk assessments for each patient. There was limited assurance that risk was assessed and regularly reviewed provided by the electronic patient record (EPR) because staff experienced difficulty in navigating the system. We accessed 31 patient records from six wards. We found some required risk assessments were missing in four of the records. We also found some staff who were unable to use the EPR to view risk assessments when they had been completed.

Irrespective of issues with the EPR, staff knew about and dealt with any specific risk issues. Performance in relation to the management of sepsis, venous thromboembolism (VTE), falls and pressure ulcers was regularly audited and within the expected range.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a patient's mental health). Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide.

Shift changes and handovers included all necessary key information to keep patients safe. Staff attended safety huddles and handover meetings at key points each day. Important information was added to the patient records.

At our last inspection the trust was in breach of regulation because staff were not always following the World Health Organisation (WHO) checklist. As part of this inspection we observed five theatre teams undertaking the 'five steps to safer surgery' procedures, including the use of the WHO checklist and found that the theatre staff completed safety checks before, during and after surgery. Performance was audited monthly by the trust. A small number of individual errors and concerns were identified by the process which were reported appropriately. Action was taken in relation to these findings to improve patient safety. There were no recurring themes or trends identified in the previous 12 months.

Nurse staffing

The service did not always have enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service had enough nursing and support staff to keep patients safe. Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. The ward manager could adjust staffing levels daily according to the needs of patients.

The service had enough nursing staff to keep patients safe. However, actual nursing staff did not always match the planned number. Over the course of the inspection, we saw deficits in the planned nursing numbers in three of the six wards we visited. Staff we spoke with confirmed nurses were not always available in the numbers planned. They told us how gaps were usually filled by the re-deployment of nurses from other wards and the allocation of additional health care assistants. We saw evidence of this practice during the inspection.

The service had low vacancy, turnover and sickness rates for nursing staff. In the planned care division, the turnover rate was between 6.13% and 7.17%. The sickness rate was 4.68%. Each of these figures compared favourably to those of the trust as a whole.

Surgery

The service had reducing rates of bank and agency nurses. Managers limited their use of bank and agency staff and requested staff familiar with the service. Managers made sure all bank and agency staff had a full induction and understood the service.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The service had enough medical staff to keep patients safe. The medical staff matched the planned number. The service had low vacancy, turnover and sickness rates for medical staff. At the time of the inspection, the vacancy rate for medical staff was less than 5%. In the planned care division, the turnover rate was 8.75% and the sickness rate was 1.34%. Each of these figures compared favourably to those of the wider trust.

Managers could access locums when they needed additional medical staff. Managers made sure locums had a full induction to the service before they started work.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. The service always had a consultant on call during evenings and weekends.

Records

Staff kept detailed records of patients' care and treatment. Records were stored securely and up-to-date but not always easy to access

Patient notes were comprehensive, but not all staff could access them easily because the EPR system was difficult for some staff to navigate. For example, we asked one member of staff to show us the risk assessments for four patients. They were unable to locate them on the EPR. However, the risk assessments were subsequently located by another member of staff who was more adept at using the EPR. Staff maintained some paper records and had developed different ways to store and retrieve information from the EPR. When patients transferred to a new team, their records were immediately available. In addition to the electronic records, each patient had a transfer document completed.

At our last inspection the trust was in breach of regulation because patient records were not always stored securely. As part of this inspection we checked facilities and security arrangements for electronic records. Records were stored securely in the surgery division. Paper records were stored in lockable cabinets on each ward. Electronic records could only be accessed after entering secure log-in details.

Medicines

Systems and processes to prescribe, administer, record and store medicines were not always safe.

Staff followed systems and processes to prescribe and administer medicines. However, they identified issues with the EPR which caused risk. For example, the absence of warnings to indicate if the administration of prescribed medicines was delayed or they had been administered for longer than prescribed. The trust did not have a system which allowed them to capture and report relevant data from the EPR in relation to delayed or prolonged administration of medicines. Data drawn from incident reports indicated there had been one incident in the previous 12 months where a medicine had been administered for longer than prescribed.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines.

Surgery

Staff completed medicines records accurately and kept them up-to-date. Staff stored and managed prescribing documents safely. Staff did not monitor the temperature of refrigerators used to store medicines consistently. Staff did not routinely monitor and record the temperature of rooms where medicines were stored. This meant there was a risk some medicines were stored outside of the recommended, safe temperature.

Staff followed national practice to check patients had the correct medicines when they were admitted or they moved between services. Staff learned from safety alerts and incidents to improve practice.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy.

The service had five never events between April 2021 and February 2022. Managers shared learning about never events with their staff and across the trust.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Staff reported serious incidents clearly and in line with trust policy. Between December 2020 and December 2021, seven serious incidents were reported in relation to the surgical division. Each had been investigated in accordance with trust policy.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong.

Managers debriefed and supported staff after any serious incident. Staff received feedback from investigation of incidents, both internal and external to the service. Feedback was shared through bulletins, safety huddles and face to face meetings. Staff met to discuss the feedback and look at improvements to patient care.

Records showed staff had been updated and made aware of changes to improve safety. There was evidence that changes had been made as a result of feedback. For example, the process for the production and distribution of patient letters had been changed following an incident.

Is the service effective?

Requires Improvement  

Our rating of effective stayed the same. We rated it as requires improvement.

Surgery

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff understood their responsibilities to protect the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. For example, The National Institute for Health and Care Excellence (NICE) and the Royal Colleges' standards. Theatre teams used checklists based on World Health Organisation guidance. Staff also used modified safety checklists for specific surgical procedures. For example, in ophthalmology.

Policies and procedures reflected current guidelines and were easily accessible through the provider's intranet. We looked at a selection of the policies, procedures and care pathways and these were up to date and based on current national guidance.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink including those with specialist nutrition and hydration needs. Staff fully and accurately completed patients' fluid and nutrition charts where needed.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. We saw a small number of patient records where this had not been completed as expected. Specialist support from staff such as dietitians and speech and language therapists was available for patients who needed it.

Patients waiting to have surgery were monitored to ensure they were not left nil by mouth for long periods.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Patients told us they received pain relief soon after requesting it. Staff prescribed, administered and recorded pain relief accurately.

Patient outcomes

Staff told us they monitored the effectiveness of care and treatment, but some information on patient outcomes was not provided when requested.

The service participated in relevant national clinical audits and was part of the Advancing Quality Programme (AQ) for NHS trusts. However, the data made available by the trust in response to our requests was limited. For example, data

from 2020 in relation to hip and knee surgery indicated the service performed better than expected in relation to the speed of patient discharges and emergency readmissions when compared to the national average. However, the trust did not provide recent data in relation to other procedures. Historic data indicated outcomes for patients were generally positive and met expectations, such as national standards.

Managers and staff told us they carried out a programme of audits to monitor performance over time. They told us the results were used to improve patients' outcomes. However, we only saw audit data relating to hip and knee surgery.

Competent staff

The service did not always make sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Managers gave all new staff a full induction tailored to their role before they started work. Managers supported staff to develop through yearly, constructive appraisals of their work. Clinical competencies were refreshed and assessed as part of a core skills course. However, data provided by the trust showed 12.9% of staff working in planned care had completed the course. This meant the trust could not be assured staff remained competent to carry out their duties.

The clinical educators supported the learning and development needs of staff. Managers made sure staff attended team meetings or had access to full notes when they could not attend.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Managers made sure staff received any specialist training for their role. Managers had systems to identify and report poor staff performance promptly and supported staff to improve where required.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. We saw evidence of effective multi-disciplinary working in records where this was required. For example, patients were referred to physiotherapy services as required and their progress was recorded in their notes.

Staff worked across health care disciplines and with other agencies when required to care for patients. The needs of patients were considered holistically. There was evidence of appropriate engagement with other health and social care services to ensure patients were discharged safely with the right support in place.

Seven-day services

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

Consultants led daily ward rounds on all wards, including weekends. Patients were reviewed by consultants depending on the care pathway.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week.

Surgery

Health promotion

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

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. The service had relevant information promoting healthy lifestyles and support on wards. We saw information to support smoking cessation, promotion of exercise and healthier diets displayed on notice boards outside and within each ward.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff gained consent from patients for their care and treatment in line with legislation and guidance. When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions.

Staff made sure patients consented to treatment based on all the information available. Records showed treatment options were discussed in appropriate detail before consent was sought. Staff recorded consent in the patients' records. However, one of the records we saw contained conflicting information about the patient's capacity to consent to care and treatment.

Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them. Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. Staff implemented Deprivation of Liberty Safeguards in line with approved documentation.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good.

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients in a respectful and considerate way. Staff followed policy to keep patient care and treatment confidential.

Patients said staff treated them well and with kindness. Each of the patients we spoke with was complimentary about the staff and the way they were treated. Comments included, 'They're brilliant', 'They do everything well' and 'The care is perfect.'

Surgery

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Individual needs were considered as part of the assessment and care planning process. Records were sufficiently detailed to provide staff with information about patient's needs and preferences.

Emotional support

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

Staff gave patients help, emotional support and advice when they needed it. Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Patients' records contained sufficient personal information to guide staff when providing emotional support. Staff shared examples of how they could adapt their practice to accommodate individual needs and preferences.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. Information was provided in face to face consultations and in written form. The patients we spoke with confirmed staff had taken time to ensure they understood. However, five of the 12 patients we spoke with said communication about their care and treatment was inconsistent. Staff were aware of the need to use communication aids where necessary.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Information about giving feedback was clearly displayed. Patients gave positive feedback about the care treatment they received at the trust. However, specific data was not available for the surgical division.

Staff supported patients to make advanced decisions about their care. These decisions were recorded in patient' notes.

Is the service responsive?

Requires Improvement 

Our rating of responsive went down. We rated it as requires improvement.

Service delivery to meet the needs of local people

The service did not always plan and provide care in a way that met the needs of local people and the communities served. It worked with others in the wider system and local organisations to plan care.

Managers did not always plan and organise services so they met the needs of the local population. For example theatre time was not used efficiently to maximise the number of procedures. This meant patients were more likely to experience a delay, or cancellation.

Surgery

Not all facilities and premises were appropriate for the services being delivered. For example, the Surgical Assessment Unit was temporarily housed in a part of the hospital that did not allow for efficient transit through the department, or for safe social distancing to be used. Some wards were designed without toilet and bathing facilities within bays. Patients had to access these facilities in busy, communal areas. There was insufficient suitable storage space within theatres to store essential equipment.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. Patients were appropriately separated in accordance with their preferences.

Managers monitored and took action to minimise missed appointments. Managers ensured that patients who did not attend appointments were contacted and a new appointment was made.

The service relieved pressure on other departments in the trust because they could treat patients without the need for admission to a ward.

Meeting people's individual needs

The service was not fully inclusive and did not always take account of patients' individual needs and preferences. Staff made some reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Staff understood their responsibilities to ensure patients received individualised care which met their needs and preferences. Additional, specialist support and resources were available if required. For example, staff could request support to fully consider the communication and care needs of patients living with dementia. However, wards were not designed to meet the needs of patients living with dementia. Each of the six wards we visited was different in design and configuration, but this did not routinely accommodate the additional needs of patients living with dementia in relation to; colours, layout, equipment and safety.

Staff did not always support patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. Staff confirmed they were familiar with the documents, but did not always have sufficient information to complete them.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. The service had information leaflets available in languages spoken by the patients and local community. Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff had access to communication aids to help patients become partners in their care and treatment.

Patients were given a choice of food and drink to meet their cultural and religious preferences.

Access and flow

People could not always access the service when they needed it and did not always receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards.

Surgery

Managers monitored waiting times. Data was provided for the period of October 2021 to January 2022. The data showed a decline in performance over this period. The percentage of patients waiting in excess of 18 weeks for treatment across surgical disciplines increased from 46% to 59%. As of January 2022, there were 25,302 patients on the waiting list. Of those, 14,928 had been waiting longer than 18 weeks for treatment.

Performance in relation to cancer care between April and December 2021 was below target in all areas except one. The 14 day target for referrals measured 68% against a target of 93%. The 14 day target for referral for symptomatic breast cancer measured 13% against a target of 93%. Other measures performed closer to target. For example, the target of 62 days from a GP referral to treatment measured 72% against a target of 85%. While the 31 day target from decision to treatment being started measured 91% against a target of 96%.

The trust had recovery plans in place and in development to improve performance. Measures included changes the EPR system to provider better data and outsourcing of procedures to private sector partners.

Managers worked to minimise the number of surgical patients on non-surgical wards and made sure they had arrangements for surgical staff to review them. Managers also worked to keep the number of cancelled operations to a minimum. However, in the six months prior to this inspection, 197 procedures had been cancelled on the day. 92 of the cancellations were attributable to issues under the control of the trust. For example, insufficient theatre time and lack of equipment. When patients had their operations cancelled at the last minute, managers made sure they were rearranged as soon as possible. However, this was not always within national targets and guidance.

Managers monitored that patient moves between wards were kept to a minimum. Staff did not move patients between wards at night.

Managers and staff started planning each patient's discharge as early as possible. Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs. Discharge notes were completed in appropriate detail with the involvement of the patient, staff, families and allied health professionals.

Managers monitored the number of patients whose discharge was delayed, knew which wards had the most delays, and took action to reduce them. Data provided for the whole trust from October 2021 to February 2022 showed an average of 56 patients per day whose discharge had been delayed. The majority of delays were caused by factors not under the control of the trust. For example, availability of social care placements.

The trust had developed a strategy to address poor performance which included; more effective data analysis, weekly meetings to assess compliance and partnership working to outsource some procedures. Please refer to the well-led section for further information in this regard.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff, but they did not always respond in accordance with their own targets. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas. Staff understood the policy on complaints and knew how to handle them.

Surgery

Managers investigated complaints and identified themes. However, complaint response times did not meet trust' targets. Between March 2021 and February 2022, 68% of complaints were acknowledged within the three day target. The same percentage of complainants (68%) received a formal response within the target of 65 working days. Of the 83 complaints received during this period in relation to planned care, 23 were upheld.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Managers shared feedback from complaints with staff and learning was used to improve the service. Staff could give examples of how they used patient feedback to improve daily practice. For example, in relation to the quality and timeliness of communication. The development of a patient experience helpdesk provided patients with access to informal complaint resolution.

Is the service well-led?

Requires Improvement 

Our rating of well-led stayed the same. We rated it as requires improvement.

Leadership

Local leaders had the skills and abilities to run the service. They understood the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The local leadership team was appropriately skilled and experienced. Staff we spoke with were positive about the leadership of the surgical division. However, we were told communication in response to concerns being raised was not always effective.

Leaders spoke openly and honestly about the impact of the pandemic and their ability to reduce waiting lists in a timely manner. They had a recovery programme in place which involved senior managers in the development and review of initiatives to reduce the time patients waited for surgery. However, issues with the implementation of the new EPR system, staffing and theatre space were cited as barriers to progress.

Vision and Strategy

The trust had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress. However, while it was mentioned in other documents, there was no specific strategy for surgery.

The trust had an overarching strategy with three distinct strands. The clinical strategy spanned 2019 to 2024, people strategy spanned 2021 to 2026 and continuous improvement which spanned 2020 to 2025. We requested the strategy document for the surgery as part of the inspection, but did not receive anything which specifically detailed plans for the division.

Surgery

Culture

Staff did not always feel respected, supported and valued. The service provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns but this did not always result in effective action being taken.

The majority of staff we spoke with were positive about the culture within the surgical division. They told us they felt supported and could raise concerns freely. However, 14 of the 15 nursing staff we spoke with expressed concern about the manner in which the new EPR was introduced and the impact this had on their ability to complete work efficiently and effectively. They told us concerns had been shared with senior managers, but the training and support put in place had not been sufficient. We also received negative feedback from other staff working in the division. They reported a culture where bullying was present and they did not always receive feedback when they raised concerns. They told us they had shared these concerns with senior managers, but the culture persisted.

Governance

Leaders operated effective governance processes within the surgery department. Staff were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Each of the staff and managers we spoke with was clear about their own roles and responsibilities. Governance systems were aligned to best-practice models for the NHS and provided mechanisms to share learning. This included audits, regular communications and revised procedures as well as opportunities to discuss changes and learning with colleagues. However, these systems were not always used effectively by the trust to identify serious concerns and reduce risk. The surgery division was represented at the planned care governance meeting by the clinical director. This meeting reported to the planned care board through quarterly meetings and the board assurance framework.

Management of risk, issues and performance

Leaders and teams did not always use systems to manage performance effectively. They did not routinely identify and escalate relevant risks and issues and identify actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

During the inspection we identified significant risk associated with fire safety, infection control measures and patient records. We were told systems were in place to audit and report on each of these areas. However, these systems had failed to identify the omissions and mitigate the risks we found. At the time of the inspection the risk register for the planned care division held 28 risks assessed as high. The majority of the risks we identified were not included on the register. Risk was reviewed on a monthly basis by the Divisional Board. The Board was tasked with considering the clinical, financial, divisional and corporate impact of the risk.

Information Management

The service collected data and analysed it. However, staff could not always find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Surgery

IT systems used for information management and governance did not always enable staff and leaders to perform their roles effectively. For example, staff were not all able to make effective use of the EPR system. In addition, the trust did not have a reliable system for monitoring patients on the surgical waiting list. We were told that the electronic patient tracking list system was not always accurate. Manual systems were in use to monitor waiting times.

Engagement

Leaders and staff described how they engaged with patients, staff, equality groups, the public and local organisations to plan and manage services.

We requested information about these activities which was specific to surgery. The trust did not break-down the information in a manner which allowed us to report on performance in this regard.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

There was a clear system in place to support improvement and innovation. Suggestions were backed with a business case and an equality impact assessment before being escalated. Staff and senior managers provided examples of improvement and innovation including changes to anaesthesia practice and the hospital at home service. Both initiatives aimed to reduce the length of patient stay.

Maternity

Inadequate

Is the service safe?

Inadequate

We previously rated this service alongside gynaecology so we cannot compare the ratings. We rated safe as inadequate.

Mandatory training

The service provided mandatory training in key skills to all staff but had not made sure everyone completed it.

The trust provided a training policy which was undated. This covered required training within a core skills framework. Core skills training compliance figures supplied by the trust for the Women and Children's Directorate showed only 19 of 253 staff (7.5%) had completed the core skills training. The document did not clearly specify the date of this compliance.

Staff did not keep up-to-date with their mandatory training. Medical staff received and kept up-to-date with their mandatory training. The mandatory training was not comprehensive to meet the needs of women and staff.

PROMPT training is an evidence-based multi-professional obstetric emergencies training package that has been developed for use in local maternity units. It is recommended in the NHS England National Maternity Review: Better Births (2016). We reviewed the mandatory training plan for 2022 and whilst they included training in some obstetric emergencies such as post-partum haemorrhage and shoulder dystocia, they did not include training in other obstetric emergencies such as cord prolapse, antepartum haemorrhage or breech birth.

The maternity report to Board in March 2022 reported 100% compliance with "90% of each maternity unit staff group having attended an 'in-house' multi-professional maternity emergencies training session"

However, there was limitations to the maternity emergencies covered in the inhouse training package and we spoke with one consultant anaesthetist who told us that the annual Practical Obstetric Multi-Professional Training (PROMPT) was not mandatory for them.

Only 55% of community midwives attended the Student Midwife integrated Learning Environment [SMiLE] course in 2021-22. We were not assured that clinical staff completed training on recognising and responding to women with mental health needs, learning disabilities or autism.

The mandatory training plan for maternity staff 2022 did not have any training on mental health, learning disabilities or autism listed.

Safeguarding

Staff understood how to protect women from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

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

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

At the time of the inspection the trust reported Mental Capacity Act Training, including DoLS (delivered as part of Level 2 training) compliance was 87.86%. Female Genital Mutilation Training (delivered as part of face-to-face level 3 safeguarding children training) compliance was 95.2% and Prevent Training compliance was 79%.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff followed the baby abduction policy and undertook baby abduction drills.

Staff told us they had received training in baby abduction. Entrance doors to the Cestrian ward, the antenatal and postnatal ward were secured meaning no one could enter or exit the clinical areas inappropriately. However, in other clinical areas such as the central labour suite there was a button for anyone to exit the area unsupervised.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect women, themselves and others from infection. They kept equipment and the premises visibly clean.

All clinical areas appeared clean and had suitable furnishings appeared were clean and well maintained. We observed cleaning schedules that were up to date during our inspection.

Staff followed infection control principles including the use of personal protective equipment (PPE). During our inspection we observed staff using the correct PPE at appropriate times when carrying out clinical care.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We observed there were “I am clean” stickers on equipment throughout the maternity service.

We noted that the hand hygiene audit was 100% at the time of the inspection.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff managed clinical waste well.

The design of the environment did not always follow current national guidance. There was only one maternity theatre on the central labour suite. This was due to the age of the building and during our inspection we were told of plans to build a purpose built maternity unit and we saw a proposal paper for a business case to this effect.

The trust board paper (March 2022) identified the lack of a second theatre on Central Labour Suite as a significant risk. It stated that patients were at risk of deterioration when women requiring theatre were transferred over the main bridge. It reported six patient safety incidents linked to this risk within the previous six months.

It also reported that undertaking caesarean sections in main theatre was a significant distance from the Neonatal Unit. This would increase the time taken for the neonatal team to arrive in main theatre over the bridge into the main hospital and also the transfer time back to the neonatal unit for the baby from the theatre. To mitigate this risk all elective caesarean sections were undertaken in main theatre B however there was an increasing number of procedures being undertaken within the unit.

Maternity

Any baby that was to be delivered that may require Neonatal team input was being delivered in the maternity theatre within central labour suite. However, this could not always be predicted. At the time of the inspection Room 15 was used as a second theatre on the central labour suite, as a back-up theatre, however, it did not comply with all theatre regulations.

The service did not have enough suitable equipment to help them to safely care for women and babies. We reviewed the service's SBAR reports into women who had undergone an unplanned emergency hysterectomy and it was highlighted that a delay in carrying out this procedure had occurred due to having to request a hysterectomy kit from another part of the hospital before being able to perform the lifesaving surgery.

Staff carried out daily safety checks of specialist equipment. We observed that specialist equipment was checked regularly as per recommendations. The service had a system in place whereby staff would manually report if a piece of equipment was faulty or due a service.

The service had some suitable facilities to meet the needs of women's families. We observed that the service had a bereavement room at one end of the labour ward which we were told was utilised for women and their families experiencing a bereavement.

We observed clinical waste being stored and disposed of safely. Sharps bins were used correctly.

Assessing and responding to risk

Staff did not always complete or update risk assessments for each woman nor take action to remove or minimise risks. Staff did not always identify or act quickly upon women at risk of deterioration.

Staff used a nationally recognised tool to identify women at risk of deterioration.

In the 10 sets of womens' maternity records we reviewed we found the appropriate use of Modified Early Obstetric Warning Score (MEOWS) to identify women at risk of deterioration. However, the service used a single emergency trolley on both the central labour suite and Cestrian ward. We were told that these trolleys had all of the equipment for use in the event of an emergency and that stocking and checking compliance had improved with these trolleys versus grab bags. On each trolley were flow charts for certain obstetric emergencies such as post-partum haemorrhage (PPH), shoulder dystocia and eclampsia. There were none for other obstetric emergencies such as antepartum haemorrhage (APH), breech birth or cord prolapse. These latter three were not scheduled on the PROMPT mandatory study days for the coming year.

During our inspection we were told that the information technology system did not correctly calculate womens' venous thromboembolism (VTE) risk. Therefore, staff were having to carry out this risk assessment manually to mitigate the risk to women. During inspection, we reviewed electronic records, this confirmed that the electronic system did not correctly calculate risks such as VTE.

Other potential risks which were not being addressed were women having their labours induced on Cestrian ward with limited ability to monitor their wellbeing appropriately due to being in side rooms; minimal staffing on elective caesarean section days; a lack of certain obstetric emergency guidance for staff and no priority lift calling to get women to the theatre on the ground floor in an emergency.

Maternity

Midwifery staffing

The service did not have enough maternity staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment.

Over time nursing and midwifery staff sickness at a trust level has gradually increased between December 2020 and November 2021. National data reviewed as part of the inspection, showed that overall sickness rates remained below the North West average throughout the year.

For the maternity core service, there had been an increasing trend for sickness rate of nursing and midwifery staff over the last 12 months. In November 2021 it was at 7% slightly reduced from the highest levels during summer 2021. The turnover rate for nursing and midwifery staff peaked at 7.3 WTE leavers in August 2021, but on average 1.8 WTE per month from December 2020 to November 2021.

In the 12 months prior to the inspection the service was closed for a total of 144 hours and 35 minutes, during these closures' women were unable to access the maternity unit. Thirty-three women had to be diverted to other maternity units for some or all aspects of their care. Of these, 13 women birthed their baby in a maternity unit not of their choosing. The main reasons cited for these closures were acuity with approximately a third being due to short staffing. We reviewed the incident reports for 2021 and over the whole year the lack of staff was the most reported incident and was almost twice as high as the next highest category.

The service did not consistently have enough midwifery staff to keep women and babies safe. The labour ward coordinator was not always supernumerary. Women did not receive 1:1 care when in established labour. The supernumerary status of the coordinator and the 1:1 care in labour provision was not monitored by managers, for example by audits. The service relied on staff submitting an incident form to report that the service had been too busy for them to provide safe care. This was not in line with the 'Safer Childbirth' recommendations, (October 2007), which state: 'every labour ward must have a rota of experienced senior midwives as shift coordinators, supernumerary to the staffing numbers required for one-to-one care'.

Midwives in differing clinical areas told us they frequently worked over their contracted hours and missed breaks which they were not paid for due to staff shortages and high patient acuity.

The antenatal and postnatal ward [Cestrian ward] did not have a ward manager at the time of our inspection. Staff told us that on elective caesarean section days, Tuesday and Thursdays, one of the midwives had to stay with the women birthing their babies by caesarean section, a second had to leave the ward to take the second woman on the list to theatre (in the main hospital building) and bring the first back and the maternity support worker had to scrub for the theatre list. We were told that in the absence of the ward manager, this had meant that on occasions there was only one midwife and one maternity assistant on the ward. We escalated this to the interim Head of Midwifery during our inspection and were told that there was never only one midwife on the ward. However, during inspection we noted only one midwife on the ward on three separate occasions.

The service utilised a nationally recognised tool to calculate staffing requirements. However, the number of midwives, maternity support workers and midwifery assistants did not always match the planned numbers. We were told that there should be 27 community midwives but that seven were off work at the time of our inspection. This meant the remaining 20 midwives had to cover both their own clinics and visits as well as the other workloads of those off sick. The maternity safety champions meeting minutes of January 2022 showed that lack of staff was the second highest subcategory of reported incidents in the November 2021 Quality and safety report.

Maternity

Community midwives provided support to the central labour suite when required, in the period January to December 2021 community midwives had been called to work on the central labour suite on 32 separate occasions for a total of 158.2 hours. This means that on 32 occasions during the time specified, the community midwife team was depleted due to staff being called into the trust.

From the Maternity update paper to the Trust Board in March 2022 it was reported that as part of the Ockenden recommendations, providers were asked to identify staffing gaps that would benefit from additional funding. The trust was successful in a bid for six WTE midwives however, at the time of this report only one WTE midwife had been recruited due to limited applicants.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep women and babies safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

In September 2021, the proportion of consultant staff reported to be working at the trust was higher than the England average and the proportion of junior (foundation year 1-2) staff was about the same.

Sickness rates for medical staff were low. Over time staff sickness at trust level had reduced between December 2020 and November 2021. It has been below the sector average since February 2020, though showed signs of increasing trend in latest four months data available.

The sickness rate for Medical staff within maternity core service has generally remained low through the last year.

In the maternity core service, the turnover rate for medical staff fluctuated throughout the year though at a much lower level than other core services with no more than two WTE leavers in any month.

From the Maternity update paper to the Trust Board in March 2022 it was reported that as part of the Ockenden recommendations, providers were asked to identify staffing gaps that would benefit from additional funding. The trust was successful in a bid for 0.9 WTE obstetrician. However, at the time of this report the 0.9 WTE obstetric post had been adapted and put back out to advert due to no applicants.

Staff told us that the service always had a consultant on call during evenings and weekends. We were told that consultant obstetricians were onsite seven days per week between 08.30 and 20.30 hours each day and were on call outside of these hours. There were two consultant led ward rounds twice per day.

Records

Staff did not always keep detailed records of women's care and treatment. Records were not always clear, up to date, nor easily available to all staff providing care. Staff did not always have access to up-to-date, accurate and comprehensive information on women's care and treatment.

Women's notes were not always comprehensive. The trust had implemented a new information technology records system across the trust in July 2021 and in maternity they had to adapt to a combination of the new EPR system and the existing paper records.

The electronic patient record (EPR) was not an effective safe documentation system in women's and children's services. The EPR system was not being used to document intrapartum care. Patient risk assessments were being documented on

paper booklets with a discharge summary being completed on EPR. However the trust was unable to provide data to demonstrate that risk assessments were completed for all women. Having no antenatal and intrapartum risk assessments on EPR is a breach of Ockenden recommendations to document an ongoing risk assessment of women. This was noted on the risk register; however evidence of mitigations were limited.

A requirement of all maternity services is to enquire about domestic abuse. The response should be recorded in the woman's records. There was a facility to do this on the electronic system at the booking appointment but if a woman was accompanied by her partner she should not be asked. If a woman was accompanied by her partner at all antenatal appointments, there was nowhere to document whether she had been asked this question. During our inspection we reviewed 10 complete sets of maternity records, of which it was highlighted in three sets that the woman had not been asked. One failsafe for this system is to audit the records to ascertain that all women had been asked but we were told that staff were unaware if this was an option on this new EPR system. We saw evidence such as internal emails to staff about improving documentation in women's records.

We found that when women transferred to a new team, there were no delays in staff accessing their paper records. We noted that records were stored securely.

Medicines

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

Staff followed systems and processes to prescribe and administer medicines safely.

Community midwives collected their medications from the central labour suite store and monitored when they were nearing their expiry date. Entonox was ordered for women planning a home birth and delivered directly to the woman’s home.

Staff completed medicines records accurately and kept them up to date.

Medicines records were prescribed and documented on the services online information technology system. We reviewed 10 of these during our inspection and found all to be satisfactory.

Staff stored and managed all medicines and prescribing documents safely.

During our inspection we observed that all medicines were stored correctly and securely. For medicines that had to be stored in the fridges, we observed that fridge temperatures were checked daily to ensure the safety and efficacy of the medicines.

However, we noted two incidents, one relating to a controlled drug error and another where induction of labour drugs were found that could not be accounted for.

Incidents

The service did not manage safety incidents well. Managers did not consistently investigate incidents or share lessons learned with the whole team and the wider service.

Staff reported incidents and near misses in line with trust/provider policy.

Maternity

Staff had been reporting incidents, but the service had not investigated two of the five incidents of major post-partum haemorrhages and/or admission to the intensive care department that resulted in hysterectomy. Whilst the trust had a Postpartum Haemorrhage Policy in place, there was evidence from the clinical reviews of the Post-Partum Haemorrhage undertaken by clinicians within the trust, using the Situation, Background, Assessment and Recommendation [SBAR] methodology. The SBAR methodology, is a system developed by the NHS Institute for Innovation and Improvement. Highlighted that clinicians were not always following the trust guidance when undertaking SBAR's.

We found 21 incidents affecting 13 patients. Five of the patients required an unplanned hysterectomy with an unplanned return to theatre. One of these was classified as severe harm, two classified as moderate harm and two classified as no harm in relation to an unplanned hysterectomy. This mean that the trust could not be assured that it recognised and addressed incidents that were significant.

The service had not consistently reported incidents to external stakeholders. The Care Quality Commission were only made aware when a whistle blower contacted us. At an internal meeting to discuss one such case, other clinicians working at the trust raised concerns about the number of such incidences. The service then decided to carry out a cluster review into the relevant cases. The actions identified through this review in December 2021 were still not implemented or completed at the time of our inspection.

The service had maternity safety champions who met every two months. They reviewed safety incidents including themes and trends however the action log for the meeting in January 2022 had no reference to actions from the themes and trends information.

Over the last 12 months there has been one never event reported for maternity core service in October 2021. This related to a retained swab post forceps delivery.

Managers told us they shared learning about never events with their staff and across their trust but did not share learning with their staff about never events that happened elsewhere.

We reviewed the never events from August 2020 which stated the learning would be shared across all clinical teams. Staff told us they reported all incidents and we noted that the service had processes and procedures in place. However, despite repeated requests to the trust, we did not receive the information we requested relating to managing incidents and any shared learning. This meant we were unable to fully assess how effectively incidents were managed and learning from incidents was shared.

We did not see any evidence that managers had shared never events which had occurred at other maternity units. Incidents from maternity units across the region, were shared with senior midwives through local maternity service boards [LMS] and NHSE/I updates. This meant that staff where not given the opportunity to share learning from incidents that had happened in other maternity units.

Between January 2021 and January 2022, the same time period the trust reported eight STEIS incidents.

Staff understood the duty of candour. Staff were able to articulate to us their understanding of duty of candour and what they would do to comply with this. We were shown documentation that highlighted that duty of candour had been followed when something had gone wrong.

Managers did not consistently investigate incidents thoroughly. Women and their families were not involved in these investigations.

Maternity

The service carried out a more in depth 72 hour review after an incident but did not always carry out a root cause analysis. We reviewed five of their investigations and there was no evidence of women, or their families, being involved in these investigations.

Managers debriefed and supported staff after any serious incident. During our inspection we were shown documentation that highlighted that staff had been debriefed after a serious incident.

Is the service effective?

Requires Improvement

We previously rated this service alongside gynaecology so we cannot compare the ratings. We rated it as requires improvement.

Evidence-based care and treatment

The service did not always provide care and treatment based on national or local guidance and evidence-based practice. Staff protected the rights of women subject to the Mental Health Act 1983.

Staff were not able to consistently follow up-to-date guidelines and policies to plan and deliver high quality care according to evidence-based practice and national guidance.

At our inspection on 16 and 17 March 2022 we observed that 26 out of a total of 131 guidelines were past their expiry date for review. The “Obstetric Analgesia” pathway had been out of date for review since 30 November 2018. We told the leadership team about this during our inspection who told us the out of date ones were currently being reviewed, that there were few changes, but there was a delay in getting them online. Nonetheless, this meant that at the time of our inspection staff only had access to out of date guidance in 26 instances.

The service employed a specialist midwife for mental health who co-ordinated care for women with a mental health condition alongside their named community midwife and consultant obstetrician. The service also facilitated specialist antenatal clinics for women with diabetes and other medical disorders.

Staff could access emergency mental health support 24 hours a day seven days a week for women with mental health problems.

We reviewed the statistics that the perinatal mental health midwife had collated for the three months November 2021 to January 2022 inclusive. Maternity staff had made 74 new referrals to the service in this period. Following a triage assessment 64 had been seen and 40 had been referred to external agencies.

Clinical audit was conducted and the plan included most expected audits. It included WHO safety checklist audit, fetal monitoring training audit and audit of third/fourth degree perineal trauma.

Nutrition and hydration

Staff gave women enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for women’s religious, cultural and other needs.

Staff made sure women had enough to eat and drink. All patients we spoke with told us that the staff made sure they had enough to eat and drink.

Staff did not always fully and accurately completed women's fluid and nutrition charts where needed. We reviewed patient information and found that some information was missing or not readily available. Staff told us this was due to the new patient record system. This meant that some staff had a clear understanding of the new system, and some did not. There was a risk that vital information regarding a woman's care and treatment might be missed by staff caring for her.

Specialist support from infant feeding midwives was available for women who needed it. The service employed a specialist infant feeding midwife. We noted that expressed breastmilk was stored securely in a fridge on Cestrian ward.

Pain relief

Staff assessed and monitored women regularly to see if they were in pain and gave pain relief in a timely way.

Staff assessed women's pain using a recognised tool and gave pain relief in line with individual needs and best practice.

Women told us they received pain relief soon after requesting it.

Medicine administration charts showed that staff prescribed, administered and recorded pain relief accurately. We reviewed 10 sets of maternity notes and observed that pain medicines were prescribed, administered and recorded correctly.

Patient outcomes

Staff did not consistently monitor the effectiveness of care and treatment. They were not always able to use the findings to make improvements to achieve good outcomes for women.

The service did not consistently participate in relevant national clinical audits. We saw evidence that the service carried out some audits but due to the ongoing issues with the information technology system they were unable to participate in all relevant national audits.

Outcomes for women were not always positive, consistent or met expectations, such as national standards. For example Trust performance in the 2021 MBRRACE-UK Perinatal Mortality Surveillance Report for births in 2019. Showed that when compared against trusts with a similar service provision, Countess of Chester Hospital NHS Foundation Trust was within 5% of the comparator group, across two measures. These are: Perinatal mortality including congenital anomalies and Perinatal mortality excluding congenital anomalies.

Expected numbers of caesarean sections are calculated by comparing rates at a given trust to national rates on a quarterly basis. Within this comparison, indirect standardisation is carried out to adjust for differences in the age of women delivering at the trust, as well as adjusting for the percentage of privately funded deliveries.

The latest data available (for the period between October and December 2020) also showed the observed rates for emergency caesarean sections (22%) was higher than the expected level (19%).The observed rates for elective caesarean sections at hospital had been consistently higher than the expected levels during the past three years (from April 2017 to December 2020. The latest data available (for the period between October and December 2020) showed there had been an improving trend in the difference between the observed and expected rate for elective caesarean sections.

Maternity

Perinatal mortality is defined as any in-hospital death within seven days of birth. It includes both stillbirths and neonatal deaths. Neonatal deaths that occur in any hospital within seven days are included in this indicator.

Late neonatal mortality is defined as any in-hospital death between seven and 27 days of birth.

The latest national data available shows the observed rate for perinatal mortality at Countess of Chester had been better than expected during the reporting period between September 2020 and March 2021, showing an improvement following a peak during the previous reporting period (June to August 2020). However, due to a lack of overall data reporting in 2022, there is currently no latest data available which establishes the trust's current position.

The trust reported following the inspection that internal outcomes data had been benchmarked against the Northwest Coast (NWC) average. Trust data showed the maternity services performed in line or better than the NWC average for neonatal deaths, still births and babies requiring cooling for the period between April 2021 and March 2022.

Competent staff

The service did not always make sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

We were not assured that staff were always experienced, qualified or had the right skills and knowledge to meet the needs of women.

Staff told us that they provided care for women receiving high dependency unit (HDU) care. The leadership of the service told us that they did not provide such care and during our inspection we were shown evidence that when women were transferred back to the central labour suite from intensive care they were signed back to midwifery led care. However, one of the 26 out of date guidelines we reviewed was named "Maternity High Dependency Care", which had been out of date for review on 23 February 2021, a little over 12 months before our inspection. Also, the trust's investigations into incidents frequently referred to midwives providing HDU care.

Managers did not make sure staff received any specialist training for their role.

Midwives and maternity support workers were providing immediate postnatal recovery care to women who had birthed their baby by emergency caesarean section in the obstetric theatre on the central labour suite. We were told that these staff had not received any training for this type of care but that they had undergone a competency assessment for this type of care. During our inspection we were shown a completed assessment of one member of staff to provide this type of care. However, the assessment sheet that was titled "Recovery" was listed as "Draft copy for review by Clinical Skills Group 2008". Following the inspection, we requested the competency compliance in percentages for each of these staff groups. We were sent a sample of 10 members of staff competencies, the dates that they achieved them (from) and the date to. It was not clear whether these members of staff were midwives or maternity support workers. Two had achieved their competency in 2021, one in 2020, one in 2019, two in 2018, one in 2017, two in 2016 and one in 2015. None had a date for when they should be reassessed and we were not shown any evidence that any training had taken place for staff carrying out this aspect of clinical care.

Managers gave all new staff a full induction tailored to their role before they started work.

Managers supported staff through yearly, constructive appraisals of their work. All the staff we spoke with during our inspection told us they had had an appraisal within the last 12 months. The service carried out group supervision for staff in the same groups that most staff said they were happy with. A small number of staff told us they did not like group appraisals, but they were entitled to ask for 1:1 if they would prefer.

The clinical educators did not always support the learning and development needs of staff.

We found limited assurance around staff undertaking cardiotocograph (CTG) training during the inspection. Following the inspection, we requested the weekly cardiotocograph (ctg) meetings with attendees and their profession for the last three months. We were supplied with a spreadsheet documenting 16 meetings that had taken place. Three of these had no date documented. Throughout 2021 there had been one in February, three in March, four in June, one each in July and August and two in September. This equates to 12 out of a possible 52 weeks where these meetings were held. There had been one meeting in February 2022. Numbers of attendees at these meetings ranged between 10 and one. A minority of the attendees had their professions listed. Therefore, it was not possible to be assured that these meetings were multidisciplinary. On the spreadsheet it was documented that the fetal monitoring lead midwife, part of whose role was to work as a labour ward coordinator for 12.5 hours per week, would facilitate teaching sessions during this time. However, there was no evidence to confirm whether this had taken place at any time.

Seventy-nine percent of community midwives had been supported to attend external training which covered subjects such as obstetric emergencies in the community setting.

Managers gave staff the time and opportunity to develop their skills and knowledge. We were shown evidence that where staff had previously been completing online mandatory training in their own time at home, the service had amended the structure of their training to allow staff a paid half day to complete their mandatory online training.

Maternity support workers at this service scrubbed for elective caesarean sections. Their competency compliance rate was 92%.

Managers identified poor staff performance promptly and supported staff to improve. We reviewed the actions that had been highlighted during incident investigations which highlighted how they would support staff to improve.

Multidisciplinary working

Doctors, midwives and other healthcare professionals did not always work together as a team to benefit women.

Staff did not always hold regular and effective multidisciplinary meetings to discuss women and babies to improve their care.

NHS Improvement: Implementing huddles and handovers — a framework for practice in maternity units (25 March 2019) provides a structure for maternity units to create and develop their own approach to effectively communicating clinical data and transferring key safety information. It is intended as a good practice guide for healthcare professionals involved in the care of pregnant women and their infants. It recommends that maternity services carry out daily safety huddles but we saw no evidence that this service was doing so.

As part of our inspection process we observed the meeting that the service termed the daily safety huddle at 08.30 on the second day of our inspection. However, this was actually the handover of medical staff as midwives had already handed over at 07.30. It is recommended that a safety huddle should include the delivery suite co-ordinator, neonatal

consultant and midwife/nurse in charge, person(s) responsible for theatre/anaesthesia, staff responsible for triage unit, antenatal wards, postnatal wards and community midwifery oversight. At the meeting we attended those in attendance were the labour ward co-ordinator, consultant anaesthetist and obstetric consultant, registrar and senior house officer. There was no representation from the other clinical areas.

Staff referred women for mental health assessments when they showed signs of mental ill health, depression.

Seven-day services

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

Consultants led daily ward rounds on all wards, including weekends. Women were reviewed by consultants depending on the care pathway.

Staff could call for support from doctors and other disciplines, including mental health services and some diagnostic tests, 24 hours a day, seven days a week.

Health Promotion

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

The service had relevant information promoting healthy lifestyles and support on wards/units.

We observed posters on the walls throughout the unit informing women and their partners of the benefits of skin to skin with their newborn babies, smoking cessation, breastfeeding and post pregnancy exercise classes.

Staff assessed each woman's health when admitted and provided support for any individual needs to live a healthier lifestyle.

We reviewed 10 sets of womens' maternity records and noted it had been documented that a woman's health had been assessed in areas such as smoking and alcohol intake and advised on leading healthier lifestyles in areas such as these and healthy dietary intake.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff supported women to make informed decisions about their care and treatment. They followed national guidance to gain women's consent. They knew how to support women who lacked capacity to make their own decisions or were experiencing mental ill health.

There was a standard operating procedure which showed how women were enabled to participate equally in all decision making processes and to make informed choices about their care. However, there was no audit information to demonstrate compliance.

Staff understood how and when to assess whether a woman had the capacity to make decisions about their care.

There had been no recent occurrences where women had not had the capacity to consent. However, staff that we spoke with during our inspection were able to articulate to us what they would do in such an event.

Maternity

Staff gained consent from patients for their care and treatment in line with legislation and guidance. For example, Staff we spoke with, could describe the principles of Gillick competency used to assess whether a child had the maturity to make their own decisions and how decisions were made with the involvement of parents

Staff made sure women consented to treatment based on all the information available and clearly recorded consent in the woman's records.

We reviewed 10 sets of women's maternity records and consent was obtained and documented correctly where appropriate.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act. However, there was no training on these subjects planned for this year.

Is the service caring?

Good

We previously rated this service alongside gynaecology so we cannot compare the ratings. We rated it as good.

Compassionate care

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

Staff were discreet and responsive when caring for women. Staff took time to interact with women and those close to them in a respectful and considerate way.

During our inspection we observed staff of all professions within the maternity services treating women and their partners with the utmost respect.

Women said staff treated them well and with kindness.

Feedback from the women that we spoke with during our inspection and from the CQC survey confirmed that women were treated well and with kindness.

Staff followed policy to keep women’s care and treatment confidential.

During our inspection we observed that women's confidential healthcare records were always stored securely and did not breach women's confidentiality.

Staff understood and respected the personal, cultural, social and religious needs of women and how they may relate to care needs.

Emotional support

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

Maternity

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

There was a bereavement room situated on the labour ward which we were told was used when providing specialist care for women and their families should there be a bereavement.

Staff supported women who became distressed in an open environment and helped them maintain their privacy and dignity.

On the fetal medicine unit, we observed women being given results of their ultrasound scan in either the scan room or a private room.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

Staff were able to articulate to us how they had cared for women and their families empathetically.

Understanding and involvement of women and those close to them

Staff supported and involved women, families and carers to understand their condition and make decisions about their care and treatment.

Staff mostly made sure women, and those close to them, understood their care and treatment. However, in the recent CQC maternity survey published this year some women felt that they could have been given more information regarding having their labour induced.

Staff talked with women, families and carers in a way they could understand, using communication aids where necessary.

During the inspection we spoke with three women, one with her partner. All said their care was good, very good or great.

Staff had access to an interpreting service if required to converse with women and their families.

Women and their families could give feedback on the service and their treatment and staff supported them to do this.

Women and their families were actively encouraged to give feedback about their care via the local Maternity Voices Partnership which we observed on posters throughout the unit.

Women gave positive feedback about the service.

Overall, the trust performed similarly to or better than other maternity services in the CQC maternity survey. In the 2021 survey, published in 2022, service scored '*better than expected*' for one question, '*somewhat better than expected*' for four questions and '*about the same*' for the remaining 45 questions.

Is the service responsive?

Requires Improvement

Maternity

We previously rated this service alongside gynaecology so we cannot compare the ratings. We rated it as requires improvement.

Service delivery to meet the needs of local people

The service did not always plan and provide care in a way that met the needs of local people and the communities served. It did not consistently work with others in the wider system and local organisations to plan care.

Managers did not always plan and organise services so they met the needs of the local population. At the time of our inspection the service had suspended the implementation of the Continuity of Carer implementation in the unit.

Facilities and premises were not always appropriate for the services being delivered. The service told us they risk assessed women who were recommended to have their labours induced. Those who were deemed as low risk were transferred to the Cestrian (antenatal/postnatal) ward on the first floor following insertion of a pessary. If the pessary did not induce the labour, women were recommended to have a gel inserted to induce their labour. The Cestrian ward consisted of 24 beds made up of bays and single rooms. Only 22 beds were being used for maternity at the time of our inspection and we were told that induction of labours were performed in the single rooms at one end of the ward and the office was at the opposite end of the ward. When administering the induction gel to a woman in one of the side rooms on the ward a normal fetal heart rate pattern should be confirmed using electronic fetal monitoring to exclude uterine hyperstimulation (the uterus contracting too much) which may result in fetal heart rate abnormalities, uterine rupture, or placental abruption. Due to the layout of the ward, it would not always be possible for staff to hear an alarm sounding on a cardiotocograph machine that something may be wrong.

Staff could access emergency mental health support 24 hours a day seven days a week for women with mental health problems.

The service had systems to help care for women in need of additional support or specialist intervention.

Meeting people's individual needs

The service was not fully inclusive, however we noted that staff did try and take account of women's individual needs and preferences. Staff made reasonable adjustments to help women access services. They coordinated care with other services and providers.

Staff made sure women living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. We saw that women who had such needs were referred onto the specialist mental health midwife and, if appropriate, were referred onto other services.

We did not see evidence of specialist midwives working with women from vulnerable groups for example, young parents, homeless and women from a Black Asian and minority ethnic (BAME) background.

We also did not see midwives providing specialist support for women with complex pregnancies for example diabetes and multiple pregnancy.

The service did not have information leaflets available in languages spoken by the women and local community. However, we saw that local managers made sure staff, women, loved ones and carers could get help from interpreters or signers when needed.

Staff told us they had access to an interpreting service for women who needed this.

Maternity

Access and flow

People could not always access the service when they needed it. We were not assured that they consistently received care promptly.

Following the inspection, we requested the times that the unit and the birth centre were closed or diverted for the last 12 months. We were not sent details of birth centre closures but were sent details of 10 separate instances where the unit had closed in this period.

Managers did not consistently monitor anti natal waiting times to ensure women could access services when needed and received treatment within agreed timeframes and national targets.

Following the inspection, we requested audits into waiting times in the maternity day unit, triage and antenatal clinics. We were told that there are no waiting lists for appointments in maternity and that other waiting times are monitored when staff submit an incident form and triage waiting times were monitored via their own care metrics audit. We reviewed the quarterly care metrics audit for October to December 2021 inclusive and found no mention of any triage audits.

Staff we spoke with in the antenatal clinics were not aware of any audits of waiting times for women attending their clinics.

When women had their operations delayed at the last minute, however, managers made sure they were rearranged as soon as possible and within national targets and guidance. During our inspection we were told that there had been occasions where womens' elective caesarean section births had been delayed due to the one theatre on labour ward being used for emergencies. Therefore, the elective caesarean section births were carried out in the general theatres to avoid future delays.

Staff supported women and babies when they were referred or transferred between services. Staff were able to articulate to us how they had supported women and their partners when their babies had been transferred to another neonatal unit.

Managers monitored transfers and followed national standards. The service was part of a regional network with six other maternity units that monitored and facilitated transfers between these services to meet the needs of women and babies at times of high acuity and women or baby's needs.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. We were not assured complaints were always acknowledged or responded to within the timelines stated in the trust's policy for listening and responding to concerns and complaints.

Women, relatives and carers knew how to complain or raise concerns.

There were 14 complaints received between March 2021 and February 2022 in maternity services, across a range of areas.

Staff knew how to acknowledge complaints and women received feedback from managers after the investigation into their complaint.

Maternity

Managers shared feedback from complaints with staff and learning was used to improve the service. During inspection we reviewed two complaints and noted that they followed the trust complaints policy and timescales.

Is the service well-led?

Inadequate

We previously rated this service alongside gynaecology so we cannot compare the ratings. We rated it as inadequate.

Leadership

We were not assured that leaders had the skills and abilities to run the service. They did not appear to understand nor manage fully the priorities and issues the service faced. They did not consistently support staff to develop their skills and take on more senior roles. However, local leaders were visible and approachable in the service for staff.

The senior leadership team was formed of an interim head of midwifery, medical director and a general manager. A new director of midwifery had been appointed and was due to commence in their role in early April 2022. We were told maternity was, at the time of inspection, part of the planned care division within the trust. There were plans to change the divisional structure and create a Women's and children's directorate which included with neonatal services at the trust.

Most of the staff that we spoke with told us that the interim head of midwifery was visible in the clinical areas on a regular basis.

Vision and Strategy

The service did not have a vision for what it wanted to achieve nor a strategy to turn it into action, developed with all relevant stakeholders.

The five year clinical strategy for the trust 2019/2024 stated that they were committed to the delivery of high-quality care for women in Chester and West Cheshire. The trust strategy stated that its aim was 'to provide safe, effective and productive maternity services, working in partnership within the local health economy to ensure that care provision was supported and guided by best practice evidence and national peer review'. The trust would be active participants in higher-level care model revision within the ICP and beyond; their provision of neonatal services would be guided by regional reconfiguration within which they would advocate for a care model that saw then providing high-acuity maternity services on site.

We were told that the vision and strategy for the maternity department were under development. They had started to review their aims and priorities for the coming years as the initial stages of developing their future strategy.

The service leaders told us that engagement sessions would commence following consultation with the newly appointed Director of Midwifery who would commence this post on 4 April 2022.

Culture

Not all staff felt respected, supported and valued. The service did not consistently provide opportunities for career development. Nevertheless, staff were focused on the needs of women and babies receiving care.

Maternity

Several of the midwives that we spoke with during our inspection told us that midwives were not valued by all the leadership team. Whilst midwives were able to expand their competencies, they were not supported to progress to the next pay banding. We were told that it was for this reason that so many midwives had left the service to work elsewhere.

Not all staff felt that if they raised concerns they were listened to or acted upon. We saw no evidence of a freedom to speak up champion within the service. In the 2021 General Medical Council National (GMC) Trainee Survey the service scored significantly better than above the national aggregate in clinical supervision, out of hours, educational governance and facilities but worse than below national aggregate for curriculum coverage.

All staff we met during our inspection were welcoming, friendly and helpful. We spoke with maternity staff across a variety of grades and professions.

Governance

Leaders did not operate effective governance processes throughout the service or with partner organisations.

The service did have a dashboard at the time of our inspection, however, we noted that it was rudimentary and only went back six months. The maternity dashboard enables clinical teams in the maternity service to compare their performance with their peers on a series of Clinical Quality Improvement Metrics (CQIMs) and National Maternity Indicators (NMIs), for the purposes of identifying areas that may require local clinical quality improvement. The service was unable to comply with this recommendation in order to submit data nationally to the maternity services data set due to the information technology system not facilitating the collection or collating of the required data.

Following the inspection, the service shared with us a "select metrics from the North West coast maternity dashboard". We reviewed this following our inspection and it included 12 monthly metrics including the number of women experiencing a haemorrhage of greater than 1500 mls and the number of births from June 2021 to January 2022. However, some of this data was missing as the data from the old information technology system and the current one had not been combined.

There was a lack of oversight of incidents and serious incidents.

Our review of your STEIS data determined that 21 women recorded as incidents between 1 February 2021 and 1 January 2022 with a post-partum (PPH) haemorrhage determined as major or above. PPH is determined as minor (500–1000 ml) or major (more than 1000 ml). Major can be further subdivided into moderate (1001–2000 ml) and severe (more than 2000 ml).

We found discrepancies in the risk stratification used as similar incidents had varied risk ratings. This means that it was not possible to be assured of the correct level of review for these incidents.

The governance team consisted of one consultant obstetrician and one specialist midwife. The specialist midwife for governance told us she was leaving her post in the near future to take up a more senior role in another maternity unit. The trust had a Women and Children's Governance committee. There was a quarterly update to board on the quality, performance and risk within maternity services. We reviewed the report submitted to the March 2022 meeting of the Trust Board shortly after our inspection.

We saw the service had implemented the saving babies lives care bundle. This programme is designed to tackle stillbirth and early neonatal death by bringing together four key elements of care, reduce smoking in pregnancy, risk assessment and surveillance for fetal growth restriction, raising awareness of reduced fetal movement and effective fetal

monitoring. We saw the service had a lead midwife and obstetrician for saving babies lives. We did not see any formal implementation plan however, minutes for the January 2022 maternity safety champions meeting stated the service was compliant in all elements. At the time of our inspection, due to concerns with the electronic patient record system data was being collected manually.

The trust had developed an implementation plan following the Ockenden report recommendations. The trust reported in December 2021 that they had achieved compliance in 106 of the 122 indicators and were in the process of the implementing the remaining 16 indicators. Planned actions included implementing midwifery continuity of carer (MCoC) and the on-going recruitment of midwifery and consultant obstetric posts to meet the Ockenden report recommendations The trust had also recently appointed a director of midwifery that was due to commence employment in April 2022.

The finance and performance committee (March 2022) included a performance report which included performance against the Women and Children's continuity of care performance metric. The report showed the maternity services had achieved 0% compliance between January 2021 and July 2021. The trust reported the reporting of this metric had been affected by the implementation of the new electronic patient record system.

Management of risk, issues and performance

Leaders and teams did not use systems to manage performance effectively. They did not consistently identify and escalated relevant risks and issues nor identified actions to reduce their impact.

During the inspection we found that the trust was notsafely and effectively managing the risk to service users in maternity services particularly in relation to the risks of post-partum haemorrhage (PPH) and unplanned hysterectomy. Between April 2021 and November 2021 inclusive five service users had experienced a major PPH (greater than two litres of blood loss) resulting in an unplanned hysterectomy in each case. Learning from the case in August of that year included implementation of the All Wales Pathway (a guideline of how to manage PPH effectively). This had not been implemented at the time of our inspection.

Emergency caesarean sections were normally carried in the one obstetric theatre within the central labour suite. At the time of the third hysterectomy in October a staff member had submitted an incident highlighting that there were no hysterectomy kit or staff trained in its use present in this theatre and that both staff and this equipment had to be requested from main theatres, leading to a delay in carrying out the lifesaving procedure. There was no learning highlighted in relation to either the trained staff or the equipment and neither of these were in place at the time of our inspection.

We requested the incident trends for maternity services for 2021, which was presented as the top three by month. Lack of staff appeared in 11 of the 12 months. Post-partum haemorrhage 1500 mls or more appeared five times, and over 2000mls three times. It is not clear what actions were taken regarding these themes.

Since the implementation of the new patient information technology system[EPS] in July 2021 the trust had been unable to provide external reports on maternity services data set (MSDS). The Maternity Services Data Set (MSDS) is a patient-level data set that captures information about activity carried out by maternity services relating to a mother and baby(s), from the point of the first booking appointment until mother and baby(s) are discharged from maternity services. This means that the service is unable to monitor performance. Which could lead to a lack of timely recognition and implementation of action to mitigate risk.

The service is, not meeting the mandatory requirement to submit this data to comply with the NHS contract and future modelling requires this robust data to be accurate.

There was no dashboard despite the trust manually submitted entries and running validation processes. A Band 7 Digital Midwife post was in the process of recruitment was a dedicated Women and Children's analyst. Local leaders told us these posts were developed to focus on the development of maternity reporting, as the lack of local and national reporting, was highlighted as a risk on the service risk register.

We observed a gold command sitrep meeting via Teams between the Head of Midwifery and the heads of the other six maternity units in the region. They discussed areas such as acuity in each unit, staffing, induction of labours and neonatal beds. We were told that if, for example, a woman needed an induction of labour and the service she was at did not have capacity, she could be transferred to another unit in the region to have her labour started. This meant that the service was working with other maternity units across the region to ensure women received timely care.

Information Management

The service did not always collect reliable data or analyse it. Staff could not always find the data they needed, in easily accessible formats, to understand performance, make decisions or improvements. Data or notifications were not consistently submitted to external organisations as required.

The service did not have clear performance measures which were effectively monitored, we were told that this was mainly due to the implementation of the new EPR that would not facilitate this.

The service was only able to submit minimal required data to external bodies meaning they were unable to benchmark their performance against other providers and national outcomes appropriately.

Managers did not consistently collect recommended data to support all women deemed high risk at booking appointments. For example, women from black and minority ethnic communities were not asked about all of the four recommendations from the national chief midwife. These include continuity of care and enhanced care which may benefit women from BAME backgrounds include group antenatal care.

Engagement

Leaders and staff did not consistently engage with women, staff, equality groups, the public and local organisations to plan and manage services. We did observe some collaboration with partner organisations to help improve services for women and babies.

The NHS Patient Survey Programme (NPSP), commissioned by CQC, collects feedback on adult inpatient care, maternity care, children and young people's inpatient and day services, urgent and emergency care, and community mental health services. The maternity survey is split into three sections that ask questions about:

- antenatal care
- labour and birth
- postnatal care

The 2021 survey for Countess of Chester showed that in 45 questions they performed about the same as other trusts; somewhat better than expected in four questions and better than expected in one question. Their top five scores that were somewhat better than expected were:

- Being able to speak with midwives when needed
- Midwife support
- Information and explanations of care
- Help and advice post birth
- Communication after birth

There was one recommendation, the Trust Board was asked to consider whether the assurance mechanisms within this trust were effective and, with the local maternity system (LMS). Notes from the meeting showed the board are assured that the positive reporting culture and the review process for listening and learning.

Staff told us that listening events were supposed to be held with midwives to learn of any concerns regarding the working model of continuity of carer such as changes in working patterns, more frequent on calls and a poor work life balance.

Some staff told us that they had not been included in the planning, nor told of the action plans, to address national drivers in maternity such as the report from Donna Ockenden.

During our inspection we observed a poster in the antenatal clinic encouraging service users to join their maternity voices partnership. It also highlighted that they wanted to improve communication with women about their week postnatal check-up and to improve the opportunities for birth partners to stay on the postnatal ward. The views on the care received ranged from 91% to 98%. However, this poster also highlighted key improvements for mums since 2017 so it was unclear how up to date this information was.

We observed that the service was collaborating with an external organisation to help improve services for women. During our inspection we saw posters around the service inviting women to join their local Maternity Voices Partnership.

Medical care (including older people's care)

Requires Improvement ● ➔➔

Is the service safe?

Requires Improvement ● ➔➔

Our rating of safe stayed the same. We rated it as requires improvement.

Mandatory Training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

The mandatory training met the needs of patients and staff. It included sepsis, equality, diversity & human rights, fire safety, infection prevention & control levels one & two, information governance & data security, moving & handling levels one & two, preventing radicalisation, basic life support, safeguarding adults levels one & two and safeguarding children levels one, two and three.

Staff received mandatory training. Data from the trust reported that compliance rates for medical wards was 86% for registered nursing staff, 90% for medical staff, 82% for clerical staff and 84% for ancillary staff against a target of 90%. There was no information shared for unregistered staff on the wards.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

The Trust had safeguarding policies in place for adults, children, in order to support staff to recognise potential abuse and neglect and how to act on this information.

Safeguarding training was mandatory to all staff. From the trusts safeguarding training framework, there was an expectation, for staff in clinical areas, to complete levels one and two for adults and update every two years that was delivered by an E Learning package.

For the urgent care division, data received from the trust reported that there was 89% compliance with level two safeguarding for registered nurses and 75% compliance for medical staff against a target of 90%.

Any staff member who was band seven or above were expected to complete safeguarding level three that was a combination of electronic and face to face learning over a three year period.

On admission, staff completed a form as part of admission documents. We observed safeguarding flow charts, in ward offices for staff to follow.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

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

Medical care (including older people's care)

The safeguarding and complex care team supported staff to keep patients safe.

Any safeguarding alerts received were assessed and investigated. This included working with other stakeholders, where appropriate, to safeguard patients. The division was an active member of the trusts 'Think Family Strategy Group' where all safeguarding activity data is shared and considered for learning and action.

Cleanliness, infection control and hygiene

Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Staff followed infection control principles including the use of personal protective equipment (PPE). There were sufficient supplies of gloves, aprons and clinical masks available. Clinical sinks were in all areas, including additional temporary sinks, with hand-washing instructions, soap and hand sanitisers. There were additional bags of PPE, alongside resuscitation trolleys, in case of an emergency.

Staff completed infection prevention and control (IPC) training as part of mandatory requirements. For IPC level two, for the urgent care division, there was 100% compliance for allied health professionals, 68% for medical staff and 76% for registered nurses against a target of 90%.

Staff generally adhered to social distancing, if possible. We observed a safety brief that included staff from two ward areas in a space-restrictive area.

Staff cleaned equipment after patient contact. ‘I am clean’ stickers, to indicate when equipment was last cleaned, were available on wards but, for the wards we visited, only seen used in cardiology.

At the time of inspection, visiting was restricted to patients who needed support of someone close to them, such as dementia or at end of life.

Housekeepers / domestic staff were visible on all areas we visited, although no cleaning schedules were seen.

All areas had disposable curtains for the windows and privacy curtains around patient bed spaces. These were not always dated. Staff we spoke with were not aware of a routine schedule for changing curtains but told us they were routinely changed during deep cleaning such as following a Covid outbreak. The trusts standard operating procedure (SOP) ‘Decontamination Process for Bed Spaces for Bed Turnaround Team’ indicated that curtains should be dated.

Wards included clinical rooms that were locked except for the dirty utility rooms that were not lockable. On all wards visited, we observed that cleaning fluid, used for sanitising beds and equipment, were not locked away. There were cupboards for the control of substances hazardous to health (COSHH), however; these were not always locked.

COVID-19 clinical pathways were in place for all inpatients. We observed a safety brief where staff were reminded which patients were due their routine PCR swab. These were taken on days one, three and five and compliance monitored. In April 2021, compliance with day three screening was 58%. This increased to 73% in December 2021. For five day screening, compliance was 72% in April 2021 and 88% in December 2021.

Patients with suspected infections were nursed in siderooms or established co-horted areas. We did not visit any ward identified as ‘red’ with Covid positive patients present.

The infection, prevention and control (IPC) team monitored Covid patients daily along with other infection risks. Two Covid outbreaks were reported in December 2021 and two in January 2022. Reviews were carried out if there was an outbreak with action plans completed if needed. The trust were above their trajectory of 29 for clostridium difficile (C.Diff) by December 2021 with 45 cases identified. Of these 34 were identified as hospital acquired and 11 as community acquired. The highest number of seven for a ward was on a care of the elderly area. Each case was reviewed using a root cause analysis approach highlighting learning points, areas of good practice, with any themes identified and judgements made to see if avoidable. An improvement plan was in place. There had been two cases of Methicillin-resistant Staphylococcus aureus (MRSA); one was in the community and the other reviewed to be unavoidable.

The trust completed IPC audits for each area. The trust had identified 21 IPC champions who were required to submit routine monthly data and weekly if there was any outbreak. Prior to our inspection, results were between 86% and 98% and these audit scores contributed to overall ward accreditation scores. Action plans were produced to target any areas of non-compliance.

We were shared details of audits completed during 2021, including photographs of non-compliance, however; there was no indication if concerns had been addressed.

IPC audits of wards were carried out. They included inspections of the ward environment, ward kitchen, handling & disposal of linen, departmental waste, management of equipment, safe handling & disposal of sharps, hand hygiene, personal protective equipment and isolation precautions.

Results of audits varied in compliance from month to month across clinical areas. Results included: in May 2021, endoscopy scored 90%, in July 2021 wards 33 and 34 scored 89%, ward 45 scored 85% in August, ward 43 scored 93% in November. In December 2021, ward 42 scored 87%, AMU/AMAC scored 90% and ward 44 scored 93%. These were all assessed as partial compliance. Action plans indicated areas of non-compliance and actions taken. In December 2021, cardiology scored 98% and ward 50 scored 96%; both assessed as compliant.

The discharge lounge had been modified to accommodate patients that had been identified either as Covid positive or a Covid contact. These patients were cared for in alternative rooms to the main area with staff allocated to these areas. The main discharge lounge could facilitate up to 25 patients but had reduced to a maximum of eight to maintain social distancing. There were separate toilet facilities. For Covid positive patients, a temporary structure had been constructed that was outside the building, with pipes and wires in the waiting area. It was accessed by automatic doors. This meant members of the public access the building form outside, and walk through a Covid positive area. This meant there was a risk of the public being exposed to Covid. It also meant patients would need to go outside whatever the weather conditions or temperature.

Staff disposed of clinical waste safely appropriately. Dirty utility areas were organised and clear from clutter. Sharps bins were dated and not overfilled.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff were trained to use equipment.

Wards were a combination of bays, and siderooms that were gender-specific.

The service had enough suitable equipment to help them to safely care for patients. In specialist areas such as cardiology and acute medical unit, there was monitoring equipment that was connected to central consoles so staff could monitor remotely. We observed any alarms being responded to promptly.

Staff carried out daily safety checks of specialist equipment. Monitoring equipment we sampled all included stickers to indicate maintenance checks within the last 12 months. Each area we visited had resuscitation trolleys that were sealed for security. Checks of the top of the trolleys were completed daily with a monthly full check of the trolleys contents. Pharmacy supported with emergency medicines checks. Checks were recorded electronically and alerted wards if they hadn't been completed. Dashboards meant compliance rates were available in real time. Data was collected for the urgent care division. As of 2 March 2022, there was 100% compliance with checks. Of the 25 resuscitation trolleys, six had items missing and one had expired items. This meant an overall compliance of 72% (18 out of 25 trolleys). This meant there was a risk that resuscitation equipment may not be available in the event of an emergency.

Patients could reach call bells and staff responded quickly when called. At the time of inspection we did not hear many call bells; there were nursing assistants based in bays so staff were easily accessible for patient care.

Following the last inspection CQC issued a requirement notice to rectify problems with emergency call bells. During this inspection we observed a safety brief where it was shared there was a trust wide issue with call bells. Following this inspection, we spoke with the leads for the division; they were unaware of any call bell problems.

During the inspection we observed an activation of the fire alarm that was not the routine weekly check. We noticed that not all doors designated as fire doors automatically closed securely. At the last inspection, the trust was issued with a requirement notice for regulation 12 to ensure that fire escapes were available for use in an emergency. We observed that fire doors, on wards we visited, including wards 50, 51 and the acute medical unit, were obstructed with equipment due to a lack of storage areas. The lack of storage areas was highlighted on the last inspection report. We escalated concerns about fire exits to senior managers while we were onsite, and immediately again post inspection, with assurances requested from the trust, however; not complete.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

The trust had a teletracking system that was an electronic system that showed the patients in each area. Patients were given a tracker, on admission, to wear alongside their wrist name band. This meant that if a patient left the ward, for example to attend x-ray, staff knew their location. Staff could also track movement on the ward. Entry to wards was restricted with swipe access for staff. Staff could view visitors to the ward via cameras when requesting entry. We found delays in accessing wards where there was an absence of a ward clerk. Wards were exited by either by non-touch sensors or exit buttons. This meant vulnerable patients, who had been assessed as lacking capacity requiring Deprivation of Liberties safeguards, could potentially exit unescorted.

Resuscitation equipment was available and accessible in all areas we visited. Ward areas included piped oxygen and suction in patient bed spaces. Basic life support was part of mandatory training. For the urgent care division, data from the trust reported that there was 72% compliance for registered nurses and 55% compliance for medical staff.

Staff completed sepsis training as part of mandatory training requirements. For the urgent care division, compliance for medical staff was 68%. For the medical wards, compliance for registered nurses was 97%.

Medical care (including older people's care)

Staff were allocated to patients and remained close by when needed. We observed that if a nurse needed to leave an enhanced care bay, requests were made for a colleague to cover.

On admission staff completed records on the electronic system that included risk assessments such as pressure area care, bed rails and nutrition. Due to the staff understanding of the system, it was not clear if all risk assessments were completed and reviewed appropriately.

Patients who had a particular enhanced need were identified by discreet symbols on the tele tracking boards. Symbols such as the dementia flower or footprints for pressure area care were used to alert staff that the patients had additional needs. Tissue viability nurses were available to advise, for example pressure relieving mattresses or frequency of need for repositioning.

Pathways were in place for certain conditions such as stroke, sepsis and acute kidney injury. Sepsis training was included in mandatory training requirements. Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Observations of vital signs were recorded by staff and the national early warning score (NEWS2) were calculated. These were recorded electronically. In the records we reviewed we found that any rise in the score had been escalated appropriately. We were told that the electronic system alerted staff if the score was four or above. Between July 2021 and January 2022, the audit of NEWS2 was paused, following the implementation of the electronic patient record system. From the exception reports of medical wards, the average compliance for NEWS2 audits was 83% prior to this.

As part of a sepsis review, 42 patients were identified who had died following diagnosis of sepsis. In all cases it was found that NEWS2 had been appropriately calculated and escalated appropriately.

Stroke services had been reorganised the week prior to our inspection. There were 16 acute beds at this location and rehabilitation services at the other hospital. On the first day of inspection, there were beds available for acute admissions, however; on day three we observed patients had been identified as outliers due to the lack of capacity on other areas. The ward manager had escalated the need for alternative wards. There were three stroke co-ordinators available daily 8am to 8pm with an on-call system out of hours. There was a tele-medicine system available for stroke thrombolysis meaning senior specialist doctors could be available for support. (Thrombolysis is the breakdown of blood clots formed in blood vessels, using medication.)

We spoke with the critical care outreach team. They told us that ward staff, nurse or doctor, referred patients either verbally or in writing if they were concerned about a patient. The outreach team were available from 8.30am to 9pm daily. There was a business case to increase the outreach service to cover a 24 hour period once there were enough staff with the appropriate competencies. This meant they would have more capacity to proactively monitor patients and work closer with ward staff. The hospital at night meeting at 9pm highlighted any patients that could potentially deteriorate overnight and the clinical co-ordinator was aware of any critical care step down patients and those with central lines.

The trust had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a patient's mental health). The mental health trust was co-located with the trust.

Staff shared key information to keep patients safe when handing over their care to others. Daily safety briefings took place as well as handover meetings. Briefings identified patients with a specific need, for example if they were due to have a Covid swab, needed enhanced care, commode checks or special diets. Staff allocated to patients were given a detailed handover from colleagues transferring care.

Patients requiring specialist support such as non-invasive ventilation (NIV) or post stroke thrombolysis, were nursed in areas where staff had the correct competencies.

In the endoscopy unit, staff completed the World Health Organisation (WHO) checklist. We received a copy of an audit that showed that there was 100% compliance except for the de-brief when two members of staff had left the room. This audit was not dated. Staff participated in resus simulations and emergency training scenarios.

Nurse & Allied Health Professional staffing

The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix.

The service had enough nursing and support staff to keep patients safe.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. Managers utilised a recognised staffing tool to calculate daily requirements. A nurse staffing review took place between January 2021 and June 2021 and this had increased establishments.

All newly qualified registered nurses undertook a period of preceptorship following the induction programme during which time a period of supernumerary status was applied and additional support was given by the practice development nurses.

The Trust had also been involved in the international recruitment of registered nurses and for this group of staff a bespoke induction programme had been developed. These nurses also had access to an identified practice development nurse.

Ward managers could adjust staffing levels daily according to the needs of patients. Bed meetings were held three times daily to review staffing levels as well as sharing any other concerns.

Wards utilised social media platforms to engage with staff and requests for additional shifts.

Boards displayed the actual and expected numbers of registered nurses and carers for each shift. Advanced nurse practitioners and ward managers were available to support staff.

For new starters there was a 12 week period of being supernumerary; this could be extended in necessary.

We received staffing fill rates from September 2021 to January 2022. For registered nurses, the average fill rate during the day was 88% and 100% at night. For unregistered staff, the average fill rate was 85%, during the day and 101% at night.

Any shortfalls in staffing numbers were supplemented with bank and / or agency staff. The central workforce team supported with staffing requirements. Staff told us that staff could be moved from their substantive ward to cover,

whilst an agency nurse, would cover them in order to maintain an equitable skill mix across the trust. Data from the trust indicated that, between January 2021 and January 2022, there was, for each area, an average of 31% hours of bank and agency unfilled for registered staff and 28% for unregistered staff. This meant that there was potentially a lack of continuity for patients that may impact on their care.

We requested vacancy rates, however; the data we received was presented trustwide so we could not identify the vacancies for this core service alone. The data showed that there were a total of 26.5 whole time equivalent (WTE) registered nurse vacancies across the trust. There were 18.1 WTE vacancies for allied health professionals across the trust. These included 0.9 WTE vacancy for an occupational therapist and 1.8 WTE speech and language therapy vacancies.

In the 12 months prior to inspection, for the urgent care division, there was a monthly average of 5.4% sickness for registered nursing staff and 8.2% turnover.

A nurse handover briefing we observed during the inspection, with all nurses present, included a theme of the week, ward accreditation, update in NEWS policy and sharing of a compliment for a staff member, submitted through the electronic system.

The night ward managers handed over all patients to the day ward manager. At the same time, other staff were allocated patients and took handover for those patients in their bay. This was held in one area where other patients could hear. This meant confidential information could potentially be overheard.

Clinical staff on wards, were supported by ward clerks, however; at the time of inspection there were shortages meaning additional work for clinicians. We noted delays in answering external bell entry and phones ringing for extended lengths of time. The acute medical unit (AMU) had 24 hour clerical cover. We observed staff that were new to the role being trained.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave locum staff a full induction.

The service had enough medical staff to keep patients safe.

The medical staff numbers matched the planned number. There were 126.9 WTE doctors of all grades planned in the medical wards. The actual number was123.5 doctors. The acute medical unit had vacancies for a consultant and a trainee, gastroenterology had vacancies for a junior doctor and a consultant and there was a part-time vacancy in rheumatology.

There was an additional 14 doctors, classified as temporary, to support the Covid modular ward and winter pressures.

Doctors we spoke with reported sufficient cover during working hours and out of hours. Any shortfalls in junior doctors were covered by their senior team members. There had been some adaptations in rotas following Covid risk assessments. Locums were utilised for gaps not filled by substantive staff.

In the 12 months prior to inspection, for the urgent care division, there was a monthly average of 1.4% sickness for medical staff and a turnover of 26.9%.

Medical care (including older people's care)

Managers could access locums when they needed additional medical staff.

Managers made sure locums had a full induction to the service before they started work.

The service had a good skill mix of medical staff on each shift and reviewed this regularly.

The service always had a consultant on call during evenings and weekends. There was a physician of the week and a cardiologist of the week.

Ward rounds took place daily and more frequently in speciality areas. Consultants for speciality areas attended wards daily. There was medical presence on the acute medical unit throughout the day and doctors were easily accessible out of hours.

Records

Staff kept records of patients' care and treatment. Records were not clear, not stored securely or easily available to all staff providing care.

Patient notes were not comprehensive and staff could not access them easily.

The trust had implemented a new electronic patient record (EPR) system in July 2021. All records were recorded electronically with the exception of Deprivation of Liberty Safeguards (DoLS) and do not attempt cardiopulmonary resuscitation (DNACPR) documentation that were paper-based.

Records were stored electronically and in note trolleys if needed. We observed occasions when computers were not locked and information was visible to others. Although visiting restrictions were in place, there were family members present supporting patients with particular needs.

The trusts teletracking system included boards on each ward of the patients present. This included the full names as well as other specific information visible to any visitors on the wards.

There were core mandatory assessments required to be completed in the electronic system including falls, Braden for pressure ulcer assessment, manual handling, MUST (nutritional risk assessment), VTE (risk of a blood clot) and a basic admission assessment. From the records reviewed it was difficult to assess if all assessments had been completed and in a timely manner.

We found the EPR difficult to navigate and that staff competencies in navigating varied. Senior leaders had identified that staff required training additional to when the system was implemented with plans to support staff.

When the system was implemented, it was found that there were delays in ward rounds due to insufficient numbers of computers. This resulted in the trust investing in 150 extra laptops to meet the needs of ward staff.

Medicines

The service did not have robust systems and processes in place to safely prescribe, administer, record and store medicines.

Staff followed trust systems and processes when administering, recording and storing medicines. We found that all prescription records had allergies recorded.

The service used an electronic system to prescribe, administer and record medicines for patients However; staff without prescribing qualifications were able to prescribe medicines through this system. This meant there was a risk that an unqualified or non-prescribing staff could access and prescribe medication for a patient.

We also found that when patients were administered oxygen this was not always prescribed or recorded as administered on the system.

Staff reviewed patient's medicines regularly and provided specific advice to patients and carers about their medicines. The pharmacy team were known and visible on the wards we visited and were available on the ward on weekdays and staff we spoke to were aware of the procedure for obtaining pharmacy support and medicines out of hours. Pharmacy staff followed current national practice/guidance to check patients had the correct medicines.

Staff stored and managed all medicines and prescribing documents in line with the provider's policy.

We reviewed a sample of ward fridge temperatures, including cardiology. We found that when the temperature exceeded the maximum expected eight degrees, no actions had been taken. This was highlighted during the inspection.

This meant there was a risk the temperatures went beyond the recommended storage temperature and that the safety of medicines could have been affected.

We reviewed the storage and recording of controlled drugs. We found they were stored securely in locked cupboards in restricted access rooms. All medicines we looked at were within their expiry date and recorded correctly in the controlled drug register.

Each areas we visited had piped oxygen and portable cylinders. These cylinders were generally attached to wall mounted brackets for safety, although we saw areas where they were not secured.

For discharge medicines, there was a requirement for a second checker by either registered nurse or pharmacy representative.

Information from the trust following the inspection showed the EPR system had the functionality for recording oxygen prescribing and administration. However, the majority of staff we spoke with during the inspection did not have a clear understanding of this. They were either not aware of or had no accessed the oxygen prescribing functionality within the EPR system.

Incidents

Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned, from never events, with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff we spoke with knew what incidents to report and how to report them.

Staff raised concerns and reported incidents and near misses.

Medical care (including older people's care)

There were 24 serious incidents reported for the medical wards, 10 of which were in care of the elderly wards. We requested copies of the last three root cause investigation reports of serious incidents, however; none were received for medical wards. This meant that we had limited assurance that incidents were investigated effectively. In the 12 months prior to inspection, there were a total of 3861 incidents reported for medical ward areas.

The trust had identified that falls were a theme from incident reports. An internal 'deep dive' exercise was carried out in November 2021. The investigation resulted in limited assurance. The falls improvement group had been re-instated to support with staff training requirements. Areas of improvement were identified with an action plan in place that included use of flat lifting equipment and the taking of lying and standing blood pressure of all patients at least once.

A 'deep dive' of pressure ulcers was completed in November 2021 that resulted in moderate assurance. The action plan included that any pressure ulcer graded as a two or above need for Duty of Candour to be actioned. It also recommended that a BRADEN score (calculated to check the risk of developing a pressure ulcer) be completed on admission and 72 hours later.

Patient safety summits were available for staff to attend; we were told that different topics were shared each month.

Managers shared learning about never events with their staff and across the trust.

Managers shared learning with their staff about never events that happened elsewhere.

Staff understood the duty of candour. They were open and transparent, and gave patients and families an explanation if and when things went wrong.

Staff we spoke with told us that they received feedback from investigation of never events, via email across the trust but not other serious incidents. Senior leaders told us that incidents were feedback in safety bulletins.

Is the service effective?

Requires Improvement ↓

Our rating of effective went down. We rated it as requires improvement.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice.

Staff followed policies to plan and deliver high quality care according to best practice and national guidance. However, the trust had identified a number of policies were passed their date for review. In the January 2022 governance meeting minutes it was recorded that there were over 80 policies passed their date for review with some dated back to 2018/19. This meant staff might not have the most up to date best practice to follow.

A sample of pathways and guidelines were reviewed during the inspection, including stroke, sepsis and deteriorating patient; these were found to be in line with national guidance.

We were told that the trusts risk and safety team managed the notification of any new or updated guidance for cascading to staff. Any changes in National Institute for Health and Care Excellence (NICE) guidance was shared to divisional level.

At handover meetings, staff referred to the psychological and emotional needs of patients, their relatives and carers.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs.

Staff completed patients' fluid and nutrition charts where needed. Fluid balance charts were completed electronically and seen completed in the records we reviewed.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. From the records we reviewed it was not clear if they had been completed appropriately due to the electronic system at the trust. This meant we were not assured all records were accurate and patients had been reviewed in a timely manner.

The trusts ward accreditation scheme identified poor compliance with completion of the Malnutrition Universal Screening Tool (MUST) on the acute medical unit. The wards completed dashboards. These included MUST audit results. The trusts target was 90% compliance. Between August 2021 and January 2022, the average compliance for the medical wards was reported as 83% for MUST and 68% for fluid balance, however, we were told there had been no formal audits of fluid balance and MUST audits since the implementation of the electronic patient record system in July 2021.

Specialist support from staff such as dietitians and speech and language therapists was available for patients who needed it. We saw evidence of review by dieticians in patient records and spoke with a speech and language professional during the inspection.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice.

Patients received pain relief soon after requesting it.

Staff prescribed, administered and recorded pain relief accurately.

Patient outcomes

Staff monitored the effectiveness of care and treatment. The service had been accredited under relevant clinical accreditation schemes.

Medical care (including older people's care)

The service participated in relevant national clinical audits. We requested results from audits, however only the schedule and status were shared. This meant we were not assured that action plans were in place and any concerns were being addressed appropriately.

We were told that the urgent care division was registered for a total of 194 audits from April 2019 to January 2022. Of these 97 had been completed, with a further 62 in progress. Of those in progress, 25 were national audits, 27 were local audits and 10 were regional audits.

All audits had a target date for completion that were monitored by the clinical audit department including, for example; National Confidential Enquiry into Patient Outcome and Death (NCEPOD) such as for non-invasive ventilation or heart failure or other audits such as the Stroke-Sentinel Stroke Audit Programme (SSNAP) or Elderly Medicine-National Audit of Dementia Round 4 (NAD).

We were told that clinical audits were reviewed at divisional meetings. The stroke service had recently changed partly in response to the results of the SSNAP audit where the trust had been assessed as level E. (Level E is the poorest level when assessed; grading is from A to E based on a number of indicators.) Outcomes were monitored through SSNAP data, mortality and morbidity reviews and the stroke steering group.

The endoscopy service was accredited with the endoscopy Joint Advisory Group for gastro-intestinal endoscopy (JAG).

We were told that the division had completed a number of quality and operational peer review assessments, audits and commissioning standards and participated in clinical audits. The division used the Getting it Right First Time (GIRFT) and National Quality Board Specialist Commissioning Frameworks that provided a summary of performance. We requested GIRFT results, however; did not receive any to review.

The ward accreditation programme continued during the Covid pandemic. Wards completed monthly exception reports where metrics were recorded on dashboards including nurse fill rates, incidents, falls, pressure ulcers and audits.

Cardiology services had been re-organised in line with GIRFT recommendations. These focused on consultant establishment, acute pacing services, pathways, the 16 bedded cardiology unit and in-reach services to the wards. There were plans to replace the pacing lab and to work closer with other cardiology teams, at other trusts in the region to develop enhanced seven day services such as acute pacing.

Prior to the Covid pandemic, the respiratory support unit (RSU) consisted of four dedicated beds in an open bay. In the first pandemic surge the respiratory team managed the Covid negative patients requiring non-invasive ventilation (NIV) in side rooms on a red ward. An enhanced respiratory support unit had been completed with nine side rooms and an additional two bedded bay to be in line with the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) and British Thoracic Society (BTS) quality standards.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.

Managers gave all new staff a full induction applicable to their role before they started work. All staff employed by the trust attended an induction programme, designed with the necessary competencies for the relevant speciality and monitored on the trusts electronic systems. Staff training was assessed as part of the ward accreditation scheme.

Managers supported staff to develop through yearly, constructive appraisals of their work. Skills and competencies formed part of the annual appraisal review process. Staff we spoke with told us that the process had changed; it was straightforward to navigate and a supportive process. The process linked in with any training requirements. Information received from the trust reported that, for the medical wards, there was 84.6% compliance for medical staff appraisal completion and 79.7% for registered nurses.

The clinical educators supported the learning and development needs of staff. Designated professional development nurses were attached to areas including the acute medical unit respiratory and cardiology specialities.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge.

Managers made sure staff received any specialist training for their role. Specialist nurses were assigned to areas including cardiology care, stroke co-ordinators for thrombolysis (Thrombolysis is the breakdown of blood clots formed in blood vessels using medication),and respiratory for non-invasive ventilation(NIV). (Non-invasive ventilation is the use of breathing support administered through a face mask, nasal mask, or a helmet. Air, usually with added oxygen, is given through the mask under positive pressure). We were told that there were no incidences where staff were not available with the appropriate competencies in speciality wards. For NIV, 69.8% of registered nurses had completed this competency on the AMU and 64.2% on the respiratory unit. For electrocardiograms (ECG) competency, there was 77.3% compliance for registered nurses in the AMU and 56.2% compliance for unregistered staff. There was 62.2% compliance for peripherally inserted central catheter line medication competency for registered nurses on the AMU. For tracheostomy competency, there was 60.7% compliance on the respiratory unit.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care.

Staff worked across health care disciplines and with other agencies when required to care for patients such as with mental health liaison or community stakeholders.

Patients had their care pathway reviewed by speciality or general consultants dependent on the reason for admission. Ward rounds were multidisciplinary including doctors, advanced nurse practitioners, dieticians, occupational therapists, physiotherapists, discharge to assess staff and rapid response teams.

Staff we spoke with said there was good team working across all clinical staff. This included doctors, nurses and allied health professionals. We observed therapists including physiotherapists, occupational therapists, pharmacists and speech and language therapists supporting patients on wards along other clinicians.

Seven-day services

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

Consultants led daily ward rounds on all wards during weekdays. Patients were reviewed by consultants depending on their care pathway.

Medical care (including older people's care)

Staff called for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. These included the outreach team who were available daily from 8.30am until 9pm. The discharge lounge was open daily between 9am and 6.30pm.

The endoscopy service was available Monday to Friday with plans to extend to seven days.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support on the wards. Patient information leaflets had been re-introduced on the wards we visited such as smoking cessation but also in patient leaflets such as falls prevention, relieving the pressure and C.Diff.

The trust website included a link to the NHS 'Better Health' campaign. This included support for physical and mental health.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They knew how to support patients who lacked capacity to make their own decisions.

Staff gained consent from patients for their care and treatment in line with legislation and guidance.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.

Staff made sure patients consented to treatment based on all the information available. If a patient was identified as having no next of kin, an independent mental capacity advocate (IMCA) would be sourced to advocate for the patient.

Staff we spoke with understood the process for assessing mental capacity, however; did not always clearly record consent in the patients' records. During the inspection we reviewed patient records. We found that assessments of the Mental Capacity Act 2005 (MCA) were either missing or difficult to locate.

According to the trusts safeguarding training framework, training in the Mental Capacity Act and Deprivation of Liberty Safeguards were part of mandatory training requirements. Compliance for medical wards was 81.4% against a target of 90%.

Staff knew how to access policies and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff implemented Deprivation of Liberty Safeguards in line with approved documentation. The complex care team supported ward staff with completion of documentation including DoLS and MCA.

We requested results of audits for MCA, DoLs and DNACPR, however did not receive them.

Is the service caring?

Good 

Medical care (including older people's care)

Our rating of caring stayed the same. We rated it as good.

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed good interactions by staff including housekeepers, nurses, allied health professionals and doctors.

Patients we spoke with told us that staff treated them well and with kindness. On the wards we visited there were members of staff present in bays or staff were close by. Patients said that staff were caring, approachable and explained care in a way that they understood.

We observed doctors communicating well with patients during their rounds and they spent time to explain treatment and investigation results.

Prior to the Covid pandemic some wards were designated as either male or female. At the time of inspection, the areas we visited were all mixed. Wards included bays of patients, gender-specific and side rooms. Not all side rooms included en-suite facilities. This meant mobile patients needed to cross corridors to access bathrooms. Staff monitored that patients accessed them appropriately. Toilets included signage to indicate if for male or female use.

We were told that floor walkers were deployed to assist patients with making video calls, or telephone calls during visiting restrictions; however, we did not see any during our inspection.

Wards we visited displayed thank you cards from patients and their families. Staff were encouraged to record compliments on the trusts electronic system.

The trust collected data for the NHS Friends and Family test. The data was collected for all in-patients, and not specifically for medical patients. For the 12 months prior to inspection, the average satisfaction scores were 92.6% positive and 3.9% negative with an average response rate of 21%. The trust participated in the CQC in-patient survey which had an average response rate was 44%. The results reported that 98% of patients were treated with respect and dignity overall, 86% rated their overall experience as seven out of 10 overall, however; only 8% said they were asked to give their views about the quality of care during their stay. This was below the England average of 14%.

Emotional support

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

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

Staff understood the emotional and social impact that a person’s care, treatment or condition had on their wellbeing and on those close to them.

Staff utilised private rooms to discuss sensitive details or for breaking bad news.

Medical care (including older people's care)

The trust had a spiritual care centre available for patients, visitors and staff of different faiths and beliefs if requested; public worship times were displayed on the trust website.

Staff were able to refer patients to the mental health liaison team if deemed appropriate.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment.

Staff talked with patients, families and carers in a way they could understand.

Patients and those close to them could give feedback on the service and their treatment. Boxes were available on wards for feedback forms to be shared with the trust.

Staff supported patients to make informed decisions about their care.

Patients gave positive feedback about the service.

Is the service responsive?

Requires Improvement 

Our rating of responsive stayed the same. We rated it as requires improvement.

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

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services so they met the changing needs of the local population. The trust worked with community stakeholders, including commissioners and GP's to discuss any changes, such as the implementation of the electronic system or changes in pathways.

The Covid pandemic resulted in a number of dynamic changes to ensure patients were safe.

The stroke service had been re-organised, the week prior to our site visit. Patients were admitted to the acute stroke ward initially with rehabilitation facilities at the trusts other hospital location following the acute phase of their illness.

Changes to the respiratory unit facilities were underway at the time of inspection. Senior leaders told us that they were committed to ensuring patients were in the right place to meet their needs.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. All staff we spoke with were aware of the importance of separate facilities for male and female patients.

Staff were able to access emergency mental health support 24 hours a day, 7 days a week for patients with mental health problems. There was a mental health liaison service and the trust was co-located with the mental health trust.

The service had systems to help care for patients in need of additional support or specialist intervention. There were wards with particular specialities, such as stroke, cardiology or respiratory where monitoring and staff with specialist skills were available including advanced nurse practitioners. The hospital alcohol liaison team, for example, visited the acute medical unit daily to support any patients identified as having need of their services.

The division worked with other stakeholders to find alternative pathways to help reduce the length of in patient stays.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff understood meeting the information and communication needs of patients with a disability or sensory loss.

Staff supported patients living with dementia and learning disabilities by using 'this is me' documents and patient passports that included the dementia flower.

Due to the Covid pandemic, visitor restrictions remained in place at the time of inspection. However, for some patients including anyone identified with a cognitive impairment or a patient close to end of life, families were encouraged to visit and support patients.

In the endoscopy service, for patients identified with a mental health issue or learning disability, someone close to them were able to stay with them.

Wards had been decorated to help meet the needs of patients living with dementia. We observed clocks on the wards that were dementia friendly. Some areas, including cardiology, had coloured borders around bays to assist with orientation. Toilet facilities had larger yellow signs to assist patients with visual impairments. Disabled facilities were available in all areas; most toilets had blue coloured seats and hand rails.

We observed an area which had been adapted to meet the needs of dementia patients when approaching wards 50 and 51. This included a dayroom that was decorated in the style of a living room and there was an enclosed garden attached. Corridor walls were decorated with dementia boards that included historic photographs and a quiz for patients to guess the singers. We were told these changed periodically. We saw walking frames painted red to quickly identify patients who may have a cognitive impairment.

In cardiology we observed patients were given a pack that included ward details as well as information leaflets and a Covid pack.

For patients identified as at risk of developing a pressure ulcer, red pillow cases were used under patients feet to remind staff. Tissue viability nurses were available to support staff if advice needed.

There were other staff identified in yellow t-shirts as care and comfort nurses; these visited wards to speak with patients and support with activities.

The service had recently re-introduced information leaflets. These were easily accessible on all wards visited. They were printed in English, however; most had details about obtaining in alternative formats including languages other than English and larger fonts.

Managers made sure staff, patients and those close to them could get help from interpreters or signers. Interpreters could be accessed by a trustwide service if needed.

Patients were given a choice of food and drink to meet their cultural and religious preferences. There were daily menus that patients could choose from. In the discharge lounge, patients had access to hot and cold drinks. If there was a delay in leaving the discharge lounge, staff in the discharge lounge could request food from the hospital kitchens. The lounge included a range of styles of chairs as well as walking aids and wheelchairs. At the time of inspection, some toilet facilities were being updated for Covid patients there was a temporary structure outside the building.

Access and flow

People could access the service when they needed it and received the right care promptly.

The service moved patients, from one ward to another ward, only when there was a clear medical reason or in their best interest. During the Covid pandemic, patients were screened and placed in wards according to Covid status and medical need.

Staff did not always move patients between wards at night. The trust reported a number of metrics in their integrated performance report. For December 2021, the report included a compliance of 98.8%, trustwide (target 98%). We did not receive data for any other time requested.

During the pandemic, ward changes and the reduction in elective activities meant that some surgical wards were reorientated to medical wards. This was being reversed with three wards reverted back to surgery. A modular ward for Covid patients was installed and in use at time of inspection.

Managers monitored that patients moved between wards/services were kept to a minimum. There were occasions when patients were admitted to wards, other than medical wards. Managers made sure there were arrangements for medical staff to review any medical patients on non-medical wards. These patients were identified as outliers. During the inspection, we visited surgical wards where there were identified medical outliers.

We reviewed care records and spoke with staff and saw that the patients were reviewed on a daily basis during weekdays in line with other general medical wards. We observed involvement of family and therapists.

A newsletter was shared amongst staff outlining the trusts clinical vision of non-elective flow explaining focus on criteria to reside and discharges.

Managers and staff worked to make sure that they started discharge planning as early as possible.

Managers monitored the number of delayed discharges, knew which wards had the highest number and took action to prevent them.

The trust reported that the electronic teletracking system had helped to reduce times patients had been waiting in the emergency department for an in-patient bed. The system indicated when a bed became available, with a focus on cleaning, ahead of the admission.

Medical care (including older people's care)

There had been a focus on patient flow at weekends, with clinicians attending wards to facilitate discharges.

Staff supported patients when they were referred or transferred between services.

Managers and staff worked to make sure patients did not stay in hospital longer than they needed to. At the time of inspection we were told that there were 35 patients in the trust, that did not meet the criteria to reside (patients who were medically fit for discharge).

At the time of inspection, 209 (51.7%) patients had occupied beds for a minimum of seven days. There were 106 (26.2%) patients had occupied beds for at least 14 days and there were 63 (15.6%) patients who had occupied beds for 21 days or more. These figures were the lowest numbers when compared to other hospitals in the integrated care system.

Between August 21 and February 22, the average length of stay for emergency patients was 5.7 days and 4.1 days for elective patients. We requested data for individual core services, however; data was presented trustwide.

Of the total number of people who had a length of stay of 21 days or over who had been assessed as not meeting the criteria to reside, the number of additional days in total they had remained in hospital was between 10 (December 21) and 320 (February 22) days with an average of 113 days. Patients' needs were classified using a pathway system. Pathway 1: awaiting availability of resource for assessment and start of care at home, pathway 2: awaiting availability of rehabilitation bed in community hospital or other bedded setting and pathway 3: awaiting availability of a bed in a residential or nursing home that is likely to be a permanent placement. These were reported as the reasons for the highest numbers of delays.

Managers had reviewed patient flow and identified they needed to focus on lengths of stay of seven, 14, 21 and more. A 'perfect week' event took place in November 2021; this resulted in 92 discharges. A further event released 90 discharges.

Discharge processes included discharge to assess and rapid response services. The hospital home team supported discharges. Between January 2021 and December 2021, 100% of patients received support within four hours of referral.

Managers monitored patient transfers and followed national standards. We were told that the division followed the trusts discharge policy. During the Covid pandemic, the trust worked in collaboration with community stakeholders to help prevent delays in discharges. Leaders accessed additional community beds for patients and increased the rapid response provision. A virtual Covid ward was introduced. Patients were Covid screened prior to discharge to minimise any risk of community transmission.

The trust monitored cancer targets at 14, 31 and 62 days. Between August 21 and December 21, for the 14 day referral target, the trust target was 93%, however, they achieved on average, 67.6% of patients . For 31 days from decision to treat, the trust had a target of 96%, however, they achieved on average 90.9% of patients. For the 62 day target from GP to referral to treatment, the trust target was 85%,however; they achieved 72.4% of patients.

The trust carried out events such as perfect weeks and multi agency discharge events (MADE) as part of the trusts discharge and flow improvement programme. The trust completed 'criteria to reside' workbooks daily across both acute and intermediate care. Transport was increased to meet the demands of discharges. Staff were informed of the outcome by use of a short poster that included numbers of discharges, successes, challenges and date for the next event.

Medical care (including older people's care)

Between January 2021 and January 2022, the rapid response team supported on average, 74 patients discharged each month requiring an average of 11 days care and treatment. There were 102 patients who re-attended the emergency department. This ranged from three to 15 patients monthly.

As part of our inspection, we visited the discharge lounge. Prior to the pandemic, the lounge could take up to 25 patients at one time. With Covid restrictions they accommodated a maximum of eight patients in the main waiting area. There were additional rooms for Covid positive or contact patients. The trusts electronic tracking system identified patients for discharge. The staff booked transport, if needed according to patient need and their locality.

The trust was constructing a same day emergency care (SDEC) facility with the aim of reducing overnight admissions. Other streaming pathways were being developed in alignment with the SDEC to support admission avoidance including the increase in the hospital at home programme.

Learning from complaints and concerns

People could give feedback and raise concerns about care received. The service investigated complaints however responses were not timely.

Patients we spoke with did not always know how to complain or raise concerns but said they would speak with staff in the first instance.

The service did not display information about how to raise a concern in patient areas. We observed leaflets on most of the wards we visited. The information was presented in English, however; the back of leaflets indicated how to obtain the patient experience team leaflet in an alternative format such as larger print or language other than English. Staff understood the policy on complaints and knew how to handle them.

Between March 2021 and February 2022, there was a total of 73 complaints for the medical wards including acute medicine, care of the elderly, cardiology, haematology, endoscopy, gastroenterology, stroke and respiratory services.

Managers investigated complaints and identified themes however, they were not responded to in a timely manner. Complaints made included concerns regarding communication, clinical treatment, delays in treatment and general patient care.

Of the 73 complaints, 24 were upheld (14 were for care of the elderly patients). For the same time period, there were no complaints made to the *Parliamentary and Health Service Ombudsman* (PHSO).

We were told managers shared feedback from complaints with staff and learning was used to improve the service, however we did not receive any complaints to review.

Is the service well-led?

Requires Improvement 

Our rating of well-led stayed the same. We rated it as requires improvement.

Medical care (including older people's care)

Leadership

Local leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They supported staff to develop their skills and take on more senior roles.

The medical wards were part of the urgent care division within the trust. Senior leaders including managers and clinicians represented these areas. Service managers and assistant service managers were responsible for nominated specialities and they were overseen by the two directorate managers.

Leadership programmes had been available for senior staff, matrons and ward managers. Staff we spoke with told us that senior leaders were not visible on the wards. We saw that wards recorded when members of the senior leadership team had visited.

We were told that matrons visited daily and staff were well supported by them. Staff felt comfortable to raise concerns with leaders. We observed that ward managers supported staff on the wards when needed.

Vision and Strategy

The service did not have a vision for what it wanted to achieve or a strategy. The service followed the trusts strategy.

The trust had a people strategy dated 2021 to 2026 however, there was no strategy received for medical care or the urgent care division. The people strategy focused on talent retention, growing the workforce, development across systems with new ways of delivery care and flexible ways of working. The strategic aim was to “attract and retain talented people with the right skills and attitude to create a positive environment with a shared sense of pride and ambition for everyone by focusing on availability, capability and experience.”

The trust vision was “we will improve the lives of our community and provide excellence in health and care, through partnership and innovation.”

The trust values were a commitment to be safe, kind and effective.

Staff we spoke with were not aware of a local vision or strategy and not clear about the overall trust strategy.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Individual wards reported good teamwork and morale despite the pressures of the Covid pandemic. We observed staff working together to benefit care and treatment for patients and those close to them. Staff supported each other and individual wards had social media groups to contact each other. Staff were recruited from the local areas and internationally and care was given to any pastoral needs.

Senior leaders we spoke with were proud of the staff. They reported good relationships between all medical, nursing and operational staff with them being flexible across departments and divisions particularly during the Covid pandemic delivering safe and quality care.

Medical care (including older people's care)

Governance

Within the service leaders operated governance processes throughout the service. Staff at all levels were clear about their roles and accountabilities and had opportunities to meet, discuss and learn from the performance of the service. However, during the pandemic some processes had been stepped down.

The division followed the trust good governance handbook. For assurance and oversight the division presented information quarterly to the executive team.

Governance committee and divisional committee meetings were scheduled monthly however, were stood down if unable to proceed due to operational pressures. Action plans showed that items were actioned and closed on completion.

Speciality meetings were held departmentally. We reviewed a sample of meeting minutes. Meetings were held monthly, bi monthly or quarterly with some regular agenda items and some variations in agenda items. These included capacity, staffing, the electronic system, performance, restoration, national updates and audits. Attendees were invited across the speciality pathway to include in-patient and outpatient services. We noted that some specialities, such as cardiology included embedded minutes from clinical leads meetings and divisional meetings with similar structures for each of the meetings.

There were agenda items for policies however, no details were recorded on a number of the sample of minutes we reviewed. We requested results from clinical audits, however, did not receive any information. This meant we were not assured that action plans were in place and any concerns were being addressed appropriately.

Quality governance meetings were held that included the trusts ward accreditation scheme.

Learning from deaths meetings were held monthly where mortality indices were reviewed. There was senior executive representation as well as clinical staff from the trust divisions and the medical examiner. Mortality indicators were presented and reviewed at these meetings.

There were daily system overview meetings, trustwide. These monitored information such as numbers of patients who did not meet the criteria to reside and were awaiting packages of care in the community.

Management of risk, issues and performance

Leaders and teams had systems to manage performance, however, did not always identify relevant risks and issues and identify actions to reduce their impact.

The division had a risk register that was reviewed monthly. We were told actions were discussed in the senior team meeting, divisional committee and governance meetings and escalation was made at quality governance group. We were told that the risk management group was to be re-instated in April 2022 with a plan to oversee risk registers across the trust.

Senior leaders shared the top risks for the division; these included falls. This had resulted in a ‘deep dive’ exercise with the re-instatement of the falls improvement group and an action plan in place to help drive improvements. Ward managers we spoke with were aware of the top risks in their areas. We received a copy of the divisional risk register. The register included risk levels, the speciality, controls in place and dates for review. We requested copies of ward risk registers, however, did not receive them.

Medical care (including older people's care)

At the last inspection, a requirement notice was issued to improve the quality of local and divisional risk registers to show actions, areas of responsibility for actions, progress and completion dates. However, we reviewed the divisional risk register and found that risks identified on the inspection were not included, such as blocked / ineffective fire doors and issues with staff accessing the electronic system were not included.

A copy of the trust integrated performance report was shared, however, this was recorded at trust level only. It captured data for a range of metrics such as incidents, bed moves, HSMR, cancer and IPC.

The trust were a statistical outlier for Hospital Standardised Mortality Ratio (HSMR) at 113.8 between December 2020 and November 2021. The threshold was 100. (HSMR is a tool that adjusts for factors that affect in-hospital mortality rates, such as patient age, sex, diagnosis, length of stay, comorbidities and admission status.) There were six diagnosis groups that were outliers including connective tissue disease, hereditary neurological disorders, bronchitis and acute cerebrovascular disease.

Information Management

The service collected data. Staff could not always find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements.

The trust had moved to a new patient record system in July 2021 which meant all patient records were captured electronically. However, we found staff had experienced difficulties in navigating the system effectively. The trust had a digital and data strategy that outlined intentions over the coming years.

Information governance was part of mandatory training requirements. For the urgent care division, compliance was 58.5% for medical staff and 74.5% for registered nurses against a target of 90%.

In the 12 months prior to inspection, there were nine incidents recorded for the medical wards for information governance; all were recorded as no harm.

When the electronic system was implemented, it was found that there were delays in ward rounds due to insufficient numbers of computers. As a result the trust invested in 150 extra laptops.

The trust monitored quality indicators on real time dashboards and data was collected for the integrated performance reports monthly. This included a range of information including staffing fill rates, incidents, safeguarding, IPC, sepsis screening, patient feedback, training compliance and appraisal rates.

One of the stroke clinicians identified that for the Sentinel Stroke National Audit Programme (SSNAP) audit, there was no consistent way of recording data and this caused delays. A project was undertaken that resulted in a reduction in time spent inputting information meaning that staff could focus on patient care.

Engagement

Leaders and staff actively and openly engaged with patients, staff and some stakeholders to plan and manage services.

Senior leaders told us that the patient experience group were available to support patients with any feedback. Staff aimed to meet families face to face to address any emerging concerns. There was a recognition that patient voice was important and senior staff had invited patients with a long length of stay to share their experience in a learning exercise for all staff.

Senior staff participated in 'drop ins' for staff and forums for those who had been working from home, such as administrative support staff. Feedback from staff had resulted in some changes such as some re-configuring in the endoscopy department.

There was a psychologist available for staff as part of the services occupational health offer.

A 'Friday feedback' leaflet was produced for staff by the chief executive as well as operational updates and a weekly bulletin to cascade information to all staff.

For staff who completed the staff survey, a draw was made where staff could win six additional days annual leave. Staff were informed after the draws took place of winners; these could remain anonymous if preferred.

As part of the trusts 'greener strategy' purpose -built changing rooms had been constructed for staff with a cycle store to follow.

Staff participated in ward meetings if capacity allowed. We requested minutes from ward meetings, however, did not receive any.

Quality improvement projects were recognised and shared at a celebration event.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them.

The trust had developed a continuous improvement strategy dated 2020 to 2025 which had the aim of creating a culture in which staff came to work to 'do their work' and 'improve their work' through strong leadership, governance, capability, projects, engagement and learning. Leaders spoke about their improvement journey. Staff participated in quality improvement projects. For example, an endoscopy study concentrated on turnaround times. It identified that waiting times were too long for patients. Outcomes were being monitored through patient satisfaction and numbers of patients seen.

The trust had undertaken a number of improvement projects including conditions such as acute kidney injury, sepsis and pneumonia as part of their advancing quality programme.