St Helens and Knowsley Teaching Hospitals NHS Trust

Whiston Hospital

Quality Report

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

Ratings

Overall rating for this hospital	Good
Urgent and emergency services	Good
Medical care	Good
Surgery	Good
Critical care	Good
Maternity and gynaecology	Requires improvement
Services for children and young people	Good
End of life care	Good
Outpatients and diagnostic imaging	Outstanding

Summary of findings

Letter from the Chief Inspector of Hospitals

Whiston Hospital is part of St Helens and Knowsley Teaching Hospital NHS Trust and provides a full range of hospital services, including an urgent and emergency care facility, general and specialist medicine, general and specialist surgery full consultant led obstetric and paediatric hospital service for women, children and babies.

Whiston Hospital is situated in Prescot and serves a population of approximately 350,000 people residing in the surrounding area of Knowsley, Halton and St Helens. In total, the trust has 887 beds.

We carried out this inspection as part of our scheduled program of announced inspections

We visited the hospital on the 19, 20, 21 August 2015. We also carried out an out-of-hours unannounced visit on 05 September 2015. During this inspection, the team inspected the following core services:

- Urgent and emergency services
- Medical care services (including older people's care)
- Surgery
- Critical care
- Maternity and gynaecology
- Children and young people
- End of life
- Outpatients and diagnostic services

Overall, we rated Whiston Hospital as 'good'. We have judged the service as 'good' for safe, effective, and well led and 'outstanding' for caring. We noted that there were elements of outstanding practice in caring overall and in caring and well led in outpatients and diagnostic services. However maternity and gynaecology were judged as requiring improvement in three of the five areas safe, responsive and well-led.

Our key findings were as follows:

Leadership and management

- The hospital was led and managed by a cohesive and visible executive team. The team were very well known to staff and were regular and frequent visitors to the wards and departments. Staff were well engaged and were aware and committed to the organisational vision of five star patient care. There were good opportunities for staff to be included and active in service design and delivery. There was a range of reward and recognition schemes that were highly valued by staff. Staff were supported and encouraged to be proud of their service and achievements. Successes were actively acknowledged and celebrated.
- There was a positive culture throughout the hospital. Staff were open and honest and were very proud of the work they did and proud of the services they provided although there was additional work to be done to support a positive culture in maternity services. Overall staff morale was good with the exception of some staff in maternity services who were concerned regarding recent changes to shift patterns and internal rotation. Some also expressed a desire for their senior manager to be more visible and accessible to them. The senior team are aware of this concern and expressed a commitment to addressing the issues identified.

Access and Flow

- Access and flow in the emergency department remained a continuous challenge. The trust had a mixed performance against the four hourly national target over the year.
- The proportion of all patients that attended the emergency department and were treated within four hours was 93.2% (2,099 attendances) between October and December 2014, 91.7% (2,548 attendances) between January and March 2015 and 93.2% (2118 attendances) between April and June 2015.

Summary of findings

- An action plan was in place to improve performance in the four-hour waiting time targets. This included actions to review medical staffing arrangements to improve treatment and discharge times and to improve medical cover during nights and weekends.
- Patient flow through the hospital and discharge had improved. Between July 2014 and July 2015 data showed that there had been 87 medical outliers at the hospital. At the time of our inspection there were ten medical outliers. These were managed effectively from the point of admission which resulted in reduced bed moves during the hospital stay. Patients who were outliers were reviewed on a daily basis by a member of the medical team.
- There had been issues with delayed and out of hours discharges from critical care. More recently the figures for delayed and out of hours discharges had improved and are now comparable with similar units in other hospitals. This improvement has been attributed to team work, improved communication between departments and bed managers, a tightening up of the discharge process and more accurate data collection.
- Bed occupancy rates were higher than the England average from July 2014 to December 2015 in maternity, with the rates ranging from 73-88 % compared to 56 to 60% nationally. This meant the maternity services were running at a higher than usual capacity and we were not made aware of plans for managing this. Only 9.3% of midwives were trained to complete the new-born infant physical examinations and there was a lack of paediatric doctors to complete these. This led to delays in discharge within the maternity service.
- Patients were seen and assessed by the special palliative care team within 24 hours of referral. A rapid discharge processes were in place in getting people to their preferred place of care prior to their death.
- The outpatient department undertook 234,725 outpatient appointments during 2014/15. The trust met internal and national referral to treatment targets and was easily meeting the national six week target for patients waiting for a diagnostic appointment. The also trust performed better than the England average during 2013/14 and 2014/15 for patients waiting less than 32 and 62 days for treatment. We found the trust was consistent with the England average for patients seen by a specialist within two weeks from 2013/14 to 2014/15.

Cleanliness and Infection control

- Patients were cared for in a visibly clean and hygienic environment.
- Staff followed the trust policy on infection control and adhered to the 'bare below the elbows' policy.
- Cleaning schedules were in place, and there were clearly defined roles and responsibilities for cleaning the environment and cleaning and decontaminating equipment.
- There were arrangements in place for the handling, storage and disposal of clinical waste, including sharps. There was a suitable supply of hand wash sinks and hand gels available.
- Staff were observed wearing personal protective equipment, such as gloves and aprons, while delivering care. Gowning procedures were adhered to in the theatre areas.
- Patients identified with an infection were isolated in side rooms. We saw that appropriate signage was used to protect staff and visitors. The trust had employed a number of infection control link nurses and a surgical site infection specialist nurse worked across both sites. Their role was to provide training and to liaise with staff so patients that acquired infections following surgery could be identified and treated promptly.

Nurse staffing

- Nurse staffing levels were determined using an evidence based tool.
- The expected and actual staffing levels were displayed on a notice board on each unit/ward and these were updated on a daily basis.
- Staffing levels were planned to ensure an appropriate skill mix to provide care and treatment for patients.
- However, nurse staffing levels, although improved, remained a challenge in some areas. This was particularly the case in medical care services and maternity and gynaecology. Staffing levels were maintained by staff regularly working overtime and with the use of bank or agency staff. Where possible, regular agency and bank staff were used which meant they were familiar with policies and procedures. Any new agency staff received an induction prior to working on the wards.

- The trust had implemented a number of initiatives to address shortages in nurse staffing including: actively recruiting nursing staff from overseas and linking with local universities.

Medical staffing

- Medical treatment was delivered by skilled and committed medical staff.
- Consultant cover was provided 24 hours a day seven days a week on the critical care unit.
- In the emergency department the proportion of registrars and junior doctors was greater than the England average. The proportion of consultants was below the England average (19% compared with the England average of 23%). The proportion of middle grade doctors was also below the England average (4% compared with the England average of 13%).
- Consultant staff in children's and young people's services reported a shortfall in middle grade doctor staffing. Ten middle grade doctors were required but the service only currently employed eight. The two remaining vacancies were filled by locum doctors and through extra staffing in A&E.
- The trust's own specialist consultant in palliative medicine was on secondment at the time of inspection. Cover was provided by the community consultant in palliative medicine for St Helen's, Knowsley and Halton who provided five sessions per week at the hospital. In addition the hospice's specialist registrar provided two sessions per week. Managers were aware of this shortfall and plans were in place for the recruitment of a specialist consultant.
- Staff rotas were maintained by the existing staff and through the use of agency or locum consultants. Where locum doctors were used, they underwent recruitment checks and induction training to ensure they understood the hospital's policies and procedures. The majority of locum and agency doctors had worked at the hospital on extended contracts so they were familiar with the hospital's policies and procedures.

Mortality rates

- Multidisciplinary mortality and morbidity reviews were held for a 20% random sample of every death in medical services. If the review indicated any issues these were then rated as amber and further in-depth investigation took place. There had been six amber reviews in the last nine months prior to inspection.
- Mortality and morbidity reviews were held in accordance with trust policies and were underpinned by policies and procedures. Deaths were reviewed thoroughly and appropriate changes made to help to promote the safety of patients.
- Mortality meetings were held in the form of critical reviews for any deaths involving children. The service linked with maternity services to ensure a multi-disciplinary approach to review and learning.

Nutrition and hydration

- Where possible there was a period over meal times where all activities on the ward stopped, if it was safe for them to do so. These protected meal breaks enabled staff to assist patients who needed assistance to eat and drink.
- A coloured tray and jug system was in place to highlight which patients needed assistance with eating and drinking. The mealtime co-ordinators wore red aprons and other staff wore blue aprons at mealtimes. The mealtime co-ordinators communicated with the catering staff and ensured all patients had a hot meal.
- Patients we spoke with said they were happy with the standard and choice of food available. The menus were comprehensive and there was a wide variety for patients to choose from. Patients said they were also encouraged to go to the hospital restaurant to eat their meals and that they ordered their meals the same day to ensure they chose what they felt like eating that day
- Meals were managed and served by the housekeeping staff in children's services and nurses did not have an oversight of the meals provided or consumed.

We saw several areas of outstanding practice including:

Summary of findings

- The trust had developed a pressure ulcer (PU) risk assessment tool used by the tissue viability nurses across the wards. This took into account the grade of the PU risk and a care plan was determined which included the equipment to be used for the patient.
- The additional needs pathway and coordinated approach to a patient with additional needs reduced the need for repeat procedures and enhanced the patient's experience.
- In order to improve the response time and access to timely treatment for a patient, if a critical or abnormal finding on an X-ray was seen detected radiology staff could book another follow up appointment with the appropriate specialist at the time of reporting.

However, there were also areas of poor practice where the trust needs to make improvements.

Importantly, the trust must:

- Continue its efforts to meet four-hour emergency department national targets.
- Meet the DH target for handovers between ambulance and emergency department.
- Ensure there is the appropriate skill mix of staff and patient's privacy and dignity is maintained at all times on the coronary care unit.
- Ensure there is a system in place to assess and improve the quality and safety of the services provided following a serious incident. This must include actions to mitigate the risks relating to the health and safety of service users. (Maternity services).
- Ensure systems in place for the storage of medicines are safe.

In addition the trust should:

In urgent and emergency care services:

- Improve mandatory training and staff appraisal compliance in some areas.

In medical care services:

- Conduct a review of training of the medicines policy in relation to the administration of regular medication via oral or intravenous routes.
- Ensure that the implementation of the care certificate is implemented across all services within the national timeframe.
- Ensure that all staff are applying the mental capacity act principals to the use of bedrails.
- Ensure that hazardous chemicals are stored appropriately in a locked cupboard when not in use.

In surgery:

- Ensure all prosthetists receive an appraisal in a timely manner

In critical care:

- The trust should ensure that the use of CCTV cameras does not impact adversely upon patients' dignity and respect.
- Ensure that all dialysate fluids are kept locked and only accessible to appropriate staff.
- Ensure that all equipment for use in the resuscitation of patients is in date and regularly checked.
- Consider the intensive care society standards for supernumerary staffing when calculating the nurse establishment.

In maternity and gynaecology

- Ensure all midwives are competent in the assessment of CTG monitoring.
- Ensure the procedures for CTG monitoring, including assessment, are in line with best practice guidance.
- Ensure the systems for checking emergency equipment include details of which parts of the equipment are checked and how this is completed.
- Ensure the matrix used to grade incidents is reviewed to ensure near misses are included.

- Ensure specific maternity safety thermometer is used to monitor the delivery of harm free care.
- Ensure the bereavement rooms are a less clinical and provide a more comfortable environment for bereaved patients and their supporters.
- Ensure records are filed in such a way as to afford easy access for medical staff to the record required.
- Ensure medical records are stored confidentially in all areas.
- Ensure all anaesthetists are up to date with the obstetric skills and drills training.
- Ensure band 7 shift co-ordinators on the delivery suite work in a supernumerary capacity to meet best practice guidance.
- Ensure the system for documenting patients being admitted to the delivery suite, including those coming into the unit for ante-natal assessment at evenings and weekends are reviewed to ensure it is clear where patients are at all times .
- Ensure there is a seven day service for ante-natal patients to access support, including in early pregnancy.

Children and young people's services

- Ensure staff consistently follow trust policy and best practice in relation to completing vital sign observations for children and young people.
- Ensure nurses on wards 3F and 4F take an active part in managing meals and mealtimes.
- Ensure food and nutrition is always stored and accessed safely.
- Ensure staff receive training about when to consider the Mental Capacity Act for young people over 16 years old.
- Ensure a variety of opportunities are provided for children, young people and their parents to comments about the service.
- Consider promoting use of the translation service in all instances when a child or young person when English is not their first language.
- Consider additional steps to ensure all children and young people departments provide relevant and required governance reports when expected.
- Consider analysing staff survey according to directorate so specific experiences and ideas are used to influence the development of the service neonatal, children and young people service.
- Consider setting target dates by which plans should be achieved so improvements can be measured.
- Make the development of robust succession plans for the neonatal unit and children's wards a priority involving staff in the planning and delivery process.
- Consider reviewing the environment of the neonatal unit alongside best practice for example the Health Building Note 09-03: Neonatal units department of health publication.

End of life

- Develop an EOL strategy.
- Appoint a palliative care consultant.
- Discharge summaries should be sent to patients GPs when patients the have been seen by the trust SPC team.
- Consider the provision of a fully functional electronic palliative care co-ordinating System (EPACCS) across all relevant sites would enable service providers across boundaries to share information.
- Consider how the amber care bundle is to be rolled out as the facilitators post had ceased and there were currently no plans to replace this position.

In outpatients and diagnostic imaging services:

- Ensure that the therapy review is concluded to facilitate the integration of therapies into the trust following their transfer from another provider.
- Continue to seek ways to work with other partners to lessen the impact of the national shortfall of prosthetic services.

Summary of findings

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Good	We gave the emergency and urgent services at Whiston Hospital an overall rating of good. However, we found further improvements were needed in how the service responded to patient needs. This was because the Department of Health (DH) target for emergency departments is to admit, transfer or discharge 95% of patients within four hours of arrival. During this period the number of patients treated within four hours ranged from 91.3% to 93.2%. This was mainly due to a lack of available beds to transfer patients to and also due to delays of more than two hours in seeing a doctor. The trust was not meeting the targets for ambulance handovers between January and July 2015. Trust data showed 831 ambulance handovers took between 30 and 60 minutes to complete and 199 handovers took longer than 60 minutes to complete during this period. The staffing levels and skills mix was sufficient to meet patients' needs and staff assessed and responded to patient's risks. Staff received mandatory training in order to provide safe and effective care. However, the numbers of staff that had completed mandatory training was below the hospital's expected levels. Patient safety was monitored and incidents were reported and investigated to assist learning and improve care. Patients received care in safe, clean and suitably maintained premises. There were systems in place to manage resource and capacity risks and to manage patients whose condition was deteriorating. Care and treatment was provided in line with national clinical guidelines and staff used care pathways effectively. The services participated in national and local clinical audits such as the College of Emergency Medicine audits and performed in line with the England average for most safety and clinical performance measures.

Summary of findings

The majority of patients had a positive outcome following their care and treatment. Patients received care and treatment by trained, competent staff that worked well as part of a multidisciplinary team.
Patients spoke positively about their care and treatment. They were treated with dignity and compassion. Patients and their relatives were supported with their emotional needs, and there were bereavement and counselling services in place to provide support for patients, relatives and staff. There were systems in place to support vulnerable patients. Complaints about the service were shared with staff to aid learning. There was effective teamwork and clearly visible leadership within the department. The majority of staff were positive about the culture within the emergency department and the level of support they received from their managers.

Medical care	**Good**	We gave the medical care services at Whiston Hospital an overall rating of good. However, we found further improvements were needed in how the service provided care that was effective to patient needs Patients received compassionate care and their privacy and dignity were maintained. Patients were involved in their care, and were provided with appropriate emotional support. Incidents were reported by staff through effective systems and lessons were learnt and improvements made from Investigations where findings were fed back to staff. Staff were aware of how to ensure patients' were safeguarded from abuse and neglect. The wards were visibly clean and staff followed good hygiene practices. There were effective systems in place to ensure patient safety was monitored and maintained. Staffing levels were overall sufficient to meet the needs of patients. Care was provided in line with national best practice guidelines and medical services participated in the majority of clinical audits. There was a strong focus on discharge planning from the moment of admission and services to support timely discharge were provided seven days a week.

Summary of findings

We found that staffs' understanding and awareness of assessing people's capacity to make decisions about their care and treatment were variable.
Services took into account the needs of the local people. There were good ambulatory care services and a specialist unit for the frail and elderly.
The hospital had implemented a number of schemes to help meet people's individual needs, such as the forget-me-not sticker for people living with dementia or a cognitive impairment and the falling leaf symbol to indicate that a patient was at risk of falls. This helped alert staff to people's needs.
Medical services captured views of people who used the services with changes made following feedback. A survey showed that people would recommend the hospital to friends or a relative.
Staff told us that they felt valued and supported. There was good staff engagement with staff being involved in making improvements for services. All staff were committed to delivering good, compassionate care and were motivated to work at the hospital.

Surgery	Good		We gave the surgical care services at Whiston Hospital an overall rating of good. This was because patients, carers and families were positive about the care and treatment provided. They felt supported, involved and staff actively engaged with patients whilst providing kind compassionate care. We observed positive interactions when staff were seeking consent. Staff supported patients and their relatives with their emotional and spiritual needs. Safe systems were in place for reporting incidents, duty of candour and safeguarding issues. Staff were aware of current infection prevention and control guidelines. Equipment was sufficiently available, clean, safe and well maintained, appropriately checked and decontaminated regularly with checklists in use. Medicines, including controlled drugs, and records were stored securely. The World Health Organization surgical safety checklist data was reviewed on a monthly basis. There was a

documented strategic business continuity and internal major incident plan within surgical services with the possible key risks that could affect the provision of care and treatment.
Staff provided care and monitored compliance in line with national best practice guidelines. There was participation in national audits. Data from the audits was positive and the trust had appropriate action plans in place to address any identified shortfalls.
Patients were assessed individually for pain relief and for their nutritional requirements. Staff were competent and well supported by managers.
Multidisciplinary team working was well established and effective within the surgical wards and theatres.
Discharge planning began at the point of admission with multidisciplinary input.
NHS England data showed national 18 week referral to treatment targets were being met. The number of elective operations cancelled was better than the England average and all patients that had their operations cancelled were treated within 28 days since April 2011. Trust data showed the number of surgical outliers on medical wards was very low.
The clinical & quality strategy outlined how the service would be improved by providing timely treatment by reducing cancelled operations and by improving discharge times. Surgical patient pathway improvement programme work streams were in place to promote efficiency.
Governance process allowed risks to be escalated appropriately. Risks were documented and escalated by the service appropriately with action plans in place to address the identified risks.

Critical care

Good

We gave the critical care services at Whiston Hospital an overall rating of good.
There were sufficient numbers of suitably skilled and experienced nursing and medical staff on duty to care for patients.
Critical care services were being delivered by caring, compassionate and committed staff. We saw patients, their relatives and friends being treated with dignity and respect. The unit provided a critical care outreach service. We found that the critical care service was well led.

Summary of findings

			Patients and those close to them were positive about their care and treatment. There were robust systems and processes in place for reporting incidents and there was evidence that learning from incidents was shared. However, we found that medicines were not always stored securely and regular checking had not picked up on some out of date equipment on the resuscitation and difficult airway management trolleys. When people required intensive care there were no significant delays in that care being delivered, however, there was often a delay in discharging patients once they had been judged as medically fit for discharge. The unit continued to collect and submit data for the intensive care national audit and research centre (ICNARC) for validation, so it was able to benchmark its performance against comparable units. This data showed that patient outcomes were within the expected ranges when compared with similar units nationally.
Maternity and gynaecology	**Requires improvement**		We gave the maternity and gynaecology services at Whiston Hospital an overall rating of Requires Improvement. The maternity and gynaecology services at Whiston Hospital required improvement in the safe, responsive and well led domains. There was a lack of systems to learn from incidents and improve practice. Equipment had not been adequately monitored, medicine storage was unsafe in three areas and the guidelines for detecting deterioration in patients were not always followed. There were some shortfalls in the midwifery staffing; however actions were in place to address this. There were issues with the access and flow of patients through the unit with particular effect on the delivery suite. Patients had limited choices for the birth of their baby due to a dominant medical model of care. There was a lack of leadership for the service and no vision or strategy for future developments. We did not see evidence of a robust risk management system. The service was rated as good in the caring and effective domain.

Summary of findings

			Patients spoke highly of the care they received and the information they were given. There was good support for bereaved patients and those with complex needs. The policies and procedures in the service met national guidance and were regularly reviewed. Practices were audited and changes made if required. There was good infant feeding support and initiatives and patient outcomes were similar to the England average in most measures.
Services for children and young people	**Good**		We gave the Services for children and young people at Whiston Hospital an overall rating of Good; however in some areas we saw elements of outstanding practice. Treatment and care were delivered in accordance with best practice and recognised national guidelines. Children, young people and their families were respected and valued as individuals. Feedback from those who used the service was positive. Staff were compassionate, caring and provided effective care to children, young people and their families. Transition and acute community nursing support was comprehensive and made a positive impact for young people transitioning into adult services. Staff were both creative and flexible to ensure care met the needs of individual children and young people. Feedback from children, young people and parents was exceptionally positive. Staff were passionate about delivering high quality care and went above and beyond the usual duties to ensure children and young people experienced high quality care The staff worked well with other teams and worked hard to provide a service to meet the needs of the child or young person who presented to the hospital. Processes were in place to provide an initial or long term service to any child or young person brought to Whiston hospital. Staff were passionate about working with children and young people and felt valued by senior managers. There was a good track record of lessons learnt and improvements being made when things went wrong. This was supported by staff working in an open and honest culture with a desire to get things right.

Summary of findings

Children, young people and their families were not provided with regular opportunities to comment about the services provided. The trust was in the process of sourcing a system to help them gain an understanding of how children and young people felt about the care provided.

End of life care **Good**

We gave the end of life care (EOL) services at Whiston Hospital an overall rating of good.

The palliative and end of life patient journey was supported by a strong Nurse led Specialist Palliative Care Team that worked closely with the ward based staff. There had recently been board approval to appoint a specialist consultant with recruitment underway.

We found that staff were committed to providing a good quality service that was delivered with compassion and dignity.

Staff were clear about their commitment to providing care that ensured patients ended their life in a dignified way in their preferred place of care.

There were good systems in place for rapid discharge so that patients could return to their preferred place of care at short notice.

Patients were involved in their care, supported to make informed decisions and were provided with appropriate emotional support at a difficult time for patients and those close to them.

The trust had acted on the Department of Health's National End of Life Strategy recommendations and was introducing the amber care bundle which encouraged talking openly about people's wishes and putting plans in place should the person die.

The service had a work programme in place and wished to develop this into a future strategy for the service. The trust had a board member with a specific lead for EOL care to ensure scrutiny and challenge regarding performance at a senior level.

Staff spoke positively about the support they were given by senior staff and management.

Systems were in place to prevent patients suffering avoidable harm. Incidents were reported by staff appropriately, they were investigated, lessons were learnt and improvements made to the service as a result.

Summary of findings

Patients' medication was well managed with the pharmacy team responding to requests promptly so patients received effective symptom control in a timely way.

Outpatients and diagnostic imaging	**Outstanding**		We gave the outpatients & diagnostic imaging services at Whiston Hospital an overall rating of outstanding. Incidents were being reported and staff were aware of the reporting system and how to use it. There was evidence of learning from incidents and how this learning was shared across the service and trust wide. Cleanliness and hygiene was of a high standard throughout the hospital outpatient departments and staff followed good practice guidance in relation to the control and prevention of infection. The service used electronic medical records that were easily accessible when patients visited the service. Information about patient's treatment and care needs were obtained from relevant sources before clinic appointments to enable the service to meet the patient's individual needs. The electronic patient record enabled timely access to information and diagnostic test results during consultation which contributed to patients making fully informed decisions about their care and treatment. Staff were aware of their role in safeguarding, a reporting process was in place, and staff knew how to escalate issues of abuse and neglect. Patients attending the outpatient and diagnostic imaging departments received care that was evidence based and followed national guidance. Staff worked together in a multidisciplinary environment to meet patients' needs. Staff were competent in their roles and supported by management systems to provide a good quality service to patients. The service had been proactive in working towards providing seven days services within radiology and pathology services. Patients were treated in a compassionate, respectful and considerate manner. The majority of patients said the staff had a good attitude, this was also reflected in a patient satisfaction survey. There were good examples of a clear pathway and assessment planning for patients with additional

Summary of findings

needs this to ensure they received the appropriate support in a timely manner. This included the use of identifying the need for pre appointment visits to relevant departments to be arranged if required.

Leadership within the outpatient and diagnostic imaging service was very positive, visible and proactive. Managers had a strong focus on the needs of patients and the roles staff needed to play in delivering good care.

All the staff we spoke with were aware of the feedback from the NHS friends and family test. The trust was ranked one of the highest in the country for extremely positive feedback received from patients.

The service had a range of forums to seek patients' feedback such as the "patient power" group.

The trust ranked in the top 100 places to work in the NHS in an external health journal.

Many of the departments we visited had awards on display and staff and patients were proud to show us what they had achieved. There were many examples of national targets being shortened by internal targets to drive improvements throughout the service.

Whiston Hospital

Detailed findings

Services we looked at

Urgent and emergency services; Medical care (including older people's care); Surgery; Critical care; Maternity and gynaecology; Services for children and young people; End of life care; Outpatients and diagnostic imaging

Detailed findings

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Background to Whiston Hospital

Whiston Hospital is part of St Helens and Knowsley Teaching Hospitals NHS Trust. Whiston Hospital is situated in Prescot, Merseyside. The hospital services a population of approximately 350,000 residing in the surrounding area of Knowsley and St Helens In total, the trust has 887 beds and employs approximately 4,200 members of staff.

In 2014/15 the total number of admissions for 14/15, including day cases, in-patients and non-elective was 102,964, 433,069 outpatient attendances and 124,682 A&E attendances.

During this inspection, the team inspected the following core services:

- Urgent and emergency services
- Medical care services (including older people's care)
- Surgery
- Critical care
- Maternity and gynaecology
- Children and young people
- End of life
- Outpatients and diagnostic services

Our inspection team

Our inspection team was led by:

Chair: Chris Harrison, Medical Director

Head of Hospital Inspections: Ann Ford, Care Quality Commission

The team included a CQC inspection manager, 14 CQC inspectors, a CQC pharmacy inspector two CQC analysts, a CQC inspection planner and a variety of specialists including: A former medical director; consultant in clinical oncology, a consultant physician, surgeon & obstetrician; surgical, medical, emergency department, maternity, critical care and paediatric senior nurses; an expert by experience (lay members who have experience of care and are able to represent the patients voice) and a clinical governance specialist.

How we carried out this inspection

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

- Is it safe?
- Is it effective?
- Is it caring?

Detailed findings

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

Before visiting, we reviewed a range of information we held about Whiston Hospital and asked other organisations to share what they knew about the hospital. These included the clinical commissioning groups, the Trust Development Authority, NHS England, Health Education England, the General Medical Council, the Nursing and Midwifery Council, the Royal colleges and the local Healthwatch.

The announced inspection of Whiston Hospital took place on 19, 20 and 21 August 2015. We held focus groups and drop-in sessions with a range of staff in the hospital, including nurses, trainee doctors, consultants, midwives, student nurses, administrative and clerical staff, physiotherapists, occupational therapists, pharmacists, domestic staff and porters. We also spoke with staff individually as requested.

The unannounced inspection took place on 5 September 2015, this was of the maternity and gynaecology services at the hospital

Facts and data about Whiston Hospital

The new Whiston Hospital opened in 2010 as part of a £338m redevelopment plan, which included the opening of St Helens Hospital.

Whiston Hospital provides care to a population of 350,000. The services are provided across the boroughs of St Helens, Knowsley, Halton and the area of South Liverpool. The Mersey regional burns and plastic surgery unit at Whiston Hospital provides treatment for patients across Merseyside, Cheshire, Isle of Man and parts of the north west which reaches a population of over 4 million. The trust employs over 4,000 members of staff.

The IMD (2010) ranked St Helens Borough as the 51st most deprived local authority in England. The borough of Knowsley is ranked as the 3rd most deprived in the country. Across both areas some of the severe health problems seen include the incidence of heart disease, lung cancer and chronic lung disease which are much higher than the national average.

Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good	Good	Good	Requires improvement	Good	Good
Medical care	Good	Good	Good	Good	Good	Good
Surgery	Good	Good	Good	Good	Good	Good
Critical care	Good	Good	Good	Good	Good	Good
Maternity and gynaecology	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Services for children and young people	Good	Good	☆ Outstanding	Good	Good	Good
End of life care	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	N/A	☆ Outstanding	Good	☆ Outstanding	☆ Outstanding
Overall	Good	Good	☆ Outstanding	Requires improvement	Good	Good

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for Outpatients & Diagnostic Imaging.

Urgent and emergency services

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

Information about the service

Emergency and urgent services for the St Helens and Knowsley Teaching Hospital NHS Trust were provided from Whiston Hospital. The service was open 24 hours a day, seven days a week and provided urgent and emergency care and treatment for children and adults across Knowsley, St. Helens and the surrounding areas.

During 2014 /15, approximately 101,200 patients attended the emergency department. This was an increase of 3.2% from the previous year. The emergency department included separate triage and waiting areas for adults and children. There was a separate children's area with four cubicles.

The ambulance stretcher triage area had five bays. The resuscitation area could accommodate up to seven patients and there was a separate trauma bay for adults and children. The emergency department was a receiving centre for major trauma patients. The minor injuries area had six cubicles and four consultation rooms. There were two major injuries areas, one with nine cubicles and the other with eight cubicles that were mainly used during busy periods to provide additional capacity.

Patients that required diagnosis, observation, treatment and rehabilitation, including overnight stay, were transferred to the emergency assessment unit / observation (EAU) ward which had 14 beds and a seating area to accommodate a further four patients.

We visited the emergency department at Whiston Hospital during our announced inspection on 18–21August 2015.

We spoke with nine patients, observed care and treatment and looked at the care records for 12 patients. We also spoke with a range of staff at different grades including nurses, doctors, consultants, the practice development nurse, healthcare assistants, a medical assistant, emergency nurse practitioners, a social worker, the mental health liaison nurse, the alcohol liaison team, the ambulance liaison officer (who was employed by another organisation), the interim directorate manager, the lead nurse and the clinical director for the emergency department. We received comments from our listening events and from people who contacted us to tell us about their experiences, and we reviewed performance information about the trust.

Urgent and emergency services

Summary of findings

We gave the emergency and urgent services at Whiston Hospital an overall rating of good. However, we found further improvements were needed regarding how the service responded to patient needs.

This was because the Department of Health (DH) target for emergency departments is to admit, transfer or discharge 95% of patients within four hours of arrival. During this period the number of patients treated within four hours ranged from 91.3% to 93.2%. This was mainly due to a lack of available beds to transfer patients to and also due to delays of more than two hours in seeing a doctor.

The trust was not meeting the targets for ambulance handovers between January and July 2015. Trust data showed 831 ambulance handovers took between 30 and 60 minutes to complete and 199 handovers took longer than 60 minutes to complete during this period.

Staff received mandatory training in order to provide safe and effective care. However, the numbers of staff that had completed mandatory training was below the hospital's expected levels. The staffing levels and skills mix was sufficient to meet patients' needs and staff assessed and responded to patient's risks.

Patient safety was monitored and incidents were reported and investigated to assist learning and improve care. Patients received care in safe, clean and suitably maintained premises. There were systems in place to manage resource and capacity risks and to manage patients whose condition was deteriorating. Patients care was supported with the right equipment. Medicines were stored and administered appropriately. Staff were aware of how to access guidance in the event of a major incident.

Care and treatment was provided in line with national clinical guidelines and staff used care pathways effectively. The services participated in national and local clinical audits such as the College of Emergency Medicine audits and performed in line with the England average for most safety and clinical performance measures.

The majority of patients had a positive outcome following their care and treatment. Patients received care and treatment by trained, competent staff that worked well as part of a multidisciplinary team. Staff sought consent from patients before delivering care and treatment. Staff understood the legal requirements of the Mental Capacity Act 2005 and deprivation of liberties safeguards.

Patients spoke positively about their care and treatment. They were treated with dignity and compassion. Data for patient satisfaction surveys showed most patients were positive about recommending the emergency department to friends and family. Patients and their relatives were supported with their emotional needs, and there were bereavement and counselling services in place to provide support for patients, relatives and staff.

There were systems in place to support vulnerable patients. Complaints about the service were shared with staff to aid learning. Key risks were logged on the emergency department risk register and these risks were monitored through monthly governance and quality monitoring meetings. There was effective teamwork and clearly visible leadership within the department. The majority of staff were positive about the culture within the emergency department and the level of support they received from their managers.

Urgent and emergency services

Are urgent and emergency services safe?

Good

Staff received mandatory training in order to provide safe and effective care. However, the numbers of staff that had completed mandatory training was below the hospital's expected levels. The staffing levels and skills mix was sufficient to meet patients' needs and staff assessed and responded to patient's risks.

Patient safety was monitored and incidents were investigated to assist learning and improve care. Patients received care in safe, clean and suitably maintained premises. There were systems in place to manage resource and capacity risks and to manage patients whose condition was deteriorating. Patients care was supported with the right equipment. Medicines were stored and administered appropriately. Staff were aware of how to access guidance in the event of a major incident.

Incidents

- The strategic executive information system data showed there were three serious incidents reported in relation to emergency and urgent care services across the hospital between May 2014 and April 2015. This included one patient fall incident, a missed diagnosis and an incident of delayed care and treatment.
- There was evidence that these incidents were investigated and remedial actions were implemented to improve patient care. This included an improved nursing triage procedure and additional training for staff in relation to falls risk assessments and completing records in chronological order.
- The lead nurse for the emergency department told us approximately 110 to 120 incidents were raised by staff each month within the department. Around half of these were in relation to patients attending the department with pressure ulcers that had been acquired in the community.
- Staff were aware of the process for reporting any identified risks to patients, staff and visitors. All incidents, accidents and near misses were logged on the trust-wide electronic incident reporting system.
- Incidents logged on the system were reviewed and investigated to look for improvements to the service. Serious incidents were investigated by staff with the appropriate level of seniority, such as the lead nurse or clinical director.
- Staff discussed incidents during monthly governance and quality improvement meetings so shared learning could take place. This was confirmed in the meeting minutes we reviewed.
- The incident reporting system identified incidents that had led to serious or moderate harm to patients and prompted staff to apply duty of candour (being open and honest with patients when things go wrong).
- The directorate manager gave an example of a complaint made in July 2015 where a patient experienced moderate harm as a result of a delayed / inappropriate diagnosis. Records showed that a formal apology was given to the patient and their relatives along with an explanation of the steps to be taken to address the issue.
- Patient deaths were reviewed by individual consultants and were presented at departmental mortality and morbidity meetings that took place every six months.

Cleanliness, infection control and hygiene

- There had been no MRSA bacteraemia infections and one C.difficile infection in the department between April 2014 and August 2015.
- We reviewed at the investigation report and action plan for a C.difficile incident in August 2015. This showed that the incident had been investigated appropriately, with clear involvement from nursing and clinical staff, as well as the trust's infection control team.
- The emergency department and emergency assessment unit (EAU) ward was visibly clean, tidy and maintained to a good standard. Staff were aware of current infection prevention and control guidelines. Cleaning schedules were in place, with clearly defined roles and responsibilities for cleaning the environment and cleaning and decontaminating equipment.
- There were arrangements in place for the handling, storage and disposal of clinical waste, including sharps. There were enough hand wash sinks and hand gels. We observed staff following hand hygiene and 'bare below the elbow' guidance. Staff were observed wearing personal protective equipment, such as gloves and aprons, while delivering care.

Urgent and emergency services

- Patients identified with an infection were isolated in side rooms. Appropriate signage was used to protect staff and visitors. However, the door to a side room on the EAU ward was partially open when the signage stated the door must be closed due to risk of spread of infection. This was pointed out to ward staff and addressed during the inspection visit.
- Staff told us all patients admitted to the hospital were screened for MRSA. Patients identified with diarrhoea and vomiting symptoms were also screened for C.difficile. Records noted patients with known infections so they could easily be identified and treated appropriately.
- There were infection control link nurses in place who cascaded information from the trust-wide infection control team.
- Staff carried out weekly and monthly monitoring of compliance in areas such as management of waste and sharps, hand washing compliance and cleanliness of the environment and equipment. The trust-wide infection control team also carried out an annual audit of the department, which showed a high level of compliance across the department (90%) following the January 2015 audit.

Environment and equipment

- The emergency department was well maintained, free from clutter and provided a secure environment for treating patients.
- The department had security guards present at all times. There was also a Police presence between 10pm and 6am on Fridays and Saturdays for the protection of patients, staff and visitors.
- The admission route was set up so that patients conveyed by ambulance and those at high risk were seen and triaged immediately. High risk patients were visible from the nursing stations for observation and timely intervention. There was clear segregation for adults and children that attended the department, including separate waiting, triage and assessment areas.
- There was a secure room that was used to assess patients with mental health needs. This was not a Section 136 room (a designated place of safety) under the Mental Health Act (1983). Patients who required a designated Section 136 room could be transferred to a nearby hospital with suitable facilities to provide appropriate care.
- Adequate equipment was available in all areas including appropriate equipment for children. Staff told us the equipment needed was readily available and any faulty equipment could be replaced from the hospital's equipment store.
- Equipment was serviced by the trust's maintenance team under a planned preventive maintenance schedule. Staff told us they received good and timely support.
- Two units of O negative emergency blood were kept in the resuscitation area in a dedicated fridge and staff carried out daily checks to ensure this was stored appropriately and kept within expiry dates.
- The departmental risk register identified a risk due to a lack of syringe pumps within the emergency department because these routinely accompanied patients when they were admitted to wards. Staff told us patients were not at risk but time was wasted trying to locate these pumps. The department planned to address this by implementing a tracking system so pumps issued to patients could be promptly located across the hospital.
- We found a number of sterile procedure packs (such as for major amputation, normal delivery and caesarean delivery) within the resuscitation area that had expired but were available for use. This meant the items within the procedure packs may not be sterile if used. We raised this with the directorate manager and clinical director during the inspection and were assured that these items would be immediately removed.
- Emergency resuscitation equipment was available in all the areas we inspected. However, we saw the daily or weekly equipment checklists were not always completed by staff. The directorate manager told us they planned to address this by allocating a senior nurse to monitor staff compliance in carrying out equipment checks.

Medicines

- Medicines, including controlled drugs, were securely stored. Staff carried out daily checks on controlled drugs and medication stocks to ensure that medicines were reconciled correctly.
- Medicines were ordered, stored and discarded safely and appropriately. Staff from the pharmacy department were responsible for maintaining minimum stock levels and checking medication expiry dates.

- Medicines that required storage at temperatures below 8ºC were appropriately stored in medicine fridges. Fridge temperatures were monitored daily to check medicines were stored at the correct temperatures.
- We looked at the medication charts for five patients and found these to be complete, up to date and reviewed on a regular basis.

Records

- Staff used paper patient records and these were securely stored in each area we inspected.
- The emergency department had developed its own patient clinical assessment record that included the patient's personal details, previous admissions and alerts for allergies and observations charts. There was a separate triage record for adults and children that also prompted staff to document the care pathways patients were placed on, such as for sepsis, asthma or chest pain.
- We looked at the records for nine patients. These were structured, legible, complete and up to date, with few errors or omissions. Patient records included risk assessments, such as for falls, pressure care and nutrition and were reviewed and updated on a regular basis.
- Patient records showed that nursing and medical assessments were carried out in a timely manner and documented correctly. Observations were well recorded and the observation times were dependent on the level of care needed by the patient.

Safeguarding

- Staff received mandatory training in the safeguarding of vulnerable adults and children. The senior nurses across the department and all nurses that cared for children received advanced safeguarding (level three) training.
- We were not able to obtain safeguarding training data specifically for the emergency department. However, Trust data showed 88% of staff in the medical care division (which included the emergency department) had completed level one children and vulnerable adults safeguarding training and the trust target for 85% training completion had been achieved.
- The data showed that against a trajectory of 52%, compliance was 56% for staff that had completed level two children and vulnerable adults safeguarding training across the medical care group (including the Emergency Department). A three year trajectory was agreed with commissioners following major changes to the number of staff requiring level two training as a result of a revision to national guidance in 2014.
- Staff were aware of how to identify abuse and report safeguarding concerns. The emergency department had dedicated safeguarding leads for adult and children and there were safeguarding link nurses in place. Staff could also obtain support and guidance from social workers or the health visitor that were based on site.
- Policies outlined the processes for safeguarding vulnerable adults and children. Staff followed specific guidelines and care pathways where concerns around safeguarding children and young people were identified, such as instances of self-harm.

Mandatory training

- Staff received mandatory training in key topics such as infection control, information governance, equality and diversity, fire safety, health and safety, safeguarding children and vulnerable adults, manual handling and harassment and bullying.
- The overall mandatory training completion rate for staff in the emergency department was 78%. This showed the majority of staff had completed their mandatory training. However, this was below the trust's internal target of 85%.
- Staff within the emergency department also received adult and children's resuscitation training such as immediate life support and advanced paediatric life support training. Records showed completion rates for these were above the 85% target and confirmed the majority of staff had received resuscitation training.

Assessing and responding to patient risk

- An escalation policy was in place and bed management meetings took place three times per day to address and escalate risks that could impact on patient safety, such as low staffing and bed capacity issues.
- All patients with minor injuries who presented to the emergency department themselves (self-referral) were booked in via the receptionist and then triaged by a nurse who asked routine questions using a recognised triage system to determine the nature of the ailment.
- Patients who were conveyed by an ambulance were seen immediately by a nurse via a separate entrance. We observed handovers of patients from the ambulance

staff to the hospital staff. These were discreet and dignified. However, we saw one nurse had received a handover from the ambulance staff and confirmed this with the patient whereas another nurse only took details from the ambulance staff and did not speak with the patient.

- An appropriately qualified nurse triaged patients depending on the severity of their ailment and streamed patients to the appropriate route such as the minor or major injuries areas.
- Patients 16 years and younger accessed the emergency department via a separate entrance where they could wait in a dedicated area before being triaged by a paediatric trained nurse.
- The electronic admissions system alerted staff if any patients had attended the hospital or the emergency department previously so they could be referred to specific wards if needed.
- On admission, patients at high risk were placed on care pathways to ensure they received the right level of care in a timely way.
- Staff used a modified early warning score system (a system that scores vital signs and is used as a tool for identifying patients who are deteriorating clinically) and carried out routine monitoring based on patients' individual needs to ensure any changes to their medical condition could be promptly identified. Staff were aware of the actions to take if a patient's condition deteriorated and were supported with medical input.

Nursing staffing

- The nursing establishment was based on a recognised staffing assessment tool based on National Institute for Health and Care Excellence (NICE) safer staffing standards and this was last reviewed during January 2015.
- The expected and actual staffing levels were displayed on notice boards in each area we inspected and these were updated on a daily basis.
- We found there were sufficient numbers of trained nursing and support staff with an appropriate skills mix to ensure that patients were safe and received the right level of care.
- Nursing staff of differing grades were assigned to each of the patient areas within the department. There was at least one nurse for every four patients in each area and one nurse to every two patients in the resuscitation area.
- Staffing levels were increased during busy periods or to provide care for patients with a higher level of needs. For example, nurse staffing levels were increased during the afternoons in the resuscitation area and the minor injuries areas as this was identified as a busy period.
- Patients with minor injuries were seen by emergency nurse practitioners (ENPs). There were two ENPs on during the mornings, three during the evenings and one ENP overnight during weekdays.
- The EAU ward had 14 beds and was staffed with three nurses and one healthcare assistant during each shift.
- There were seven existing vacancies for nurses in the department and seven vacancies for nurses that were working their notice period. The lead nurse told us recruitment was ongoing and suitable candidates had been identified for the majority of vacant posts.
- Cover for staff leave or sickness was provided by bank staff made up of the existing nursing team or by agency nurses to provide cover at short notice. Where agency staff were used, the trust carried out checks to ensure that they had the right level of training in delivering emergency care.
- The senior nurses (band six and seven) had allocated management days where they did not form part of the staffing establishment to allow them time to carry out their management duties.
- Nursing staff handovers occurred three times a day and included discussions about patient needs and any staffing or capacity issues.

Medical staffing

- The emergency department had sufficient numbers of medical staff with an appropriate skills mix to ensure that patients received the right level of care.
- The proportion of registrars and junior doctors was greater than the England average. The proportion of consultants was below the England average (19% compared with the England average of 23%). The proportion of middle grade doctors was also below the England average (4% compared with the England average of 13%).
- All medical staff worked various shifts over a 24-hour period to cover rotas and to be on call during out-of-hours and weekends. There was sufficient on-call consultant cover over a 24-hour period and there was sufficient medical cover outside of normal working hours and at weekends.

- Medical staffing in the emergency department consisted of nine consultants. Consultant cover during the week was available from 9am to 11pm on weekdays with either two or three consultants on site. At weekends one consultant was available from 9am to 9pm. Outside of these hours, there was an on-call rota where consultants could be contacted at any time.
- There were seven middle grade doctors and a team of senior house officers that worked a shift system.
- The medical team were also supported by sessions from an acute medical unit consultant who worked in the department for four hours per week. There was also support from regular GP sessions.
- Staff rotas were maintained by the existing staff and through the use of agency or locum consultants. Where locum doctors were used, they were subject to recruitment checks and induction training to ensure they understood the hospital's policies and procedures. The majority of locum and agency doctors had worked on extended contracts so they were familiar with the department's policies and procedures.
- There were no existing vacancies but a consultant was due to retire in November 2015 and this post had been advertised for recruitment. The clinical director told us they had submitted a business case to increase the establishment to 14 middle grade doctors. The clinical director told us this would allow for increased consultant cover at weekends and to reduce the use of locums.
- Daily medical handovers took place during shift changes and these included discussions about specific patient needs. The handover was attended by medical staff of all grades.

Major incident awareness and training

- There was a documented major incident and business continuity plan in the emergency department, and this listed key risks that could affect the provision of care and treatment, such as fire, loss of utilities or disruptions to staffing levels.
- Guidance for staff in the event of a major incident was available in each of the areas we inspected and staff were aware of how to access this information when needed.
- The department had decontamination facilities and equipment to deal with patients who may be contaminated with chemicals, exposure to nuclear and other hazardous substances.
- All of the Trust's major incident simulation exercises were conducted as a desktop style review annually and a live exercise every three years in accordance with the regulations of the Civil Contingencies Act 2004.
- Throughout July 2014, the trust carried out a full scale exercise to test the flow of major incident casualties and bed management strategies across the emergency department and throughout the whole trust. In July 2015, the trust carried out a full scale live strategic and tactical command and control exercise involving the executive teams, control room support and tactical care group.

Are urgent and emergency services effective?

(for example, treatment is effective)

Good

Care and treatment was provided in line with national clinical guidelines and staff used care pathways effectively. The emergency and urgent care services participated in national and local clinical audits. The services performed in line with other hospitals and performed within the England average for most safety and clinical performance measures. There were action plans in place where audit findings had highlighted the need for improvement.

The majority of patients had a positive outcome following their care and treatment. Patients received care and treatment by trained, competent staff that worked well as part of a multidisciplinary team. Staff sought consent from patients before delivering care and treatment. Staff understood the legal requirements of the Mental Capacity Act 2005 and deprivation of liberties safeguards.

Evidence-based care and treatment

- Care and treatment was evidence-based and staff provided care based on the National Institute for Health and Care Excellence (NICE) and College of Emergency Medicine (CEM) guidelines.
- Staff in the emergency department used a range of care pathways, in line with national guidance, such as for fractured neck of femur, trauma, sepsis, ambulatory emergency care guidelines and recognition of stroke in the emergency room pathways.

- The patient record's triage section listed the applicable care pathways for adults and children, so patients could be placed on the appropriate pathway and receive prompt treatment.
- During 2015/16, the emergency department staff participated in 23 local and national clinical audits. Findings from clinical audits were reviewed at clinical audit meetings every six months and any changes to guidance and the impact that it would have on their practice was discussed.
- The staff we spoke with told us policies and procedures reflected current guidelines and were easily accessible via the trust's intranet. We looked at six policies and procedures on the trust's intranet and these were up to date and reflected national guidelines.

Pain relief

- Patients were assessed for pain relief as they entered the emergency department. A screening process identified any patients that required pain relief. Staff used pain assessment charts to monitor pain symptoms at regular 30 minute intervals.
- The patient records we looked at showed that patients received the required pain relief and that they were treated in a way that met their needs and reduced discomfort. The majority of patients we spoke with told us staff gave them pain relief medication when needed.

Nutrition and hydration

- The department had facilities to make drinks and snacks. We observed staff offering snacks and drinks to patients that had been in the department for an extended period of time.
- Patients that stayed overnight in the EAU ward were offered a choice of meals. Staff on the ward carried out assessments of patients' nutritional requirements and there was regular dietician involvement with patients who were identified as being at risk.
- A nurse was allocated daily to assist patients with difficulties eating and drinking in the EAU ward. Staff also used the red tray system so patients who needed support with eating and drinking for example those living with dementia could be identified and supported during mealtimes.

Patient outcomes

- There was a consultant lead for audit in the emergency department. The department participated in national CEM audits so they could assess their practice and performance against best practice standards.
- Audits included sever sepsis and septic shock, paracetamol overdose, asthma in children, cognitive impairment in older people, mental health in the emergency department and initial management of the fitting child.
- The sever sepsis and septic shock 2014 audit showed the trust performed below the national average for obtaining blood cultures, recording serum lactate levels and administering antibiotics.
- A sepsis care pathway was put in place so staff could carry out treatments in line with best practice guidelines. There was an action plan to develop a new form for triage nurses to recognise early sepsis so antibiotics could be administered promptly and for a secure fridge to be placed in stretcher triage area with pre-prepared antidotes and antibiotics.
- The asthma in children 2013/14 audit showed the trust performed either similar or better than the national average for administering beta agonist and intravenous hydrocortisone (medication used to treat severe asthma). Further training of nursing and junior medical staff took place to improve monitoring of vital signs pre and post nebuliser use and to improve the administration of steroid treatment prior to discharge.
- The paracetamol overdose 2013/14 audit showed 100% of patients received a plasma level test, which was better than the England average of 92%. These tests were not performed until after four hours in line with CEM standards. When tested within eight hours and plasma concentration above treatment level, 78% of patients received N-acetylcysteine (NAC) within eight hours of ingestion, which was better than the England average of 50%. A new screening form for triage nurses and paracetamol proforma for medical staff was being developed and further training of staff had taken place to further improve compliance.
- The CEM cognitive impairment in older people 2014/15 audit, mental health in the emergency department 2014/15 audit and initial management of the fitting child 2014/15 audit were published in May 2015. The trust performed similar to or better than the England average for most of the standards within the audits.

- There were some areas where further improvements were needed. For example, the trust performed below the national average for risk assessments performed in the emergency department (40% compared with average of 72%) in mental health audit.
- The audit lead consultant told us findings from the audit had been reviewed and action plans were being developed to improve where shortfalls had been identified.
- The rate of unplanned re-attendance to the emergency department within seven days was above the 5% target set by the Department of Health but better than the England average between October 2013 and March 2015.

Competent staff

- The department had a practice educator that oversaw training processes and carried out competency assessments. Newly appointed staff had an induction and their competency was assessed before working unsupervised. Staff nurses were assigned a mentor and worked supernumerary during their first four weeks. Agency staff also had a competency based induction before starting work.
- Staff told us they routinely received supervision and annual appraisals. Records showed 83% of staff across the department had completed their appraisals. However, this was below the trust target of 85%.
- The clinical director told us most medical staff had been revalidated with the General Medical Council. There were two outstanding revalidations that had been delayed but were expected to be completed over the next few weeks.
- The nursing and medical staff were positive about on-the-job learning and development opportunities and told us they were supported well by their line management.

Multidisciplinary working

- There was effective daily communication between multidisciplinary teams within the emergency department. Staff handover meetings took place during shift changes to ensure all staff had up-to-date information about risks and concerns. The nursing staff had good relationships with the consultants and doctors and emergency nurse practitioners.
- There were routine multidisciplinary meetings involving the nursing staff, therapists and medical staff as well as social workers and safeguarding leads (where required) to ensure the patient's needs were fully assessed. This included identification of the patients' existing care needs, relevant social or family issues, mental capacity as well as any support needed from other providers on discharge, such as home care support or alcohol rehabilitation.
- There was a daily consultant led multidisciplinary ward round on the EAU ward, which involved nurses, therapists and the social workers.
- The mental health liaison team provided 24 hour support to patients with psychiatric issues and supported the staff in the emergency department. The team had specific pathways, management plans and confidential systems in place to support patients with mental health needs.
- The trust-wide alcohol liaison team provided daily support to staff in the emergency department and EAU ward to prevent inappropriate discharges and assist with patient discharges. There was a specific pathway for people with alcohol withdrawal symptoms. The alcohol liaison team worked with other professionals such as social workers and community nurses and also provided training for staff and patients about alcohol misuse.
- A social worker was based on site to provide support for the emergency department and EAU ward during weekdays and on weekends. Their main role was to facilitate the discharge of patients that required a complex care package, respite or intermediate care. Intermediate care assessments were done as by a multidisciplinary team involving nursing and medical staff.
- Social workers worked closely with occupational therapists and physiotherapists so specialist equipment could be provided for patients within the emergency department or at their homes following discharge. The social workers also provided support and training for staff in the emergency department on how to identify and treat patients with social care issues such as confusion, agitation or personal hygiene issues.
- The regional ambulance service employed ambulance liaison officer to engage with the emergency department. Their main role was to identify any capacity issues at the hospital and any potential escalation protocols so ambulance crews could divert patients to other trusts if needed. The ambulance liaison officer

spoke positively about their interactions with the emergency department and told us the ambulance service had a good working relationship with the emergency department staff.
- Staff told us they received good support from pharmacists, dieticians, physiotherapists, occupational therapists, social workers, mental health liaison, and alcohol liaison as well as diagnostic support such as for x-rays and scans.

Seven-day services

- Staff rotas showed that nursing staff levels were sufficiently maintained outside normal working hours and at weekends.
- We found that sufficient out-of-hours medical cover was provided to patients in the emergency department by junior and middle grade doctors as well as on-site and on-call consultant cover.
- Diagnostic support (e.g. X-rays), physiotherapy, pharmacy, occupational therapy, alcohol liaison, mental health liaison and social worker support was available during weekdays and during the day at weekends. Support was also available on-call outside of normal working hours and at weekends.
- The dispensary was open for a limited number of hours on Saturdays and Sundays. The department held a stock of frequently used medicines such as antibiotics and painkillers, which staff could access during out of hours.
- The emergency department staff told us they received good support from other disciplines outside normal working hours and at weekends.

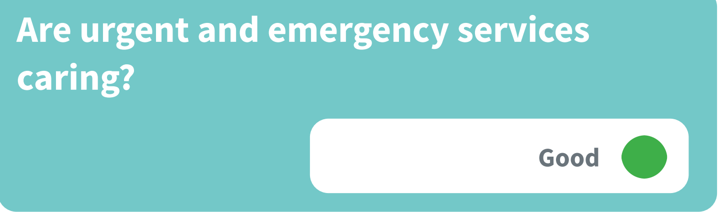
Access to information

- The trust used paper patient records. The records we looked at were complete, up to date and easy to follow. They contained detailed patient information from arrival to the department through to discharge or admission to the wards. This meant that staff could access all the information needed about the patient at any time.
- The department used an electronic system to track when patients were admitted to the department. Staff told us the information about patients they cared for was easily accessible.
- Notice boards were used to highlight where patients were located within the department and to identify high risk patients such as patients with an infection or those identified as being at risk of falls.
- We saw that information such as audit results, performance information and internal correspondence was displayed in all the areas we inspected. Staff could access information such as policies and procedures from the trust's intranet.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff had the skills and knowledge to ask patients for consent and were able to explain how they sought verbal, implied and informed consent. Written consent was sought before providing specific treatments such as anaesthetics. Patient records showed that verbal or written consent had been obtained from patients or their representatives.
- Staff received training in and understood the requirements of the Mental Capacity Act 2005 and Deprivation of Liberties Safeguards (DoLs).
- When a patient lacked capacity, staff sought the support of appropriate professionals so that decisions could be made in the best interests of the patient.

Are urgent and emergency services caring?



Patients spoke positively about their care and treatment. They were treated with dignity and compassion. Data for patient satisfaction surveys showed most patients were positive about recommending the emergency department to friends and family. Staff kept patients and their relatives involved in their care. Patients and their relatives were supported with their emotional needs, and there were bereavement and counselling services in place to provide support for patients, relatives and staff.

Compassionate care

- Patients were treated with dignity, compassion and empathy. We observed staff providing care in a respectful manner. We saw that patients' cubicle curtains were drawn and staff spoke with patients in private to maintain confidentiality.
- We spoke with 12 patients. All the patients we spoke with said they thought staff were kind and caring and gave us positive feedback about ways in which staff

showed them respect and ensured that their dignity was maintained. The comments received included “staff lovely and explained things well” and “always lovely staff, been before and treated the same each time”.

- The NHS Friends and Family Test is a satisfaction survey that measures patients’ satisfaction with the healthcare they have received. The test data between March 2014 and February 2015 showed the emergency department consistently scored above the England average, indicating that 95% of patients were positive about recommending the hospital to friends and family.
- The CQC’s accident and emergency survey 2014 showed the trust was about the same compared with other trusts for all sections and scored better than average for cleanliness of the emergency department and for providing enough privacy during examinations and treatment, based on 233 responses received.

Understanding and involvement of patients and those close to them

- Staff respected patients’ rights to make choices about their care. We observed staff speaking with patients clearly in a way they could understand.
- The patient records we looked at included nursing and medical assessments that took into account individual patient preferences.
- Patients told us the medical staff fully explained the treatment options to them and allowed them to make informed decisions. They spoke positively about the information they received verbally and also in the form of written materials, such as information leaflets specific to their treatment.

Emotional support

- We observed staff providing reassurance and comfort to patients. Patients told us they were supported with their emotional needs.
- Patients had an allocated nurse who was able to support their understanding of their care and treatment and ensure that they were able to voice any concerns or anxieties.
- A family room was available to accommodate the relatives of patients that had been involved in traumatic incidents.
- Information leaflets were available to provide patients and their relatives with information about chaplaincy services and bereavement or counselling services.
- Staff could access management support or counselling services after they had assisted with a patient who had been involved in a traumatic or distressing event, such as a fatal road traffic accident, or if they had been subject to a negative experience.
- Nursing and medical staff were included in debriefing sessions after traumatic events.

Are urgent and emergency services responsive to people’s needs?

(for example, to feedback?)

Requires improvement

The Department of Health target for emergency departments is to admit, transfer or discharge 95% of patients within four hours of arrival. The trust had failed to meet the target between October 2014 and June 2015, during which the number of patients treated within four hours ranged from 91.3% to 93.2%. This was because of a lack of available beds to transfer patients to and due to delays of more than two hours in seeing a doctor. An action plan was in place to improve the availability of medical staff and to treat and discharge patients more efficiently.

The trust was not meeting the targets for ambulance handovers between January and July 2015. Trust data showed 831 ambulance handovers took between 30 and 60 minutes to complete and 199 handovers took longer than 60 minutes to complete during this period.

An escalation policy was in place and daily bed management meetings took place to address and escalate risks that could impact on patient safety, such as low staffing and bed capacity issues. There were systems in place to support vulnerable patients. Complaints about the service were shared with staff to aid learning.

Service planning and delivery to meet the needs of local people

- The trust’s emergency and urgent care services were provided from Whiston Hospital. There was a walk-in centre / minor injuries centre at St. Helens that was provided by a different healthcare trust.

- The service provided care and treatment for patients across Knowsley, St. Helens and the surrounding areas. Trust data showed that during 2014/15, approximately 101,200 patients attended the emergency department. This was an increase of 3.2% from the previous year.
- The emergency department was a receiving centre for major trauma patients. Staff followed a trauma pathway which provided guidance for staff on the process for stabilising patients prior to transferring them to the regional major trauma centres.
- There was an escalation policy that provided guidance for staff when dealing with periods where there was significant demand for services. Daily bed management and safe staffing meetings were taking place so that capacity was constantly monitored so that patients could be managed and treated in a timely way.
- There were suitable and segregated waiting areas for both adults and children with sufficient seating arrangements.

Meeting people's individual needs

- Information leaflets about services were readily available in all the areas we visited. Staff told us they could provide leaflets in different languages or other formats, such as braille, if requested.
- Staff could access a language interpreter if needed.
- Patients with long-term medical illnesses could be directly admitted to the EAU ward or to other wards in the hospital, such as the children's ward. A regular attenders meeting took place on a monthly basis to identify and provide appropriate multidisciplinary support for patients that frequently attended the emergency department. The meeting involved the mental health liaison, social workers, alcohol liaison officer as well as nursing and medical staff.
- Patients living with dementia were assessed and treated in designated cubicles located near the nurse's station to promote their safety and so staff could monitor them closely.
- The department had two dementia link nurses in place. Staff used a 'forget me not' document for patients living with dementia. This was completed by the patient or their representatives and included key information such as the patient's likes and dislikes. Staff told us the additional records were designed to accompany the patients throughout their hospital stay. We saw evidence of this in the patient records we looked at.
- Care plans were in place to provide guidance for staff on how to care for patients with learning disabilities. Staff could contact the social workers or mental health liaison team for advice and support for dealing with patients living with dementia or a learning disability.
- There were facilities in place to support vulnerable people such as homeless people, including transport tokens. The trust was also in the process of implementing a system for providing food bank vouchers for vulnerable patients.
- Staff could access appropriate equipment, such as specialist commodes, trolleys or chairs to support the moving and handling of bariatric patients (patients with obesity).

Access and flow

- The Department of Health target for emergency departments is to admit, transfer or discharge 95% of patients within four hours of arrival. The trust had achieved the 95% target between July and September 2014 (96.7% of patients seen within four hours). However, the trust had failed to meet the target between October 2014 and June 2015.
- The proportion of all patients that attended the emergency department and were treated within 4 hours was 93.2% (2,099 attendances) between October and December 2014, 91.7% (2,548 attendances) between January and March 2015 and 93.2% (2118 attendances) between April and June 2015.
- The interim directorate manager had reviewed the data between January and July 2015 and identified the main reasons for four-hour waiting time breaches. This showed: -
  - 40% of all breaches were due to a lack of beds available to transfer patients to.
  - 20% of breaches were caused by delays of more than two hours in seeing a doctor, which mostly occurred during the night between 12am and 4am.
  - 20% of breaches were due to a lack of care facilities for high dependency patients (i.e. patients that were too ill for a general ward but not ill enough to transfer to intensive care).
- An action plan was in place to improve performance in the four-hour waiting time targets. This included actions to review medical staffing arrangements to improve treatment and discharge times and to improve medical cover during nights and weekends.

- The percentage of emergency admissions via the emergency department who waited between four and 12 hours from the decision to admit until being admitted was better than the England average between April 2014 and April 2015.
- The total time spent in the emergency department (average per patient) was 153 to 189 minutes between January 2013 and March 2015, which was consistently worse than the England average of 130 to 140 minutes during this period.
- The department was meeting current DH guidelines relating to trolley waits as no patients had waited more than 12 hours on a trolley over the past 12 months.
- The DH target is that handovers between ambulance and emergency department must take place within 15 minutes with no patients waiting more than 30 minutes.
- The trust was not meeting this target between January and July 2015. Trust data showed 12,344 ambulance handovers were completed within 15 minutes and 3,216 handovers were completed within 15 to 30 minutes. However, 831 ambulance handovers took between 30 and 60 minutes to complete and 199 handovers took longer than 60 minutes to complete during this period.
- Handovers from ambulance arrival to emergency department that take longer than 60 minutes are also referred to as 'black breaches'. These 'black breaches' were mainly caused by an increase in the numbers of patients attending the department and also by ambulances arriving together.
- Since January 2015, the emergency department set up a rapid assessment and treatment (RAT) process where a consultant was allocated at set times on a daily basis to assess and treat ambulance stretcher patients. This had led to a reduction in the number of 'black breaches' from 79 in January 2015 to one breach in July 2015. The department also had a named accountable senior nurse to lead process changes in regard to ambulance handover.
- We observed patients in the department that self-presented or arrived via ambulance. We saw that patients were being seen in a timely manner and the flow of patients was controlled and well managed by staff. There was sufficient capacity and bed spaces to treat the number of patients arriving in the emergency department and within the EAU ward.
- Throughout our inspection, there was only one instance where a patient was not treated within the four hour target. Staff told us the patient was kept for further observations and was discharged home which meant the delay in treatment did not impact the safety of the patient.
- Patient records showed discharge planning took place at an early stage and there was multidisciplinary input (e.g. from physiotherapists and social workers). Discharge summaries included all the relevant clinical information relating to the patient's attendance in the emergency department. Trust data between April 2015 and May 2015 showed electronic discharge summaries were sent to GPs within 24 hours on 98.9% of occasions and the trust target of 95% had been achieved during this period.
- The health and social care information centre data on patients leaving the department without being seen showed the rate for this trust was within the target of 5% set by the Department of Health but higher (worse) than the England average between January 2013 and March 2015.

Learning from complaints and concerns

- The emergency department had information leaflets displayed for patients and their representatives on how to raise complaints. This included information about the patient advice and liaison service. The patients we spoke with were aware of the process for raising their concerns with the trust.
- The trust's complaint policy stated that complaints would be resolved within 25 working days for routine complaints or within 60 days for complex complaints that required investigation or root cause analysis.
- The timeliness of complaint responses was monitored by the trust-wide complaints team, who notified the lead nurse and clinical director when complaints were overdue.
- There were 25 complaints relating to the emergency department between August 2014 and August 2015. 12 complaints were responded to within agreed timelines whereas five complaints were not responded to within agreed timelines. The remaining eight complaints were still being investigated.
- Information about complaints was discussed during monthly governance and quality improvement meetings to raise staff awareness and to aid future learning.

Are urgent and emergency services well-led?

Good

The risk register identified key risks relating to the emergency department and these risks were monitored through monthly governance and quality monitoring meetings. There was effective teamwork and clearly visible leadership within the department. The majority of staff were positive about the culture within the emergency department and the level of support they received from their managers. The management team understood the key risks and challenges to the service and the actions planned to address them.

Vision and strategy for this service

- The trust had a vision and strategy with clear aims and objectives. The trust's mission was 'to provide high quality health services and an excellent patient experience'. The trust's vision for 'five star patient care' was supported by five key areas: safety, pathways, systems, care, and communication.
- The clinical and quality strategy 2014 - 2018 listed 24 key objectives, including providing harm free care, to improve A&E time to first clinical assessment and to improve the patient experience.
- The trust vision, values and objectives were clearly displayed and had been cascaded to staff across the emergency department and staff had a good understanding of them.
- The clinical director had also developed a vision and values specific to the emergency department based on good clinical care and values relating to patient care, teamwork and information governance.

Governance, risk management and quality measurement

- There were monthly governance and quality improvement meetings. There was a set agenda for these meetings with standing items, including the review of incidents, key risks and monitoring of performance. Identified performance shortfalls were addressed by action planning and regular review.
- There were routine staff meetings to discuss day-to-day issues and to share information on complaints, incidents and audit results.
- Risks were documented and escalated by the service appropriately. The emergency department risk register listed the key risks relating to the service and this showed that key risks had been identified and assessed.
- Records confirmed that routine audit and monitoring of key processes took place across the emergency department to monitor performance against objectives. Information relating to performance against key quality, safety and performance objectives was monitored and cascaded to staff through performance dashboards.

Leadership of service

- The emergency and urgent care services formed part of the medical care group. The overall lead for the emergency department was the clinical director, who was supported by the interim directorate manager and the lead nurse. The directorate manager post was advertised and recruitment for a permanent directorate manager was ongoing.
- There was a senior shift coordinator on each shift that managed the day to day running of the services.
- The nursing and medical staff told us they felt the clinical director and lead nurse were approachable, visible and provided them with good support.

Culture within the service

- The staff we spoke with were highly motivated and spoke positively about the care they delivered. Staff told us there was a friendly and open culture. They told us they received regular feedback to aid future learning and that they were supported with their training needs by their managers.
- Junior doctors and nurses also told us they received a good level of support from their peers and line managers.
- Staff morale was good and the medical and nursing staff worked well as a team. The department had been nominated for team of the year 2014/15 during the annual trust awards and all the staff we spoke with were proud of their achievements.

Public engagement

- Staff told us they routinely engaged with patients and their relatives to gain feedback from them. Information on the number of incidents, complaints and general information for the general public was displayed on notice boards in the areas we inspected.

Staff engagement

- Staff received good support and regular communication from their line managers. Staff routinely participated in team meetings across the wards and theatres we inspected. Managers also engaged with staff via team briefs, newsletters and through other general information and correspondence that was displayed on notice boards and in staff rooms.
- We saw evidence of engagement meetings and workshops conducted to engage with staff following organisational changes and to gain feedback from them. For example, the medical staff participated in an away day and this included training and an opportunity for staff to discuss issues.
- The 2014 survey of NHS staff showed the trust had 16 positive indicators out of a total of 30. There were three negative indicators highlighted in the staff survey. These related to staff experiencing physical violence from patients, relatives or the public and staff reporting errors, near misses and incidents.
- The interim directorate manager, clinical director and lead nurse confirmed they had reviewed the findings from the NHS staff survey and had identified further conflict resolution and de-escalation training for staff in order to improve the level of staff experiencing physical violence.

Innovation, improvement and sustainability

- Staff from the emergency department were involved in five clinical research trials, including the 'preventable unplanned admission rates' and 'protocoled management in sepsis: v1.0'.
- A consultant from the emergency department was the appointed lead for the local specialty research group for injuries and emergencies, and worked closely with the local clinical research network to engage clinical colleagues and champion National Institute for Health Research delivery across the region.
- The department had an ongoing cost improvement programme with £195,717 of savings identified. A risk assessment had been carried out to assess and minimise any risks to patient safety as a result of cost-saving measures.
- The interim directorate manager, clinical director and lead nurse were confident about the future sustainability of the services and felt the key risk was their ability to meet the four-hour emergency department wait targets due to the increased number of patient attendances.
- The trust's five year strategic plan 2015-2020 outlined areas for future development including a strategic review of urgent and emergency care services in the Mid-Mersey region.

Medical care (including older people's care)

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

Information about the service

We visited Whiston Hospital as part of our announced inspection on 19 August 2015.

The medical care services at the hospital provided care and treatment for a wide range of medical conditions, including general medicine, cardiology, respiratory, and gastroenterology.

As part of our inspection we visited wards 1A (general medicine), 1B (acute medical unit), 1C (acute medical unit), 1D (cardiology), 2A (haematology) 2B (respiratory), 2C (respiratory), 2D (endocrinology and general medicine), 3D (gastroenterology), 5A (care of the elderly), 5B (care of the elderly), ambulatory care and the endoscopy unit.

We reviewed the environment and staffing levels and looked at 27 care records and 20 prescription charts. We spoke with two family members, seven patients and 31 staff of different grades, including nurses, doctors, ward managers, matrons, a domestic assistant, a ward clerk and the senior managers who were responsible for medical services.

We received comments from people who contacted us to tell us about their experience, and we reviewed performance information about the trust. We also observed how care and treatment was provided.

Summary of findings

Patients received compassionate care and their privacy and dignity were maintained. Patients were involved in their care, and were provided with appropriate emotional support.

Incidents were reported by staff through effective systems and lessons were learnt and improvements made from Investigations where findings were fed back to staff. There were systems in place to keep people safe and staff were aware of how to ensure patients' were safeguarded from abuse. The hospital was clean and staff followed good hygiene practices.

Staff attended mandatory training courses and compliance rates were above the trust target. There were effective systems in place to ensure patient safety was monitored and maintained. Staffing levels were overall sufficient to meet the needs of patients. Care was provided in line with national best practice guidelines and medical services participated in the majority of clinical audits. A recent national audit showed that improvements still needed to be made for people who had suffered a stroke The service had put in place an action plan to address the shortfalls identified in the audit.

There was a strong focus on discharge planning from the moment of admission and services to support this were provided seven days a week. There was some confusion at local level regarding the commissioning arrangements for the coronary care unit which meant

that the skill mix of staff was not always appropriate for the patients on the unit and there were patients of differing gender being nursed in the same area at the time of the inspection which meant their privacy and dignity was not always maintained.

We found that staffs' understanding and awareness of assessing people's capacity to make decisions about their care and treatment were variable Staff in the coronary care unit were able to fully explain how they assessed capacity and records were appropriately completed however this was not the case on ward 2C. Services took into account the needs of the local people. There were good ambulatory care services and a specialist unit for the frail and elderly.

The hospital had implemented a number of schemes to help meet people's individual needs, such as the forget-me-not sticker for people living with dementia or a cognitive impairment and the falling leaf symbol to indicate that a patient was at risk of falls. This helped alert staff to people's needs.

People were supported to raise a concern or a complaint and lessons were learnt and improvements made. Medical services captured views of people who used the services with changes made following feedback. A survey showed that people would recommend the hospital to friends or a relative.

Staff told us that they felt valued and supported. There was good staff engagement with staff being involved in making improvements for services. All staff were committed to delivering good, compassionate care and were motivated to work at the hospital.

Are medical care services safe?

Good

Incidents were reported by staff through effective systems and lessons were learnt and improvements made from investigations There were systems in place to keep people safe and staff were aware of how to ensure patients' were safeguarded from abuse. The hospital was visibly clean and staff followed good hygiene guidance. There was good monitoring of infections. Checklists for the resuscitation equipment did not include the expiry date. This was raised with the trust at the time of the inspection and they confirmed that this would be addressed. There were safe systems for the handling and disposal of medicines, but there was a fridge on ward 1A which had been left unlocked and a broken fridge on the medical assessment unit. Both these fridges were used to store medication. Cleaning chemicals had been left out in an unlocked room on a number of wards which presented a risk to people Records trolleys were left unlocked on some of the wards we visited but records we looked at were documented accurately and medical decisions were documented clearly.

Staff attended mandatory training courses and compliance rates were above the trusts target. There were effective systems in place to ensure patient safety was monitored and maintained. Staffing levels were largely overall sufficient to meet the needs of patients; however there were still some staff vacancies which were noted on the risk register and actions had been identified to mitigate this risk.

Incidents

- There were systems for reporting actual and near miss incidents across medical services. Staff were familiar with and encouraged to use the trust's procedures for reporting incidents. There was evidence that staff understood their responsibilities to raise concerns and record safety incidents.
- Learning from incidents was discussed during team meetings, shared via email and lessons learned information was displayed on notice boards in staff areas.
- There had been no never events reported in medical services (Never events are serious, wholly preventable

incidents that should not occur if the available preventative measures had been implemented). During May 2014 to April 2015 medical services reported 7136 incidents. 5862 resulted in no harm. 15 were serious incidents. These were mainly in relation to sub-optimal care of the deteriorating patient and slips, trips and falls whilst in hospital. All serious incidents had been investigated and action had been taken to prevent reoccurrence.

- An example of learning across services was the implementation of the WHO checklist in the endoscopy unit following a review of a never event in surgical services. The WHO checklist is a patient safety checklist to detect any potential error before it leads to avoidable harm.
- Multidisciplinary mortality and morbidity reviews were held for a 20% random sample of every death in medical services. If the review indicated any issues these were then rated as amber and further in-depth investigation took place. There had been six amber reviews in the last nine months prior to inspection.
- Senior staff had undertaken incident management training. This was a three day course delivered by an external company. Evaluation of the course took place by the company but had not been reviewed by medical services.
- Minutes of the governance meetings showed that incidents were discussed and actions identified.
- Since the duty of candour regulations were introduced in November 2014, the trust policy of informing patients and families about incidents that had occurred and the outcome, had been implemented. Contact with the patient or family was recorded in the report of the incident. We saw evidence that a family had been informed of an incident and involved in the review. However information was given verbally rather than in the form of a letter.

Safety thermometer

- The service submitted data to the health and social care information centre as part of the NHS safety thermometer (a tool designed to be used by frontline healthcare professions to measure a snapshot of specific harms once a month). The measurements included pressure ulcers, falls and catheter acquired urinary tract infections.
- The safety thermometer information was trust wide and not separated between the St Helen's and Whiston hospital sites in medical services.
- For the period March 2014 to March 2015 the trust figures for pressure ulcers was relatively inconsistent with a total of 37 incidents. There was a notable rise in the number of incidents of falls from November 2014 to March 2015 the total number of falls was 38. 43 urinary tract infections had occurred during this period.
- Results of the safety thermometer were displayed on every ward and area we visited. The results related to that individual ward or area.
- There had been changes to practice following results of the safety thermometer f following review of pressure ulcers on one ward 1A tissue viability training had been put in place for nurses which enabled them to grade pressure ulcers accurately.
- At the July 2015 patient safety council meeting, there was an inpatient falls report discussed. This identified a number of actions to be implemented which included an in-depth review of falls on ward 1A.

Cleanliness, infection control and hygiene

- The wards we inspected were visibly clean and well maintained. All staff were aware of current infection prevention and control guidelines. This included the use of 'I am clean' stickers to inform colleagues at a glance that equipment or furniture had been cleaned.
- Between April 2013 and March 2015, overall infection rates were inconsistent with the England average. There had been six incidents of MRSA and 70 incidents of C.difficile. Between January 2015 and July 2015 there had been 15 incident of C.difficile on the medical wards with five being on ward 5C. Compliance of Infection control standards was on the risk register with actions identified to lower the risk. These included regular audits and further training for staff in aseptic non touch techniques.
- There were sufficient hand wash sinks and hand gels. Hand towel and soap dispensers were adequately stocked.
- Staff consistently followed hand hygiene practice and 'bare below the elbow' guidance. Personal protective equipment such as aprons and gloves were readily available and in use in all areas.
- Side rooms were used as isolation rooms for patients identified as an increased infection control risk (for example patients with MRSA). There was clear signage

outside the rooms so staff were aware of the increased precautions they must take when entering and leaving the room. These rooms were also used to protect patients with low immunity,

- Cleaning schedules had been completed as required. Domestic staff told us there were sufficient supplies of cleaning materials available for their use. They were able to tell us about the national colour coding scheme for hospital cleaning materials and equipment. This ensured that these items were not used in multiple areas, therefore reducing the risk of cross infection. Cleaning storerooms were generally clean and tidy.
- Infection, prevention and control audits were carried out by the IPC nurse specialist on a regular basis on each ward. These identified good practice and poor practice. Key actions were identified to be implemented by the staff team.

Environment and equipment

- The wards and areas we visited were well maintained.
- There were systems in place to maintain and service equipment. Portable appliance testing had been carried out on electrical equipment regularly and electrical safety certificates were in date. Hoists had been serviced appropriately.
- Resuscitation equipment was available on all the wards we visited and tamper seals were in place. Emergency drugs were available and in use by date. Checks of the equipment had been completed; however the checklist did not include the expiry date. This was raised with the trust and a process was going to be put in place to address this.
- On ward 1A there was oxygen stored in an unlocked room. Health and safety best practice guidance is that oxygen cylinders should be stored securely in a well-ventilated storage area or compound when not in use
- Cleaning chemicals were left in an unlocked area on ward 1C, 2C, 5B and the endoscopy unit. These chemicals were hazardous and presented a risk of harm to people's health as a result they should have been stored securely in line with regulatory requirements.
- The main door to the endoscopy unit was sticking which meant that patient conversations could be heard. This was raised with the sister who submitted the appropriate form to the trust maintenance department to have the door mended.

Medicines

- All wards had appropriate storage facilities for medicines, and had safe systems for the handling and disposal of medicines. All ward based staff reported a good service from the pharmacy team.
- There were suitable arrangements in place to store and administer controlled drugs. Stock balances of controlled drugs were correct and two nurses checked the dosages and identified the patient before medicines were given to the patient. Regular checks of controlled drugs balances were recorded.
- All medicines were appropriately stored. Medicines requiring storage at temperatures below eight degrees centigrade were appropriately stored in fridges. Fridge temperatures were regularly checked. There was a broken fridge on the acute medical assessment unit which had been reported and a new one ordered. On ward 1A the fridge had a lock but had been left unlocked which meant medication was not securely stored.
- All medicines on wards were in date indicating there were good stock management systems in place.
- Suitable cupboards and cabinets were in place to store medicines. This included a designated room on each ward to store medicines.
- None of the seven prescription charts reviewed for patients, who were on antibiotics, had the stop date recorded. This was seen on ward 1B, 1D, 2B, and 2D.
- Between January 2015 and April 2015 there had been 211 medication errors reported in medical services. Only two of these had resulted in moderate harm the rest resulted in low or very low harm. All had been investigated and appropriate action taken.
- On ward 1C we saw that an out of date (2008) trust medicines policy was on the staff notice board. This meant that staff may not be accessing the most up to date guidelines on the safe administration of medicines.
- Two of the three prescription charts we looked at on ward 1C had multiple route options prescribed for medication that was prescribed regularly (oral or intravenously). This is against the trust medicine policy which states that regular prescribed medication would only have one route available. This was also seen on the prescription chart we reviewed on ward 1A.

Records

- Patient records included a range of risk assessments and care plans that were completed on admission and reviewed throughout a patient's stay. Patients had an individualised care plan that was regularly reviewed and updated.
- In most areas records were stored securely. However, on ward 1A, 1C and 5B patient records were stored in unlocked trolleys at nurse's stations. This increased the potential for patient confidentiality to be breached.
- All the records we looked at we saw documentation was accurate, legible, signed and dated.

Safeguarding

- There was a system for raising safeguarding concerns. Staff were aware of the process and the trust safeguarding team was accessible 24 hours a day for staff to seek advice in respect of escalating issues of abuse or neglect. Between April 2014 and April 2015 there had been 669 contacts with the trust safeguarding team with 215 being referred to the local authority for consideration of a multi-agency investigation.
- Training statistics provided by the trust showed that in medical services 88% of staff had completed safeguarding training. However, the lowest staff group to have completed the training was medical staff at 77%. The trust target was 85%
- Safeguarding training was included in induction training for all temporary staff before commencing work on the wards.
- **Mandatory training**

- Staff received mandatory training on a rolling annual programme. The mandatory training was in areas such as health and safety, fire, manual handling, safeguarding and infection and prevention
- At the time of our inspection 86% of staff in medical services had completed their required mandatory training. The trust target was 85%.
- Staff received equality and diversity training. 99% of staff in medical services had completed their training. The trust target was 85%.

Assessing and responding to patient risk

- An early warning score system was used throughout the trust to alert staff if a patient's condition was deteriorating.
- Early warning indicators were regularly checked and assessed. When the scores indicated that medical reviews were required staff had escalated their concerns appropriately. Repeated checks of the early warning scores were mostly documented accurately. On ward 1C there had been an incident when repeated observation checks had not been done after concerns were escalated for a medical review. The incident was investigated and learning had been shared with all members of staff on the ward.
- Upon admission to medical wards staff carried out risk assessments to identify patients at risk of harm. Patients at high risk were placed on care pathways and care plans put in place to ensure they received the right level of care. The risk assessments included falls, use of bed rails, pressure ulcer and nutrition (malnutrition universal screening tool).
- Care plans we saw were not always personalised but did contain the necessary information to ensure that patients were not at risk and there care managed safely.
- To continually assess patient risk, intentional observation rounds were completed on patients every two to four hours depending on individual need.
- In May 2015 a review of the early warning system had been undertaken as there had been a high number of early morning medical emergency calls. The review included looking in-depth at completed records and a number of recommendations had been made for the service to implement.

Nursing staffing

- Nurse staffing levels had improved with a number of vacancies now filled. Matrons met each day to discuss nursing staffing levels and there was good allocation of staff to ensure that skills were appropriately deployed and shared across all wards.
- There were still some nursing vacancies in medical services and this was on the risk register. There were actions identified to mitigate this risk such as a rolling eight week recruitment programme and the timely management of recruitment processes to ensure staff commence working at the hospital as soon as possible.
- Managers knew where there were shortfalls and where there was surplus on other wards so staff could be called on if needed.
- Each ward had a planned nurse staffing rota and reported on a daily basis if shifts had not been covered. The National Institute for Health and Care Excellence

(NICE) guideline 'Safe staffing for nursing in adult inpatient ward in acute hospitals' was used by the trust. However not all medical wards were consistently implementing these recommendations.

- Staff on the coronary care unit were not assessing the acuity of the patients to determine if they were level one or level two patients. This should be done to ensure appropriate skill mix of staff.
- Medical wards displayed nurse staffing information on a board at the ward entrance. This included the staffing levels that should be on duty and the actual staffing levels. This meant that people who used the services were aware of the available staff and whether staffing levels were in line with the planned requirement
- Throughout July 2015 the majority of the medical wards' shifts were filled as planned during the day. However there were wards where shifts were not filled as planned during the night. The percentage of nursing shifts filled for ward 2B was 82%, Ward 2C 83% and ward 5A 89%.
- Senior staff tried to use the same bank and agency staff to ensure that they had the required skills to work on the ward. Agency staff were given an induction before commencing work on the wards. Ward managers were able to outline the induction programme.
- The vacancy rate for nursing staff was 3%. The average turnover of nursing staff in medical services was 10% per year
- Wards allocated at least one qualified nurse to each bay to get to know the patients and provide a constant presence within the bay.
- We saw effective handover meetings between nursing staff which highlighted key risks. The system used for handover notes varied. Some wards used handwritten notes; some used printed ones which had been prepared before the meeting.

Medical staffing

- Rotas were completed for all medical staff which included out of hours cover for all medical admissions and all medical inpatients across all wards. All medical trainees contributed to this rota. The information we reviewed showed that medical staffing was appropriate.
- Patients reported that they did not always see a doctor at the weekends, although there was sufficient cover outside normal working hours and at weekends.
- Consultant cover was available on site from 8am to 8pm daily and an on-site registrar 24 hours a day.
- There was an endoscopist on call for all out of hour's emergency endoscopies.
- The percentage of consultants working in medical services was 41% which was higher (better) than the England average of 34%. The percentage of registrars was 30% which was below (worse) the England average of 39%. Middle grade and junior doctor levels were about the same as the England average.
- The vacancy rate for medical staff was 9.86%. The average turnover of medical staff in medical services was 5% per year.
- The use of locum medical staff was reasonably low between 1-9% of shifts a month. From the information provided by the trust, in April 2015, the percentage of shifts filled for medical staff in diabetes was 22%"
- There were still some medical staffing vacancies in medical services and this was on the medical risk register. There were actions identified to mitigate this risk such as a rolling recruitment programme.
- We saw an effective ward round which included a nurse to ensure that any actions identified were recorded and implemented.

Major incident awareness and training

- There were documented major incident plans within medical areas and these listed key risks that could affect the provision of care and treatment. There were clear instructions for staff to follow in the event of a fire or other major incident.
- Staff were aware of what they would need to do in a major incident and knew how to find the trust policy and access key documents and guidance.
- Staff in medical services had been involved in major incident exercises and a member of staff had witnessed the major incident plan being put into action during a serious car accident.
- The trust had circulated information to staff regarding Ebola risks and actions to take if a case was expected.

Are medical care services effective?

Care was provided in line with national best practice guidelines and medical services participated in the majority of clinical audits where eligible. For example the heart failure audit, the pneumonia audit and the stoke

audit. Recent national audits indicated that although there had been progress the service still needed to make improvements to the care and treatment of people who had suffered a stroke. However plans were in place to secure improved performance

Nutrition and fluid intake were mostly recorded correctly. There was a strong focus on discharge planning from the moment of admission and there was good multidisciplinary working to support this.

There was evidence of providing services seven days a week.

Staff said they were supported effectively and 86% of staff had received their annual appraisal which was above the trust target.

We found that staff members' understanding and awareness of assessing people's capacity to make decisions about their care and treatment were variable. Staff did not always follow capacity assessment processes in line with trust policy. For example staff in the coronary care unit were able to fully explain how they assessed capacity and records were appropriately completed however this was not the case on ward 2C where staff were not confident and competent in this regard.

Evidence-based care and treatment

- The service was using national and best practice guidelines to care for and treat patients. The trust monitored compliance with NICE guidance and were taking steps to improve compliance where further actions had been identified.
- The service participated in clinical audits for which it was eligible through the advancing quality programme. February and March 2015 audits demonstrated the trust was not meeting the appropriate care score threshold for pneumonia, sepsis and for chronic obstructive pulmonary disease. The service was aware of the shortfall and had developed action plans to improve performance including the appointment of a pneumonia specialist nurse
- The hospital had a care pathway in place for managing patients who had a stroke and for patients admitted to ambulatory care. Ambulatory care is medical care provided on an outpatient basis. The ambulatory care pathways included care of patients with cellulites, pulmonary embolism and deep vein thrombosis. These were based on NICE guidance and British thoracic guidelines.
- There were examples of recent local audits that had been completed on the wards. These included cleanliness, documentation and discharge audits. Staff said they received the results of the audits and any learning was shared with them via email.
- Following a recent falls audit the results identified that the number of falls increased at handover times. Changes now include a twilight shift to ensure the number of staff available during handover is adequate to meet the needs of the patients.

Pain relief

- Pain relief was managed on an individual basis and was regularly monitored. Patients told us that they were consistently asked about their pain and supported to manage it.
- We saw that pain scores were recorded on early warning scores documentation.

Nutrition and hydration

- Where possible there was a period over meal times where all activities on the ward stopped, if it was safe for them to do so. These protected meal breaks enabled staff to assist patients who needed assistance to eat and drink.
- A coloured tray and jug system was in place to highlight which patients needed assistance with eating and drinking. The mealtime co-ordinators wore red aprons and other staff wore blue aprons at mealtimes. The mealtime co-ordinators communicated with the catering staff and ensured all patients had a hot meal.
- Fluid balance charts were mostly fully completed and we saw from the records we looked at that patients had had an assessment of their nutritional needs.
- All patients we spoke with said they were happy with the standard and choice of food available. The menus were comprehensive and there was a wide variety for patients to choose from. Patients said they were also encouraged to go to the hospital restaurant to eat their meals and that they ordered their meals the same day to ensure they chose what they felt like eating that day

Patient outcomes

Medical care (including older people's care)

- The myocardial ischaemia national audit project is a national clinical audit of the management of heart attacks. The MINAP audit 2013/14 showed the number of patients diagnosed with a non-ST segment elevation myocardial infarction (N-STEMI-a type of heart attack that does not benefit from immediate PCI) seen by a cardiologist prior to discharge was better than the national average at 98%. The national average was 94%. 65% of patients with an N-STEMI were admitted to a cardiology ward. The national average was 55%. This meant that people who had had a heart attack received good quality care at the hospital.
- The SSNAP is a programme of work that aims to improve the quality of stroke care by auditing stroke services against evidence-based standards. This highlighted that the service still needed to make improvements to the care and treatment of patients who had suffered a stroke. The latest audit results rated the hospital overall as a grade 'C' which was an improvement from the previous audit results when the hospital was rated as the 'D'. The trust had put in place actions to improve the audit results. These included dedicated stroke beds, a stroke pathway and the implementation of an acute stroke hub with Warrington hospital.
- The 2012/2013 heart failure audit showed the hospital performed better than average for all four of the clinical (in hospital) indicators and in all of the seven clinical (discharge) indicators.
- Medical services participated in the joint advisory group on GI endoscopy and were accredited in November 2014. The JAG ensures the quality and safety of patient care by defining and maintaining the standards by which endoscopy is practised.
- The average length of stay for elective medicine at the hospital was longer (worse) than the England average at 6.8 days. The England average was 4.5 days. For non-elective medicine it was longer (worse) than the England average at 7.3 days. The England average was 6.8 days.
- There were weekly meetings to discuss length of stay and any issues around discharges. Each ward had a slot at this meeting to discuss any potential delayed discharges.
- The readmission rates for the hospital was worse than the England average in gastroenterology and general medicine but better than the England average in cardiology. Respiratory medicine was the same as the England average.
- Ambulatory care services had undertaken an audit on the outcome of patients discharged from the service. This showed that any readmissions to hospital had been due to either additional health related issues or treatment failure which could not be treated as an outpatient. Readmissions had not been due to a breakdown in ambulatory care pathways.

Competent staff

- Staff told us they received an annual appraisal. According to trust figures 86% of staff in medical services had received their annual appraisal. The trust target was 85%.
- Staff told us there was no formal system for clinical supervision. The purpose of clinical supervision is to provide a safe and confidential environment for staff to reflect on and discuss their work and their personal and professional responses to their work. The focus is on supporting staff in their personal and professional development and in reflecting on their practice to encourage improvement.
- Nurses told us that they did have regular meetings with their manager and they were able to speak to their manager at any time.
- There was a preceptorship programme which supported junior nursing staff. Competency in care procedures were assessed by higher level qualified staff.
- The hospital was involved in the apprenticeship nursing scheme with the skills for health academy. Cadet Nurses were undertaking a national vocational qualification in care. This helped ensure that any future applications for nursing posts were from competent people who had the skills and experience required.
- There was an Induction pack for student nurses, this included the ward philosophy for providing high quality individualised care, staff working on the ward, team meetings and a tour of the ward.
- The induction pack for new nurses starting work at the hospital included a competency framework and scoring system on topics such as health and safety, professional values, communication, infection control and nurse led consent.

- On the acute medical unit there were regular training sessions planned on topics such as taking blood. Staff were checked for competencies at these sessions.
- Staff in bands 1-4 were offered opportunities to undertake appropriate vocational qualifications; however there was no service overview of the numbers of staff that had gained qualifications.
- Senior management staff were aware the trust was discussing the implementation of the care certificate but said they were not aware of any specific plans in the medical service for this to take place. However, there was a trust implementation plan. The care certificate is knowledge and competency based and sets out the learning outcomes and standards of behaviours that must be expected of staff giving support to clinical roles such as healthcare assistants. This was to be introduced by trusts from April 2015.

Multidisciplinary working

- Multidisciplinary team working was well established on the medical wards. MDT meetings took place weekly and were attended by the ward manager, nursing staff as well as therapy staff such as a physiotherapist and occupational therapist.
- A psychiatric liaison service was available within the trust.
- We observed handovers, which included healthcare assistants, nurses and medical staff. There was effective communication and they were well structured.
- Daily ward meetings were held on most of the wards we visited. These were called board rounds and they reviewed discharge planning and confirmed actions for those people who had complex factors affecting their discharge. We observed two board rounds and saw that they were well attended by a range of professionals.
- Each morning there was a medical handover between accident and emergency services and medical services. These were well attended by a range of professionals. At these meetings patient's diagnosis and outstanding issues were discussed and the doctor responsible for the ongoing care of the patient was identified. Any staffing issues were discussed as well as who was the physician of the day. These meetings were formally recorded.

Seven-day services

- The trust had invested funding to support seven day working which included medical services. This included nine additional consultant physicians together with supporting staff such as pharmacists, therapist, diagnostics, advanced nurse practitioners and enhancing the multi-agency discharge team.
- The respiratory and gastroenterology wards had a consultant presence across seven days.
- There were links with social services in place to ensure the clinical teams were fully supported across all seven day of the week.
- Staff and patients told us diagnostic services were available 24 hours a day, seven days a week.
- Consultant cover was available on site from 8am to 8pm daily and an on-site registrar 24 hours a day
- The service had invested in five new acute nurse practitioners to support consultants at weekends.
- Physiotherapy services were available seven days a week. Pharmacy services were also available at weekends to ensure patients' medication was available on discharge.

Access to information

- All staff had access to the information they needed to deliver effective care and treatment to patients in a timely manner including test results, risk assessment and medical and nursing records.
- There were computers available on the wards we visited which gave staff access to patient and trust information.
- Policies and protocols were kept on the hospital's intranet which meant all staff had access to them when required.
- On the majority of wards there were files containing minutes of meetings, ward protocols and learning from incidents and audits which were available to staff.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The majority of staff knew about the key principles of the Mental Capacity Act 2005 and how these applied to patient care. However a junior doctor told us that there were unaware of the trust forms or processes.
- Staff were not always following the key principals when using bed rails for patients. On wards 1A, 1C, 2A, 2C and 5A it was observed that bed rails were in place for nine patients. There was no record in seven of the notes or care plan that a capacity assessment had been done, or a best interest decision had been made, as outlined in the trust policy documentation for using bedrails safely and effectively. Bedrails are seen as a form of restraint in

the national medical council code of practise. This was raised with senior managers at the time of the inspection who told us they would ensure action was taken.

- Staff told us that it was doctors who carried out more formal capacity assessments. We saw that these were recorded in all the records of patients who lacked capacity that we reviewed on ward 2C
- Staff knew the principals of consent and we saw written records that consent had been obtained from patients prior to procedures. However on reviewing the care records of a patient on ward 5A it was noted they lacked capacity but there was no consent form or record of best interest meeting for the insertion of a PEG tube (a PEG tube is a tube placed into the stomach through the abdomen to allow nutrition, fluids and medication to be put directly into the stomach). The trust policy has clear guidance and forms that could be used to record best interest decisions in these circumstances.
- Staff had knowledge and understanding of procedures relating to the Deprivation of Liberty Safeguards which are part of the Mental Capacity Act 2005. They aim to make sure that people in hospital are looked after in a way that does not inappropriately restrict their freedom and are only done when it is in the best interest of the person and there is no other way to look after them. This includes people who may lack capacity. We saw an example of DoLs paperwork completed fully and accurately.

Are medical care services caring?

Patients told us staff were caring, kind and respected their wishes. We saw staff interactions with people were person-centred. People we spoke with during the inspection were complimentary about the staff that cared for them. Patients received compassionate care and their privacy and dignity were maintained

Patients were involved in their care, and were provided with appropriate emotional support.

Compassionate care

- Medical services were delivered by, caring and compassionate staff. We observed staff treating patients with dignity and respect.
- All the patients we spoke with were positive about their care and treatment. Comments included 'staff have been brilliant', 'wonderful treatment' and one patient had chosen to stay at the hospital rather than be transferred to another hospital.
- Patients said that staff always introduced themselves.
- The friends and family test average response rate was 24% which was lower than the England average of 36%. The friends and family test asks patients how likely they are to recommend a hospital after treatment. 98% of patients said they would recommend the service.
- In the cancer patient experience survey for inpatient stay 2013/2014, the trust performed in the top 20% of all trusts in all but seven of the 34 areas. These included 'patient given the choice of different types of treatment, 'staff told patient who to contact if worried post discharge' and 'staff did everything to control side effects of chemotherapy. The trust did not fall in the bottom 20% of trusts for any of the areas.
- We saw that people had access to call bells and staff responded promptly
- Patient-led assessments of the care environment (PLACE) showed that the trust has achieved the best PLACE audits nationally for two consecutive years 2014 and 2015.
- The trust performed about the same as all other trusts in all areas of the 2014 CQC inpatient survey

Understanding and involvement of patients and those close to them

- Patients all had a named nurse and consultant. Patients were aware of these and they were displayed on a board above the bed.
- Patients said that they had been involved in their care and were aware of the discharge plans in place. Most patients could explain their care plan.
- Patients said that they felt safe on the ward and had received orientation to the ward area on admission.
- Family members said that they were generally kept well informed about how their relative was progressing.
- All patients we spoke with said they had received good information about their condition and treatment. One

patient described how understanding staff were and how hard they worked. They told us that the staff were very knowledgeable about their condition and answered any questions they had in a sensitive manner.

Emotional support

- Some staff said that they had sufficient time to spend with patients when they needed support, but other staff felt that time pressures and workloads meant that this did not always happen.
- Staff provided emotional support in a sensitive way for patients who were anxious or worried.
- Open visiting times were available if patients needed support from their relatives.
- Multi faith spiritual leaders were available for patients requiring spiritual support.

Are medical care services responsive?

Good

Services took into account the needs of the local people. There were good ambulatory care services and a specialist unit for the frail and elderly. There were good systems in place for the management of patients when there were shortages of beds on medical wards. Patients who were placed outside the appropriate specialty were seen regularly by a member of the medical team. There was a clear focus on timely discharge planning with ward discharge co-ordinators.

The hospital had implemented a number of schemes to help meet people's individual needs, such as the forget-me-not sticker for people living with dementia or a cognitive impairment and the falling leaf symbol to indicate that a patient was at risk of falls. There was access to translation services and leaflets available for patients about the services and the care they were receiving. However, medical services were not maintaining single sex guidance on the coronary care unit at the time of the inspection to ensure that patients' privacy and dignity was being maintained.

People were supported to raise a concern or a complaint. Complaints were investigated and lessons learnt were communicated to staff and improvements made.

Service planning and delivery to meet the needs of local people

- Ambulatory care had been significantly increased, reducing demand on inpatient beds and improving the patient experience. During 2014 to 2015 a total of 2230 overnight beds were saved which is a reduction of 7.6 beds being in use. To ensure ambulatory care was being used effectively for the local people, there was an education programme in place with the accident and emergency team to ensure that patients are referred to the service if this best met their needs. Ambulatory care was open from 7am to midnight seven days a week.

- A frailty unit had been established which assessed patients and provided comprehensive older persons review
- The facilities and premises were appropriate for the services that were planned and delivered.

Access and flow

- For the period between April 2013 and February 2015 the hospital met the 18 week standards for referral to treatment times in all specialities in medical services.
- The bed occupancy rate for the hospital at the time of the inspection was 93%. It is generally accepted that, when occupancy rates rise above 85%, it can start to affect the quality of care provided to patients and the orderly running of the hospital.
- Information provided by the trust showed that there was a shortage of medical beds and a number of patients placed on wards that were not best suited to meet their needs (also known as outliers). Between July 2014 and July 2015 data showed that there had been 87 medical outliers at the hospital. At the time of our inspection there were 10 medical outliers. These were managed effectively from the point of admission and resulted in reduced bed moves during the patients hospital stay.
- Patients who were outliers were reviewed on a daily basis by a member of the medical team.
- We reviewed four patient notes on a gynaecology ward, which were medical outliers, and saw that they had been seen by a medical consultant within 12 hours of admission and daily by a member of the medical team. There was a standard operating procedure for outlying patients that was being followed.
- The hospital held bed management meetings regularly throughout the day during the week to review and plan

bed capacity and respond to acute bed availability pressures. We attended a bed management meeting during our visit. This meeting was effective and also discussed neighbouring hospital status for demand on beds.
- Senior nurses confirmed that there was good strategic management of bed capacity across the hospital site and effective liaison with clinical commissioning groups.
- 2515 Patients had moved wards more than once during their stay; this was 13.7% of the total number of patients admitted to the hospital between April 2014 and April 2015
- There was a clear focus on effective discharge planning for patients and wards Staff discussed discharges at the daily board round and at the bed management meeting. Discharge letters were sent to general practitioners and the patient also received a copy. There were discharge co-ordinators on each ward we visited to support the process.

Meeting people's individual needs

- Patients of different gender who require a higher level of care (level two) can be nursed in the same area however those with lower lever care needs (level one) must be nursed in separate areas to promote dignity and privacy. On the day of the inspection, patients on CCU were requiring level one care and there was a mixed sex breach on the unit (a mixed sex breach is if a patient occupies a bed space that is either next to or directly opposite a member of the opposite gender). The trust was not reporting these breaches due to confusion about the commissioning arrangements for the unit.
- The service used a falling leaf symbol to indicate that a patient was at risk of falls. This alerted staff to look at the risk assessment and care plan to ensure that any reasonable adjustments were made.
- There was a nurse consultant for older people who was the clinical lead for dementia who provided support for staff and a central point for queries. The trust also employed a psychiatric liaison team who saw and assessed appropriate patients with a cognitive impairment.
- The hospital had implemented the 'forget-me-not sticker scheme. This was a discrete flower symbol used as visual reminder to staff that patients were living with dementia or were disorientated in time and place. This was to ensure that patients received appropriate care, reducing the stress for the patient and increasing safety.
- Several wards had been adapted to be dementia friendly environments, including dementia friendly signage, paintwork and flooring. Toilets also had blue toilet seats to make them stand out and were easily recognisable.
- On ward 5A we saw two reminiscence rooms which were decorated and resourced appropriately, with books, radios and furniture
- On admission people with dementia were given a forget- me-not card to complete supported by carers or nursing staff. This enabled staff to know how they like to be communicated with and how they would like to receive their care. The trust used a health passport document for patients with learning disabilities. Patient passports provide information about the person's preferences, medical history, routines, communication and support needs. They were designed to help staff understand the person's needs.
- A patient who had learning disabilities, individual needs were being met when planning for their discharge. They were remaining on the one ward whilst waiting for their placement in the community to become available. This was causing a delayed discharge on the ward but it was meeting the needs of the patient.
- The trust had undertaken two audits in respect of meeting the needs of patients with learning disabilities. The first focused on reasonable adjustments, care and discharge planning and the second focused on the locality in the hospital of people with a learning disability who were in-patients. The results of the audits led to further training around reasonable adjustments and the importance of recording appropriate information in mental capacity assessments.
- Translation services and interpreters were available to support patients whose first language was not English. Staff confirmed they knew how to access these services.
- Leaflets were available for patients about services and the care they were receiving. Staff knew how to access copies in accessible format, for people with dementia and learning disabilities, and in braille for patients who were blind.
- There was a nurse specialist for diabetes who offers specialist advice to staff caring for people with this condition.

Medical care (including older people's care)

Learning from complaints and concerns

- People knew how to raise concerns or make a complaint. The service encouraged people who used services, those close to them or their representatives to provide feedback about their care.
- There were leaflets available on all the wards we visited explaining the complaints procedure or the patient advice and liaison service.
- Staff we spoke with were aware of the trust's complaints system and how to advise patient and those close to them if they wanted to make a complaint.
- Senior staff told us how they were now working to achieve 'on the spot' resolutions of concerns where possible.
- Learning from complaints was disseminated via team meetings. An example of learning included changes to a consent form and patient leaflet in endoscopy services to include the possibility of dental damage.
- Wards also displayed the compliments they received.
- There was good evidence of responses to patient feedback and practice changing as a result, for example on the endoscopy unit a trust patient survey was undertaken twice a year. Some of the issues raised were waiting times and an untidy waiting area. Whiteboards are now in the waiting area that are regularly updated with any delays and the tidying of the waiting area is now included on the housekeeper checklist.

Are medical care services well-led?

Good

Medical care services were well led with evidence of effective communication within staff teams. The visibility of senior management was good and there were information boards to highlight each ward's performance displayed just outside each ward area. Risk registers were in place which had actions identified and risks were monitored regularly. The service undertook regular care quality assessments across all ward areas. There was some confusion at local level regarding the commissioning arrangements for the coronary care unit.

Staff felt valued and supported and able to speak up if they had concerns. Medical services captured views of people who used the services with changes made following a trust patient survey. People would recommend the hospital to friends or a relative. There was good staff engagement with staff being involved in making improvements for services. All staff were committed to delivering good, compassionate care and were well motivated.

Vision and strategy for this service

- The trust's vision was summarised as the five star approach, care, safety, pathways, communication and systems which were delivered through strategic aims and values. Staff at all levels referred to this vision.
- Trust strategic objectives were based on this vision and these objectives cascaded down to individual objectives for staff.

Governance, risk management and quality measurement

- The risk register highlighted risks across medical services and actions were in place to address concerns, for example lack of staff on the frailty unit.
- Staff at all levels knew that there was a risk register and ward managers were able to tell us what the key risks were for their area of responsibility
- There was a clear governance reporting structure in medical services and the integrated governance and quality improvement committee was held on a monthly basis. The meeting included a review of the risk register, incident, infection, audits, complaints and feedback from other meetings. Actions plans were developed after each meeting which identified the lead for the action and the date the action was to have been completed.
- Senior staff were able to tell us how their ward's performance was monitored, and how performance boards were used to display current information about the staffing levels and risk factors for the ward.
- Multidisciplinary team meetings were held regularly on each medical ward. These were minuted and cascaded to staff via email. Some wards also had a copy of the minutes in a file on the ward for staff to read.
- Senior medical service staff also undertook regular care quality assessments across all wards. These included the environment, care and leadership. Each ward was assessed and then awarded either a gold, silver or bronze standards. Action plans were put in place following each assessment.
- There was some confusion at local level regarding the commissioning of beds in the coronary care unit. The

nurse in charge told us all beds were level two beds (a level two bed is one in which a patient needs a greater degree of observation and monitoring.) The directorate manager told us all beds were 'coronary care' and were not measured as level one or two in terms of acuity.
- We reviewed a commissioning document about the care of patients on the coronary care unit and it was not clear what commissioning arrangements had been agreed. The commissioning arrangements are important because they determine what training staff are required to complete and also whether patients of the same sex can be nursed in the same area. Without an understanding of commissioning arrangements, the trust cannot be assured they are compliant with recognised requirements.

Leadership of service

- Staff reported there was a clear visibility of the trust's board throughout the service. Staff could explain the leadership structure within the trust and the executive team were accessible to staff. Staff said that the static leadership had helped them know who to go to for help with any concerns.
- All nursing staff spoke highly of the ward managers as leaders and told us they received good support. We observed good working relationships within all teams.
- Doctors told us that senior medical staff were accessible and responsive and they received good leadership and support.

Culture within the service

- There was a positive culture throughout medical services .In the 2014 staff survey, 93% of staff in medical services said they were enthusiastic about their job and 87% looked forward to going to work.
- Staff said they felt supported and able to speak up if they had concerns. They said there had been an improvement in staff morale in the last 12 months.
- Staff were comfortable challenging decisions by other colleagues when appropriate. . For example a doctor stated that a patient was ready for discharge which a nurse did not feel was appropriate. This was reviewed again by a consultant who agreed that the patient need to stay a little longer in hospital.

Public engagement

- Board meeting minutes and papers were available to the public online which helped them understand more about the hospital and its services and how they were performing.
- Patients were encouraged to provide feedback.
- Medical services had used a patient story to evaluate care pathways in ambulatory care services.

Staff engagement

- The trust celebrated the achievements of staff at an annual event. At the last event medical services had had a number of staff recognised for their work and achievements.
- Staff participated in the 2014 staff survey. This included how staff felt about the organisation and their personal development 69% off staff in medical services at the hospital felt the training and development they had undertaken had helped them to deliver a better patient experience and 70% felt it had helped them to do the job more effectively. 61% felt that they were valued by managers in medical services at the hospital. This was about the same as the national average of 62%
- In the staff room on ward 1B there was a notice asking staff what they would like to change. Two months before our visit staff had asked for a change to shift patterns and senior staff had responded positively to this.

Innovation, improvement and sustainability

- Ambulatory care services were developing further care pathways for patients with anaemia and headaches which were to be based on NICE guidelines and in collaboration with the local ambulatory care network. Ambulatory care services had received an award from this network for its leadership and development work.
- There was a project in place looking at an electronic tracking system to help with audit and evaluation of ambulatory services.
- An analysis of the 2014 staff survey results showed 85% of staff in the medical services at the hospital, who responded, felt they were able to make suggestions to improve the work of their team/department. This was about the same as the national average of 74%
- 89% of staff working in medical services said they had frequent opportunities to show imitative in their role. 73% of staff said they were involved in deciding on changes to improve services for patients.

- Wards were moving to electronic hand held devices to record nursing notes in February 2016. This would ensure that entries were inputted in a timely effective way.

Surgery

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

Information about the service

Surgical services are provided across two sites that form part of St Helens & Knowsley Teaching Hospitals NHS Trust.

Whiston Hospital carries out a range of surgical services including: urology, ophthalmology, trauma and orthopaedics and general surgery (such as colorectal surgery). Hospital episode statistics data (January 2014 to December 2014) showed 20,674 patients were admitted for surgery at the hospital of which 32% had day case procedures, 31% had elective surgery and 37% were emergency surgical patients.

There are nine surgical wards including the surgical assessment unit and 12 theatres that carry out emergency surgery procedures as well as some day case and elective surgery.

As part of the inspection, we inspected the main theatres, Ward 4A (the urology and general surgical ward), Ward 4B (the surgical assessment unit), Ward 4C (the colorectal surgical ward), Ward 4D (burns), Ward 3Alpha (fractured neck of femur), Ward 3A (plastics, trauma and pre-operative assessment ward), Ward 3B (elective orthopaedic ward) and Ward 3C (the trauma and orthopaedics ward).

We spoke with seven patients, observed care and treatment and looked at care records. We also spoke with a range of staff at different grades including nurses, doctors, ward managers, theatre managers, the divisional director, the assistant director of operations, the head of quality and designated consultant and matron leads for each surgical speciality.

We received comments from our listening events and from people who contacted us to tell us about their experiences, and we reviewed performance information about the trust.

Surgery

Summary of findings

The surgical services at Whiston Hospital were rated as good because patients, carers and families were positive about the care and treatment provided. They felt supported, involved and staff actively engaged with patients whilst providing kind compassionate care. We observed positive interactions when staff were seeking consent. Staff supported patients and their relatives with their emotional and spiritual needs.

Safe systems were in place for reporting incidents, duty of candour and safeguarding issues. Staff were aware of current infection prevention and control guidelines. Equipment was sufficiently available, clean, safe and well maintained, appropriately checked and decontaminated regularly with checklists in use.

Medicines, including controlled drugs, and records were stored securely. Staff attended mandatory training and staffing levels were sufficient to meet the needs of patients. The World Health Organization surgical safety checklist data was reviewed on a monthly basis. The WHO checklist is in place to detect any potential error before it leads to avoidable harm. There was a documented strategic business continuity and internal major incident plan within surgical services with the possible key risks that could affect the provision of care and treatment.

Staff provided care and monitored compliance in line with national best practice guidelines. The surgical care group participated in a number of local and national clinical audits and acted on any recommendations. There was participation in national audits. Data from the audits was positive and the trust had appropriate action plans in place.

Patients were assessed individually for pain relief and for their nutritional requirements. Staff were competent and well supported by managers. Multidisciplinary team working was well established and effective within the surgical wards and theatres.

Service planning and delivery took into account the needs of local people. Patients were appropriately assessed and provided with treatment plans based on clinical priority. Discharge planning took place at an early stage, following a patient's admission with multidisciplinary input.

Although bed occupancy was high, the trust data was positive and showed theatre utilisation (efficiency) was 87% and NHS England data showed national 18 week referral to treatment targets were being met. The number of elective operations cancelled was better than the England average and all patients that had their operations cancelled were treated within 28 days since April 2011. Trust data showed the number of surgical outliers on medical wards was very low.

The hospital had implemented a number of schemes to help meet people's individual needs.

The surgical care group was well led. The ethos was to ensure there were no patient safety issues and ward staff told us they felt the culture was transparent and open. The clinical & quality strategy outlined how the service would be improved by providing timely treatment by reducing cancelled operations and by improving discharge times. Surgical patient pathway improvement programme work streams were in place to reduce cost and promote service efficiency.

A "board to ward" governance process allowed risks to be escalated appropriately. Risks were documented and escalated by the service appropriately with action plans in place to address the identified risks.

Information on how the public could provide feedback was displayed in the departmental areas. The trust celebrated the achievements of staff in a number of ways including an annual awards event.

Surgery

Incidents

- Incidents were reported via the electronic trust wide reporting system. Staff knew the types of incidents to report and could demonstrate how these would be recorded and escalated.
- Incidents were reviewed and investigated by staff with the appropriate level of seniority to look for improvements and learning within the service.
- A total of 945 incidents were reported for the surgical care group between January 2015 and April 2015. The majority (908) resulted in no or low harm such as the detection of incorrect patient details on theatre lists, six severe harms were recorded which included falls resulting in fractures and one death was reported.
- We reviewed a number of incidents and found investigations were appropriately conducted using a root cause analysis process to identify any contributing factors and actions were assigned as necessary.
- Learning from incidents had been shared at meetings and changes in practice had been made where required.
- Staff were familiar with the term ‘duty of candour’ (the regulation introduced for all NHS bodies in November 2014, meaning they should act in an open and transparent way in relation to care and treatment provided) and told how they would inform the patients or carers when incidents occurred and of the outcomes for example in relation to patient falls.
- Mortality and morbidity reviews were held in accordance with trust policies and procedures. Deaths were reviewed thoroughly and appropriate changes made to help to ensure the safety of patients.

Safety thermometer

- The NHS safety thermometer assessment tool measures a snapshot of harms once a month (risks such as falls, pressure ulcers, bloods clots, catheter and urinary infections).
- Safety thermometer information between March 2014 and March 2015 showed the trust performed within the expected range for falls with harm, catheter urinary tract infections and new pressure ulcers.
- Information relating to this was clearly displayed in the wards and theatre areas we inspected.

Cleanliness, infection control and hygiene

- The wards and theatres we inspected were visibly clean. Cleaning schedules were in place with clearly defined roles and responsibilities for cleaning the environment and decontaminating the equipment.
- Staff were aware of current infection prevention and control guidelines. Arrangements were in place for the handling, storage and disposal of clinical waste, including sharps.
- We observed staff following correct hand hygiene and 'bare below the elbow' guidance with appropriate protective personal equipment, such as gloves and aprons, whilst delivering care.
- Appropriate infection control protocols and gowning procedures were adhered to in the theatre areas.
- Patients identified with an infection were isolated in side rooms with appropriate signage used to protect patients, staff and visitors.
- The trust had employed a number of infection control link nurses and a surgical site infection specialist nurse worked across both sites. Their role was to provide training and to liaise with staff so patients that acquired infections following surgery could be identified and treated promptly.
- The number of MRSA and MSSA infections were below the England average between April 2013 and March 2015. C. difficile infections relating to surgery were within expected limits at the hospital between April 2014 and December 2014.
- We reviewed an investigation report and action plan for a MSSA bacteraemia incident that occurred in April 2015. This showed that the incident had been investigated appropriately, with clear involvement from nursing and clinical staff, as well as the trust’s infection control team.

Environment and equipment

- The ward and theatre areas were well maintained, free from clutter and provided a suitable environment for treating patients.
- Equipment was visibly clean well maintained in the wards and theatre areas. Equipment was appropriately checked and decontaminated regularly with checklists in use for daily, weekly and monthly monitoring.

- Staff in the theatres told us they always had access to the equipment and instruments they needed to meet patients' needs and confirmed any faulty equipment was either repaired or replaced promptly.
- The trust used single-use, sterile instruments where possible. The single use instruments we saw were within their expiry dates.
- The service had arrangements for the sterilisation of reusable surgical instruments.
- There was sufficient storage space in the theatres and items such as surgical procedure packs were appropriately stored in a tidy and well organised manner.
- Emergency resuscitation equipment was available in all the areas we inspected and was checked on a daily basis by staff.

Medicines

- Medicines, including controlled drugs, were stored securely and access was limited to qualified staff employed by the trust. Medicines requiring storage at temperatures below 8ºC were appropriately stored in fridges with daily temperature checks.
- Medicines were ordered, stored and discarded safely and appropriately. Staff from the pharmacy department carried out daily reviews on each ward area to maintain minimum stock levels and to ensure medication was within its expiry dates.
- Staff carried out daily checks on controlled drugs and medication stocks to ensure medicines were reconciled correctly. We checked the balance of controlled drugs in the cabinets and found the stock balances correlated with the registers. Two members of staff had signed each entry upon dispensation.
- Medication charts for five patients were reviewed and found to be complete, up to date and reviewed on a regular basis.

Records

- We looked at the records for seven patients. Nursing and medical assessment information was available electronically and via paper based records. Records were structured, legible and up to date.
- Records showed nursing and clinical assessments were carried out before, during and after surgery and were documented correctly.
- Patient records included care bundles and risk assessments, such as for moving and handling, pressure care or nutrition which were completed correctly. A 'skin bundle' care plan was also in place.
- Standardised nursing documentation was kept at the end of patients' beds. Observations were well recorded with the timings dependent on the acuity and level of care needed by the patient.

Safeguarding

- Accessible policies outlined the processes for safeguarding vulnerable adults and children.
- Staff confirmed they could contact the designated safeguarding lead, safeguarding link nurses or a social worker if a patient was suspected of being at increased risk of neglect or abuse.
- Data showed safeguarding training rates were high with 81% of medical staff and 88% of nursing staff in the surgical care group having received level one adult and child safeguarding training.

Mandatory training

- Medical and nursing staff confirmed they had received an induction specific to their role when they had begun work in their departments. Agency and locum staff also followed the same process.
- We viewed local induction checklists which included departmental safety instructions, orientation and an introduction to the policies and procedures.
- Staff received mandatory training in areas such as fire safety, health and safety, equality and diversity, information governance, infection control, resuscitation and the safeguarding of adults and children.
- The trust target was to ensure at least 85% of staff were trained in each area. Records showed the majority of administrative and clinical (nursing and medical) staff had completed the majority of their mandatory training and achieved the target set by the trust.

Assessing and responding to patient risk

- Staff were aware of how to escalate key risks that could affect patient safety, such as staffing and bed capacity issues. Daily involvement by the matrons and ward managers ensured these issues were addressed.

- Upon admission to the surgical wards and before surgery, staff carried out risk assessments to identify patients at risk of harm. Patients at high risk were placed on care pathways to ensure they received the right level of care.
- The surgical wards used the early warning score for recording the vital signs so deterioration could be identified and remedial action taken immediately.
- We observed three theatre teams undertaking the 'five steps to safer surgery' procedures, including the use of the World Health Organization checklist. Theatre staff completed safety checks before, during and after surgery and demonstrated a good understanding of the 'five steps to safer surgery' procedures.
- The WHO surgical safety checklist data was reviewed on a monthly basis by the clinical leads who also monitored staff compliance by observing a number of surgical teams per week. Any compliance issues were escalated to the theatre manager.

Nursing staffing

- The wards and theatres had sufficient numbers of trained nursing and support staff with an appropriate skills mix to ensure that patients were safe and received the right level of care.
- The expected and actual staffing levels were displayed and updated on a daily basis on notice boards in each area we inspected.
- The trust was in the process of implementing an electronic roster system which included rules with numbers of staff for minimum and safe staffing which alerted management if there were shortages.
- Staffing levels were reviewed every six months using the 'safer nursing care tool (Shelford Group, 2013)' endorsed by the National Institute for Health and Care Excellence. This is an evidence based tool which allows nurses to assess patient acuity and dependency and to determine the recommended number of staff.
- The staffing report was presented to the board in July 2015 and took into account the potential issues around safe staffing levels at Mid-Staffordshire NHS Foundation via the Francis Report in 2013. The report concluded the data indicated the trust had safe staffing levels in place as compared with the national benchmark and determined six monthly reviews would be maintained.
- The ward and theatre managers also carried out daily staff monitoring based on the dependency of patients and escalated staffing shortfalls due to unplanned sickness or leave. Staffing levels on the wards were increased when necessary so patients needing direct care could be appropriately supported.
- Staffing levels were maintained by staff working overtime and with the use of bank and agency staff. Ward managers tried to use regular bank or agency staff and ensured temporary staff were accompanied by permanent trained staff where possible, so patients received an appropriate level of care. Agency staff underwent an induction and checks were carried out to ensure they had completed mandatory training prior to commencing employment.
- The number of vacancies in the surgical care group was low at the time of inspection. There were 11 vacancies for nurses in the ward areas, three in theatres and three healthcare assistants. The majority were due to staff taking maternity leave. These posts had been subject to recruitment and staff were due to start in September.
- Nursing staff handovers occurred twice a day and included discussions about patient needs and any staffing or capacity issues.

Surgical staffing

- The wards and theatres had sufficient numbers of medical staff with an appropriate skills mix to ensure that patients were safe and received the right level of care.
- There was sufficient on-call consultant cover over a 24 hour period with appropriate medical cover outside of normal working hours and at weekends. The on-call consultants were free from other clinical duties to ensure they were available if needed.
- The proportion of consultants and middle career doctors was equal to the England average. The proportion of registrars was below the England average (24% compared with the England average of 37%) and the proportion of junior doctors was greater than the England average.
- Trainee doctors and middle career doctors (e.g. senior house officers) told us they received good support and could easily access the on-call consultant if needed.
- The assistant director of operations for the surgical care group told us the group of consultants, middle career doctors and registrars at the hospital were experienced enough to meet patient needs effectively and safely and patients were receiving safe care.

- Existing vacancies and shortfalls were covered by locum, bank or agency staff when required. All agency and locum staff were provided with a local induction to ensure they understood the hospital's policies and procedures.
- Daily medical handovers took place during shift changes which included discussions about specific patient needs.

Major incident awareness and training

- There was a documented strategic business continuity and internal major incident plan within surgical services with the possible key risks that could affect the provision of care and treatment.
- There were clear instructions for staff to follow in the event of a major incident e.g. fire which included the scaling back of non-urgent routine elective surgery.
- A dedicated theatre was available 24 hours daily for emergency general surgery and trauma patients. Staff followed protocols to cancel elective procedures if emergency lists were required to allow patients requiring emergency surgery to be treated promptly.

Are surgery services effective?

Good

Staff provided care and monitored its performance in line with national best practice guidelines. The surgical care group participated in a number of local and national clinical audits. There was participation in national audits such as the national bowel cancer audit and the national hip fracture audit. Data from the audits was positive and the trust performed well. Where any issues were identified, there were appropriate action plans in place to secure improvement that were regularly reviewed and evaluated.

Patients were assessed individually for pain relief and were supported by a team of acute pain specialist nurses. Staff were competent and well supported with appraisals, on-the-job learning and development opportunities. Patients were assessed for nutritional requirements and dieticians were involved when required. Multidisciplinary team working was well established and effective within the surgical wards and theatres. There was evidence of the services being provided seven days a week but the surgical care group was in the main providing six day week working.

Evidence-based care and treatment

- The surgical care group was using national and best practice guidelines to care for and treat patients. The trust monitored compliance with National Institute for Health and Care Excellence (NICE) standards. Emergency surgery was managed in accordance with the national confidential enquiries into patient outcome and death recommendations and the Royal College of Surgeons standards for emergency surgery.
- Staff provided care in line with 'recognition of and response to acute illness in adults in hospital' (NICE clinical guideline 50) and 'rehabilitation after critical illness' (NICE clinical guideline G83).
- Enhanced recovery pathways were used in a number of surgical specialities. Enhanced recovery is an evidence-based approach to care that helps people recover more quickly after having major surgery.
- The surgical care group completed a number of local clinical audits and participated in many national audits. The audit plan for 2015/16 identified audits would be carried out to assess emergency theatre delays, pre-op fasting, review of mortality cases within 30 days of surgery and various record keeping audits.
- Previous audit findings and progress against the clinical audits and compliance with NICE guidelines was also reported to the monthly governance board meetings to ensure any issues were identified and appropriate actions taken.
- Staff told us policies and procedures reflected current guidelines and were easily accessible via the trust's intranet. We looked at a number of policies and procedures on the hospital's intranet which were up to date and reflected national guidelines.
- An audit to monitor compliance with trust policy and best practice in relation to consent for investigation or treatment 2014/15 was carried out in March 2015. This looked at 260 consent forms completed prior to procedures/treatment (for both inpatients and day cases) occurring during the period April 2014 to March 2015. The audit concluded that overall compliance with the trust policy for receiving of consent was very good with a few areas for minor improvements. Remedial actions were assigned to rectify the minor issues.

Pain relief

- Patients were assessed pre-operatively for their preferred post-operative pain relief.

- Staff were supported by a team of acute pain specialist nurses in the surgical wards and theatres across both hospitals that monitored patients undergoing major surgery such as orthopaedic surgery.
- Staff used pain scores to monitor pain symptoms at regular intervals. Patient records showed patients received the required pain relief and were treated in a way that met their needs and reduced discomfort.
- Patients told us staff gave them appropriate pain relief medication when needed. Pain relief was managed on an individual basis.

Nutrition and hydration

- Wards had protected mealtimes in place when all activities on the wards stopped, if it was safe for them to do so. This meant staff were available to help serve food and assist those patients who needed help.
- Patient records included assessments of patients' nutritional requirements, fluid and food charts which were reviewed and updated regularly. Records showed regular dietician involvement with patients who were identified as being at risk of dehydration/malnutrition.
- Patients with difficulties eating and drinking were placed on special diets and those who required support and assistance with eating and drinking were discreetly identified using a coloured jug system.
- Patients told us they were offered a choice of food and drink and spoke positively about the quality of the food offered.
- A food coordinator role was undertaken by a healthcare assistant to ensure meals were offered to patients following surgery so they could eat and drink as soon as possible.

Patient outcomes

- There was participation in national audits such as the national bowel cancer audit and the national hip fracture audit.
- The national hip fracture audit 2014 showed the hospital performed better than the England average for five out of the nine indicators, including surgery on the day of or after day of admission, bone health medication assessment, mean length of acute stay and mean length of post-acute stay.
- However, the hip fracture report highlighted that only 20.3% of patients were admitted to orthopaedic care within 4 hours compared to the England average of 48%, only 39% of patients had a pre-operative assessment by geriatrician compared to the England average of 52% and the mean total length of stay was 23 days compared to the England average of 19 days.
- The hip fracture care action plan showed many of the actions had been completed. The assistant director of operations and divisional director told us they had recruited a consultant orthopaedic geriatrician since the last audit in order to improve compliance. Trust data from January 2015 to May 2015 showed there was an overall reduction in acute phase length of stay by 1.4 days since the introduction of the Ortho-geriatric consultant.
- The national bowel cancer audit (2014) showed the trust had performed better than the England average for the number of patients that had a CT scan, the number of patients that underwent surgery, the number of cases discussed at multidisciplinary team meetings and the number of patients seen by a clinical nurse specialist. The trust also performed better than the England average for patient length of stay above 5 days (77% compared with 69%).
- The national bowel cancer audit showed the trust was slightly worse than the England average for the number of patients for whom major surgery was carried out as urgent or emergency (14% compared with 16%) and the number of patients for whom laparoscopic surgery was attempted (39% compared with 55%).
- Performance reported outcomes measures (PROMs) data between April 2013 and March 2014 showed the percentage of patients with improved outcomes following groin hernia, hip replacement, knee replacement and varicose vein procedures was either similar to or better than the England average.
- The trauma and orthopedics PROMs action plan meeting minutes from July 2015 showed a review of the action plans which included an increase capacity of patients receiving surgery in the joint school from 10 patients per week to 15. Other actions were also appropriately discussed and updated such as ensuring patients mental health and wellbeing was explained.
- The national emergency laparotomy audit (2014) showed a mixed performance in the 12 out of the 28 standards that were available at the trust.

- Hospital episode statistics data (January 2014 to December 2014) showed the average length of stay for elective and non-elective surgery was similar to the England average aside from non-elective trauma and orthopaedics which was approximately four days longer.

Competent staff

- Newly appointed staff had competency assessments before working unsupervised.
- Records showed appraisal rates varied between staff types (an appraisal gives staff an opportunity to discuss their work progress and future aspirations with their manager).
- Between April 2014 and April 2015 90% of nursing staff and 97% of medical staff had received appraisals. However, only 33% of the surgical care group's prosthetists had received an appraisal, though it was noted that this related to only 9 staff in total.
- Staff told us they had received an appraisal or were due to have one. Information provided by the trust identified the appraisal process for 2015 to 2016 had started and was still ongoing.
- Medical and nursing staff were positive about on-the-job learning and development opportunities and told us clinical supervision was in place with adequate support for revalidation.

Multidisciplinary working

- Multidisciplinary team working was well established and effective with daily communication between all teams within the surgical wards and theatres. These involved staff from the different specialties such as pharmacists, dieticians, physiotherapists, occupational therapists and social workers. A psychiatric liaison service was also available within the trust.
- Staff handover meetings took place during shift changes and safety huddles were carried out on a daily basis to ensure all staff had up-to-date information about risks and concerns.
- Meetings on bed availability were held a number of times daily to determine capacity and demand and were attended by senior staff.
- Ward staff had a good relationship with consultants and ward-based doctors.
- Patient records showed there was routine input from nursing and medical staff and allied health professionals.
- The ward and theatre staff told us they received good support from diagnostic services for example when X-rays and scans were needed they were completed promptly.

Seven-day services

- Staff rotas showed nursing staff levels were sufficiently maintained outside normal working hours and at weekends. Out-of-hours medical cover was provided to patients in the surgical wards by junior and middle grade doctors as well as on-site and on-call consultant cover. Ward and theatre staff told us they received good support outside normal working hours and at weekends.
- At weekends, newly admitted patients were seen by a consultant, and existing patients on the surgical wards were seen by the ward-based doctors.
- There was a 24 hour service with dedicated emergency and trauma theatres so any patients admitted over the weekend that required emergency surgery could be treated. Microbiology, imaging (e.g. X-rays), physiotherapy and pharmacy support was available on-call outside of normal working hours and at weekends.
- The trust had "super Saturday" clinics at the weekend and evening clinics but there were no clinics or routine surgery on Sunday. The assistant director of operations told us they were reasonably selective about which patients were operated on at weekends and weekend operating lists were for elective surgery to meet the referral to treatment targets if needed.
- The service had a policy to discharge patients seven days a week but this was sometimes difficult depending on other support services being available such as social services support.
- The trauma unit is open 8am to 6pm Monday to Saturday and 8am to 4pm on Sundays. Patients attended the trauma unit with varying injuries including: hand injuries, facial injuries, head/scalp lacerations, leg lacerations, human and dog bites, hand infections and more. These patients were referred from all accident and emergency departments from across the North West, North Wales and the Isle of Man.

Access to information

- Patient records were complete, up to date and easy to follow. They contained detailed patient information from admission, surgery through to discharge. This meant staff could access all the information needed about the patient at any time.
- Information such as audit results, performance information and internal correspondence was displayed in all the areas we inspected. Staff could access information such as policies and procedures from the trust's intranet.
- The theatre department used an electronic system to capture information about patient scheduling and theatre performance.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff had the appropriate skills and knowledge to seek consent from patients or their representatives. Staff were clear about how they sought informed verbal and written consent before providing care or treatment.
- Patient records showed verbal or written consent had been obtained from patients or an appropriate person and planned care was delivered with their agreement.
- Staff understood the legal requirements of the Mental Capacity Act 2005 and deprivation of liberties safeguards.
- If patients lacked the capacity to make their own decisions staff made decisions about care and treatment in the best interests of the patient and involved the patient's representatives and other healthcare professionals appropriately.
- Patient records showed staff carried out mental capacity assessments for patients who lacked capacity and where deprivation of liberties safeguards applications had been made, the records for these were in place and completed correctly.
- There was a trust-wide safeguarding team that provided support and guidance for staff for mental capacity assessments, best interest meetings and deprivation of liberties safeguards applications.

Patients, carers and families were positive about the care and treatment provided by the surgical care staff team. They felt supported, involved and received information in a manner they understood. We observed staff actively engaging with patients whilst providing kind and compassionate care. Staff were respectful whilst delivering care. We observed positive interactions between staff, patients and their relatives when seeking verbal consent. Staff supported patients and their relatives with their emotional and spiritual needs.

Compassionate care

- Patients, carers, their families and representatives were positive about the care and treatment provided. We observed many examples of compassionate care given to patients based on individual needs. All patients were treated by named nurses for continuity of patient care.
- Patients, their families and carers were being treated with compassion, dignity and respect by staff of all grades. Staff provided reassurance and comfort to patients who were anxious or worried.
- The areas we inspected were compliant with same-sex accommodation guidelines. Cubicle curtains and doors were closed during consultations and patients could be transferred to side rooms with single occupancy to maintain further privacy if required. Staff knocked on doors and asked before seeing patients who were behind the cubicle curtains.
- Throughout our observations, we saw very positive interactions between staff and patients and noted staff were kind, compassionate and caring. We saw staff attending to a patient who was very ill and speaking to them in a comforting manner.
- Patents were encouraged to wear their own clothes in the daytime and change into nightclothes in the evening.
- The NHS friends and family test (a survey which asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care) showed a high response rate of between 28 and 69%. The FFT results showed from March 2014 to February 2015 all eight wards received a score of 100% frequently of people who would recommend the surgical services at the organization.
- The trust performed in the top 20% of all trusts in all but seven of the 34 areas in the cancer patient experience survey for inpatient stay 2013/2014.

- Patient-led assessments of the care environment (PLACE) showed that the trust has achieved the best PLACE audits nationally for two consecutive years 2014 and 2015.
- The trust performed similar to other trusts in all areas of the 2014 CQC inpatient survey.

Understanding and involvement of patients and those close to them

- Patients, carers, their families and representatives received information about their care and treatment in a manner they understood. They felt involved in the planning of their care and contributed to developing their care plan.
- Patient records included assessments that took into account individual preferences. Staff were caring and compassionate and acted on the wishes of patients whilst ensuring the impact of those wishes was communicated clearly.
- Upon admission, patients were allocated a designated member of staff to oversee the provision of care they received to ensure continuity. The patient and member of staff were involved in the planning for discharge or transfer from the department.
- We observed positive interactions between staff, patients and their representatives when seeking verbal consent.
- We observed one nurse discussing a patient's discharge who had expressed some anxieties about leaving the hospital. The nurse took time to encourage the patient and assure them support would be available.

Emotional support

- We observed staff emotionally supporting patients who were anxious or worried. For example, we saw a nurse reassure and comfort a patient whilst accompanying them back onto a ward after theatre.
- Patients and staff could be referred to the counselling services if necessary, where specialist support was available.
- Staff made people aware of the support groups that they could access.
- Clinical nurse specialists were available for specific support such as a cancer nurse specialist and nurses with leads in stoma, colorectal surgery and urology.
- Each area had a falls champion who was part of the falls team. Clinical nurse educators also assisted to ensure nurses could learn specific skills to assist patients with specific medical conditions and treatments.

Are surgery services responsive?

Good

Service planning and delivery took into account the needs of local people. Patients were appropriately assessed and provided with treatment plans based on clinical priority. Discharge planning took place at an early stage with multidisciplinary input.

Patients were provided with care and treatment in a timely way. NHS England data showed national targets (90 per cent of admitted patients should start consultant-led treatment within 18 weeks of referral) were being met. The number of elective operations cancelled was better than the England average and all patients that had their operations cancelled were treated within 28 days. Trust data showed the number of surgical outliers on medical wards was low.

The hospital had implemented a number of schemes to help meet people's individual needs, such as the "forget me not" passport for patients who were living with dementia and the "passport document" for patients with learning disabilities.

Staff could access translation services and leaflets for patients about the services and the care offered.

People were supported to raise a concern or a complaint and lessons were learnt and improvements made following any investigation.

Service planning and delivery to meet the needs of local people

- Arrangements were in place with neighbouring trusts to allow the transfer of patients for surgical specialties not provided by the hospital. The trust was part of the Cheshire and Merseyside major trauma network collaborative between Aintree University Hospital supported by trauma units at other hospitals within the network.

- Routine engagement and collaboration took place with staff from the neighbouring trust, such as on-site outpatient clinics and regular multidisciplinary team meetings.
- The surgical assessment unit (SAU) was used for surgical/GP assessment and as the elective surgery ward. Patients are referred to the SAU from the accident and emergency department, GPs and walk-in centres to undergo further assessment. On arrival to the SAU, patients are reviewed by a doctor and following further assessment a plan of care will be commenced.
- The trauma and orthopaedic department deal with any pain or damage, especially fractures, to bones and joints. They offer treatment for orthopaedic disorders including hip and knee, spine, foot and ankle and to the shoulder and elbow.
- The Mersey regional burns, plastic and reconstructive surgery unit provides world class care to patients from Merseyside, Cheshire, North Wales, the Isle of Man and increasingly from across the UK.
- There was also a plastic surgery trauma unit where patients attend to be assessed by the plastics team, and a plan is made for them as to whether they need any kind of operation, or if they are to be managed conservatively. If surgery is necessary patients are added onto a waiting list with other patients. The list is based on clinical priority.
- The hospital had a total of 12 operating theatres including an emergency general surgery and trauma theatre which was staffed 24-hours, seven day per week so that patients requiring emergency surgery during out of hours and weekends could be treated promptly.
- There was sufficient bed space in the theatres to ensure patients could be appropriately cared for pre and post-operation.

Access and flow

- Our inspection did not highlight any concerns relating to the admission, transfer or discharge of patients from the surgical wards and theatres. Patient records showed discharge planning took place at an early stage with multidisciplinary input from specialities such as physiotherapists and social workers.
- Staff completed a discharge checklist, which covered areas such as medication and communication with the patient and other healthcare professionals to ensure patients were discharged in a planned and organised manner. Discharge letters written by the doctors included all the relevant clinical information relating to the patient's stay at the hospital.
- Patients were admitted through a number of routes including pre-planned day surgery, via the accident and emergency (A&E) or via a GP referral. Patients admitted via A&E or GP referral were directed to the surgical assessment unit to be assessed by staff.
- NHS England data showed the overall hospital-wide bed occupancy rates between April 2013 and March 2015 were higher than the England average with percentages ranging from 93-95%. The high level of bed occupancy meant less surgical beds were available for patients. Bed occupancy was monitored on a daily basis and patients were transferred to other surgical wards if no beds were available within a specific surgical specialty.
- Trust data showed overall theatre utilisation (efficiency) at Whiston Hospital was 87% from February 2015 to April 2015. The trust target was to achieve 85% theatre utilisation but this didn't take into account the specific surgical specialities.
- NHS England data showed national targets (90 per cent of admitted patients should start consultant-led treatment within 18 weeks of referral) were being met between April 2013 and February 2015 for all the specialities apart from trauma and orthopaedics which was only slightly behind at 89.3% and was due to a national mandate.
- NHS England data showed the number of elective operations cancelled was better than the England average from July 2014 to September 2014. Trust data between April 2014 and July 2015 showed 291 operations were cancelled at Whiston Hospital. Reasons for cancellations included the unavailability of ward beds and theatre lists overrunning.
- When an operation was cancelled, staff arranged a new date with the patient on the day of the cancellation. NHS England data showed there have been no patients who were not treated within 28 days of having an operation cancelled since April 2011 which was better than the England average.
- The percentage of patients who didn't attend appointments in the surgical care group was on average around 8% (November 2013 to April 2014). The trust had looked at systems such as messages to mobile phones to reduce this.

- We attended hospital bed management meetings which were held throughout the day to review and plan bed capacity and respond to acute bed availability pressures.
- Patients placed on wards not best suited to meet their needs are known as "outliers". Trust data showed the number of surgical outliers on medical wards was low. The assistant director of operations for surgery confirmed this information is not tracked for this reason.
- The surgical care group counted any surgical patient who was not on their specific ward as outliers. During the inspection we found these patients were managed effectively. Surgical doctors told us they were issued with a daily list of surgical outlier patients who were then seen daily.

Meeting people's individual needs

- A variety of information leaflets were available but were mostly in English. Staff told us they could provide leaflets in different languages or other formats, such as braille, if requested.
- Staff confirmed they would ask relatives or family members if interpretation was needed but would only use official interpreter services for consenting procedures during treatment. Interpreter services were available by the use of a telephone service or face-to-face where English was not the patient's first language.
- Staff asked patients with learning disabilities if they had a completed "passport document" with them. The passport is a document completed by the patient or their representative, which includes key information such as the patient's medical history and their likes or dislikes.
- The trust had a "forget me not" passport for patients admitted to the hospital who were living with dementia completed by the patient or their representatives. This passport was designed to accompany the patients throughout their hospital stay to help with communication and reduce anxiety.
- Ward 3 Alpha had a reminiscence room created especially for elderly patients and those who are living with dementia. The room was designed to remind patients of their past, decorated with ornaments and furniture from earlier times, so they could recognise memorable items.
- A number of staff had attend a training session as part of the "Alzheimer's society's dementia friends programme" which is an initiative to change people's perceptions of dementia.
- The safeguarding teams worked with link nurses with an interest in learning disability and dementia to ensure the patients' needs were met such as ensuring consent was appropriately taken before a procedure.
- Staff could access appropriate equipment such as specialist commodes, beds or chairs to support the moving and handling of bariatric patients (patients with obesity) admitted to the surgical wards and theatres.

Learning from complaints and concerns

- Information on how to raise complaints was displayed in the ward and theatre areas and included contact details for the patient advice and liaison service.
- The hospital's aim was to respond to complaints within 25 working days or a timescale negotiated with the complainant.
- Complaints were recorded on the trust-wide incident reporting system. The ward and theatre managers were responsible for investigating complaints in their areas. The timeliness of complaint responses was monitored by the trust-wide complaints team, who notified individual managers when complaints were overdue.
- Staff told us information about complaints was routinely discussed during team meetings to raise staff awareness and aid future learning.
- A total of 121 complaints had been received about the surgical care group between April 2015 and August 2015. 67% had been resolved in the agreed timescales to date with 43 open complaints of which 41 were within the agreed timescales.

The surgical care group was well led with good support and visible leadership. The ethos was to ensure there were no patient safety issues and ward staff told us they felt the culture was transparent and they could raise any concerns with more senior staff. Surgical patient pathway improvement programme work streams were in place to reduce efficiency and costs.

Surgery

A "board to ward" governance process allowed risks to be escalated appropriately. Risks were documented and escalated by the service with action plans in place to address the identified risks.

Information on how public could provide feedback was displayed in the departmental areas and feedback mechanisms for the public to engage with the trust were also on the internet site.

The trust celebrated the achievements of staff in a number of ways including an annual event where staff had their accomplishments and achievements recognised.

A bespoke human factors training course (a course to reduce risk of human error) had been developed and rolled out for theatre staff.

Vision and strategy for this service

- The trust vision was "to provide five star care patient care" across the trust with the five areas of focus being care, pathways, safety, communications and systems.
- The clinical & quality strategy and action plan for 2014 to 2018 outlined how the surgical care group would achieve the vision. Actions included providing timely treatment by reducing cancelled operations, improving discharge times and providing timely cancer care.
- Staff had a clear understanding of the vision and strategy and could articulate what the vision and values meant for their practice.

Governance, risk management and quality measurement

- The head of quality for surgical care spoke about a "board to ward" governance process which was embedded at the trust. This meant governance was everyone's responsibility.
- A clinical governance system was in place that allowed risks to be escalated to divisional and trust board level through various committees and steering groups.
- The head of quality for surgical care was the lead for risk and told us staff recognised, reviewed and actioned the moderate and high risks via monthly risk management council meetings. They confirmed the process was not fully embedded but progress had been made over the last year to improve understanding and the importance of this forum.
- Senior staff were aware of the departmental risks, performance activity, recent serious untoward incidents and other quality indicators. Information relating to performance against key quality, safety and performance objectives was monitored and cascaded to staff through performance dashboards.
- We reviewed the risk register for the surgical care group. Risks were documented and escalated by the service appropriately with action plans in place to address the identified risks. The risk register was reviewed at routine clinical governance meetings.
- Key performance indicators were discussed at the governance meeting and specialist nurses would be invited to discuss their specific areas e.g. the tissue viability nurse would discuss pressure ulcers and falls.
- There were regular staff meetings and daily safety huddles to discuss day-to-day issues and to share information around complaints, incidents and audit results. Information and audit results were also shared on notice boards around the wards and theatre areas and daily matron meetings were held.

Leadership of service

- The surgical care group was overseen by a divisional director and an assistant director of operations. The group was supported by a head of quality and designated consultant and matron leads for each surgical speciality.
- There were clearly defined and visible leadership roles within the ward and theatre areas such as the matrons, ward managers and theatre managers to oversee the day to day running of services.
- Leaders were visible and accessible to staff. Staff told us they understood the reporting structures clearly and received good management support.

Culture within the service

- There was a positive attitude and culture within the surgical care group where staff valued each other. Staff from all specialities worked well together and had mutual respect for each other's contribution to the holistic care of their patients. Staff were dedicated, committed and felt proud to work at the hospital.
- Ward staff told us they felt the culture was transparent and were comfortable sharing incidents and experiences to improve their learning.

- Staff were encouraged to speak freely and to raise concerns so that action could be taken. The introduction of HALT (a hierarchical challenge tool) had supported staff to challenge practices or areas of concern.
- Morale within the department was good and had improved due to recent increased staffing levels.
- Trust data showed that between April 2014 and March 2015 the staff sickness levels ranged between 4.5% and 6.8% in the surgical care group and were better than the England average.

Public engagement

- Information on how the public could provide feedback was displayed in the departmental areas and feedback mechanisms for the public to engage with the trust were also on the internet site.
- Staff told us they routinely engaged with patients and their relatives to gain feedback from them.
- The department included 'you said we did' information on notice boards which listed improvements made as a result of public engagement such as responses to complaints.
- A patient safety quarterly bulletin had been introduced to share learning across the trust.
- Board meeting minutes and papers were available to the public online which helped them understand more about the service and how it was performing.

Staff engagement

- Staff received regular communications from the trust and the department. Communication was disseminated from their line managers, from team meetings and during huddles.
- The trust also engaged with staff via emails, newsletters and through information displayed on notice boards in staff areas.
- Staff accessed information electronically such as policies and procedures, daily safety alerts and messages regarding updates to practices.
- The trust celebrated the achievements of staff in a number of ways including an annual event where staff had their accomplishments and achievements recognised.
- Ward 3C (trauma & orthopaedics) had received an award for being an outstanding clinical placement for nursing students from John Moore's University.
- The trust had reviewed the findings from the 2014 survey of NHS staff. The majority of areas were positive including staff feeling there were sufficient opportunities for them to develop their career in this organisation and staff felt very positive about their colleagues and strongly agreed with the statement "I would consider some of my work colleagues to be good friends".

Innovation, improvement and sustainability

- A bespoke human factors training course had been initially developed and rolled out for theatre staff. This had been successful and was being rolled out across the trust.
- The divisional director, assistant director of operations and a consultant told us the local deanery was reducing the numbers of student doctors they were allocating to the trust. They had been involved in a project to recruit student doctors from countries with the degree taught in English. The service had been successful in recruiting seven students from the Czech Republic and were looking at other countries. This had enabled the organisation to ensure the skill mix was sufficient.
- Ward 3C (trauma & orthopaedics) was redesigning its plaster cast pathway with input from the tissue viability nurses to reduce the number of plaster cast related pressure ulcers.
- Ward 3C had recently introduced wipes used for bed baths and personal care that were warmed up before use. Staff told us these were in response to patients who couldn't shower due to complex operations. The new wipes reduced wastage, were warm, scented and patients felt cleaner. Patient response was very positive and as a result the initiative was being implemented in other areas. We reviewed the surgical patient pathway improvement programme: work stream status report (July 2015) which set out a plan to provide a robust savings forecast. Work streams included looking at the pre-theatre pathway, theatres productivity, a service reconfiguration, recruitment and the analysis dashboard. The streams had been risk rated with estimated savings assigned to each stream.

Critical care

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

Information about the service

The critical care unit at Whiston Hospital was a 14 bedded unit commissioned to provide care for eight level three and six level two adult patients. In reality this configuration did flex according to demand and we saw that the unit was equipped to be able to take 14 level three patients if required. The unit had been designed with the input of staff and opened five years ago with the clinical areas divided into two separate spaces within the critical care unit footprint. The larger area had ten commissioned bed spaces and the smaller 'isolation' area had four beds all housed in isolation rooms. A medical emergency team, which also provided an outreach function sat within the critical care management structure. In addition to providing critical care support to medical and surgical patients, special expertise was also available in the management of patients with burns. The unit admitted and cared for in the region of 800 patients per year and was a member of the Cheshire and Merseyside Critical Care Network.

For the purposes of governance the unit sat in the medical care group. Operational management of the critical care unit was ultimately the responsibility of the Director of Operations for the trust. The clinical director for critical care was responsible for leading the medical team and for ensuring that trust policy and governance issues were implemented. The critical care matron was responsible for the leading the nursing team and other health care workers and was responsible also for the business management of the unit.

During the inspection we spoke with six medical staff, more than thirty members of the multi-disciplinary team and four sets of relatives. We also reviewed patient records, policies, guidance and audit documentation. We also looked at the occasional level 2 provision in both the coronary care unit and regional burns centre.

Critical care

Summary of findings

At this inspection, we have judged that over all the critical care service provided at Whiston Hospital was good.

There were sufficient numbers of suitably skilled and experienced nursing and medical staff on duty to care for patients.

There were robust systems and processes in place for reporting incidents and there was evidence that learning from incidents was shared. We found that medicines were not always stored securely and regular checking had not picked up on some out of date equipment on the resuscitation and difficult airway management trolleys.

When people required intensive care there were no significant delays in that care being delivered, however, there was often a delay in discharging patients once they had been judged as medically fit for discharge.

The unit continued to collect and submit data for the intensive care national audit and research centre (ICNARC) for validation, so it was able to benchmark its performance against comparable units. This data showed that patient outcomes were within the expected ranges when compared with similar units nationally.

Critical care services were being delivered by caring, compassionate and committed staff. We saw patients, their relatives and friends being treated with dignity and respect. The unit provided a critical care outreach service. We found that the critical care service was well led.

Are critical care services safe?

Good

There were good systems and processes in place to protect patients from avoidable harm. There was a well embedded incident reporting culture. Staff were aware of what and how to report incidents using the electronic system.

There were sufficient numbers of suitably skilled nursing and medical staff on duty to care for their patients. The unit was visibly clean and spacious and we saw staff adhering to infection prevention and control principles delivering virtually 100% harm free care.

Sat within the critical care management structure was the medical emergency team (MET), which also provided a critical care outreach function. The aim of the MET was to provide 24 hours, seven days a week, critical care expertise at the point of need to all acutely ill patients on the Whiston Hospital site.

There were some areas where improvements were needed. More specifically, we found some out of date equipment had not been identified and removed and medicines were not always being safely stored.

Incidents

- The trust had a policy and electronic system for the reporting and management of incidents and investigations.
- All the staff that we spoke with were familiar with the reporting system and knew how to use it. They gave us examples of incidents that had been raised such as delayed discharges and needle stick injury. We saw an incident overview report extracted from Datix which showed that there had been 63 reported incidents between January 2015 and the end of July 2015. This report gave an overview of the number and type of incident. However, it was possible to extract a more detailed report which included the severity of harm, actions taken and lessons learned for each reported incident.
- A monthly report of all the incidents recorded on the electronic system was displayed on the staff

noticeboard. These included incidents where the actions had included a response from the trust in accordance with its responsibilities under the duty of candour.

- All new incidents were discussed at the weekly multi-disciplinary team (MDT) meeting held on Fridays. Mortality and morbidity discussions were also held at the weekly MDT meeting.
- We saw a range of methods used to share learning from incidents both trust wide and from within the unit. These included root cause analysis reports on the staff room noticeboard, newsletters, patient safety group and minuted governance and staff meetings.
- There was a departmental risk register in place and staff were aware of the current risks to the unit. There was a documented process in place to ensure that risks were regularly reviewed and reported. This included the immediate escalation of any new risks scoring 15, indicating significant or extreme risk, to the Head of Quality and care group Medical Director.

Safety thermometer

- The NHS safety thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. Safety thermometer data was submitted from the unit and reported at trust level. This included data on patient falls, pressure ulcers, urinary catheter related infections and episodes of venous thromboembolism.
- Reports showed that between August 2014 and August 2015 the unit was delivering predominantly 100% harm free care. However, for some months over the 2014 winter period, the report showed a fall in harm free care to approximately 90%.

Cleanliness, infection control and hygiene

- The trust had infection prevention and control policies in place which were accessible to staff.
- We spoke with domestic staff who were proud to be part of the critical care team. The unit itself was very well presented, visibly clean and tidy. This included not just the clinical areas but also the corridor, bathrooms, offices and storage rooms.
- Personal protective equipment was available for staff and we saw it being used appropriately.
- Staff adhered to the 'bare below the elbows' policy that was in place. There were sufficient hand washing facilities and antiseptic gels.
- Infection prevention and control audits were undertaken monthly and we saw the published report for July 2015. This showed the following results:
  - 100% compliance with urinary catheter monitoring tool completion.
  - 100% for carbapenemese producing enterobacteriacea risk assessment. (Enterobacteria are bacteria that usually live harmlessly in the gut of humans. However, if the bacteria get into the wrong place such as the bladder or bloodstream they can cause an infection.)
  - 100% for visual infusion phlebitis scoring.
  - 100% for commodes cleaned, signed and dated.
  - 100% for isolation room signage.
  - 94% for sharps boxes correctly labelled and not overfull.
  - 96% compliance with bare below the elbows.
  - 88% compliance with hand hygiene observation
- We saw evidence of detailed root cause analysis following a patient acquisition of an e coli bacteraemia. The findings of which included actions relating to staff adherence to aseptic non touch techniques and compliance with hand hygiene expectations. (Root cause analysis is a method of problem solving used to identify the root causes of problems.)
- According to the submitted and verified intensive care national audit and research centre data, the unit performed as well and sometimes better than similar units for unit acquired MRSA and C.difficile infection rates.
- The January 2014 patient led assessment of care environment audit which reported an overall score of 97%. The only section not scoring 100% was the ward condition section which reported some minor decorative and maintenance issues.

Environment and equipment

- The unit was housed on the fourth floor of the main hospital building. The patients were cared for in one of two distinctly separate clinical areas. The larger area was spacious and utilised natural light to assist patients' sensory awareness. The smaller 'isolation' area contained four single isolation rooms, each with an entry air lock. We could see that it was not always easy to summon assistance because staff outside the rooms could not hear anyone trying to vocally raise an alarm. The rooms did have an alarm system where help could

called for, but staff said if they were managing a particularly distressed or agitated patient then it wasn't always easy to reach the alarm button, situated at the back of the room.

- Each bed space was suitably equipped and able to manage the care and treatment of a level three patient.
- Resuscitation and emergency/difficult intubation equipment was available in both patient areas and staff were aware of its location in the event of an emergency. When we checked the resuscitation trolley in the isolation area we found that despite the records showing that the trolley had been checked, there were two Guedel airways that were out of date. We also found several items of equipment out of date on the difficult airway trolley including a laryngeal mask airway and an Airtraq device. These issues were escalated to the senior nurse on duty at the time and the out of date items were removed.
- All equipment displayed a label indicating when it was last serviced and when the next service was due. Servicing was undertaken by the trust's electro-biomedical engineering department. All the equipment we checked had been serviced within the past 12 months.
- There was sufficient equipment for all 14 patient bays to be utilised.

Medicines

- There was a dedicated senior clinical pharmacist allocated to critical care for 0.5 whole time equivalents (WTE). The intensive care society pharmacy standards state that there should be at least 0.1 WTE for specialist clinical pharmacist for each level three bed. This ratio indicates that the critical care unit falls short of meeting the standard by 0.6 WTE. We were told that there was no additional pharmacy cover by technicians or other junior pharmacy staff.
- The pharmacist attended the daily multidisciplinary ward round.
- Throughout the inspection we observed the administration of a controlled drug to a patient. (Some prescription medicines are controlled under the misuse of drugs legislation e.g. morphine and pethidine). The administration was appropriately managed by two nurses who followed the trust policy aside from the fact that they signed the controlled drugs register prior to administering the drug to the patient. We took the opportunity to check the stock levels of controlled drugs with the controlled drugs register and they tallied correctly.
- The medicines storage room and fridges had their temperatures monitored and recorded daily.
- Medicines that were stored in the fridge were labelled with the date they had been opened.
- There was no electronic prescribing so as patients were discharged or stepped down to the wards a new hand written drug prescription chart was written.
- We found dialysate fluids were not always stored securely. There was a fluid warming cupboard containing prisma dialysate fluids with and without potassium that was unlocked. In addition within an unlocked bed area not being used for patient care, near to the unit entrance dialysate fluids containing potassium were being stored on wooden pallets on the floor. This meant that the fluids were open to potential tampering.

Records

- Each patient had three sets of records. Some paper (nursing and medical) and some electronic. We looked closely at seven sets of patient records.
- The paper records comprised a range of clinical records, assessments and plans. These included, for example, nutritional risk, falls assessments, physiotherapy treatment plans and skin bundles. All entries were completed, signed and dated though not all signatures were legible.
- The unit also used an electronic clinical information system for automatically recording physiological observations. Though observations were recorded automatically, they had to be validated by the nurse at the bedside.

Safeguarding

- There was an internal system for raising safeguarding concerns and staff were aware of the process and could explain what constituted abuse and neglect.
- Safeguarding adults and children training was part of the trust mandatory training programme. We saw records that stated that currently 85% of the staff had completed adult safeguarding training and 84% had completed children's' safeguarding training. This was in line with the trust target figure for safeguarding training.

Mandatory training

- Records were kept at care group level to monitor compliance with mandatory training. We were told by the senior staff on the unit that mandatory training compliance currently sat at about 87%.
- A range of subjects were included in the mandatory training programme, not all topics being appropriate for all staff groups. Subjects included in the programme included health and safety, fire safety, load handling, patient handling, infection control, slips trips and falls, security, mental capacity, equality and diversity, harassment and bullying, resuscitation, modified early warning scoring, medicines management, information governance, medical devices, conflict resolution, blood administration, sampling and safe transfusion.

Assessing and responding to patient risk

- There were tools in place for the early detection and escalation of changes in a patient's condition. The hospital used a modified early warning system (MEWS) that scores vital signs and is used as a tool for identifying patients who are deteriorating clinically.
- Sat within the critical care management structure was the medical emergency team (MET), which also provided a critical care outreach function. The aim of the MET was to provide 24 hours, seven days a week, critical care expertise at the point of need to all acutely ill patients on the Whiston Hospital site.
- The MET team has amalgamated with the cardiac arrest team to provide one team for medical emergencies including cardiac arrest.
- The MET/outreach specialist nurses were experienced in critical care and attended the critical care shift handovers.
- A Whiston Hospital MET team operational policy sets out all aspects of the service including membership of the MET team, MET call criteria and audit of performance.
- There was a standard operating procedure covering all aspects of the intra-hospital transfer of patients requiring a higher level of care.
- The MET call activation records showed that the team received between 150 and 260 calls per month. A recent retrospective study into 82 early morning MET calls showed that the biggest reason for triggering a call to the MET team was a MEWS score of five or more.

Nursing staffing

- On the day of inspection there were adequate numbers of suitably skilled and qualified nursing staff on duty to ensure that people received safe care and treatment. We also historically checked back through four weeks of staffing rotas and saw that safe staffing levels were maintained.
- The Intensive Care Society standard for patient acuity was used to determine the number of staff required.
- The unit had a supernumerary clinical co-ordinator per shift to provide clinical nursing leadership, supervision and support. However, the unit was generally not meeting the intensive care society standard for additional supernumerary nursing staff for units with 10 or more beds. This shortfall did not make the unit unsafe.
- The unit had in its nurse staffing establishment a number of specialist nurses at band 6 and above including a rehabilitation nurse lead, an audit and quality nurse lead and a full time practice educator.
- We were informed that the unit had recently filled 6.8 WTE band 5 posts and that the new staff were currently completing their employment checks.
- The current sickness rate was reported as being 3.02% against the trust target of 3.5%.
- Agency nurses were regularly used for between 11 and 18 shifts per week though many had been working on the unit for some time and were familiar with its layout and operation. For those agency nurses new to the unit, an induction sheet was completed and evidence of competency tested. Whilst the agency nurses continued to receive training from their supplying agency they were also able to attend trust based training in their own time.

Medical staffing

- The unit had a designated clinical director.
- The unit operated a closed unit model with critical care doctors responsible for planning the care of patients.
- There were seven WTE plus one part-time consultant intensivists. Many of the consultants had originally come from differing specialities (e.g. anaesthetics, medicine) but were all Faculty of Intensive Care Medicine accredited.
- The unit operated a consultant of the day rota with one consultant on for 24 hours. This way the consultants maintained seven days a week cover with a 1 in 7.5 on

call ratio. Out of hours the duty consultant was able to get into the unit within 30 minutes though for those that couldn't there was the advantage of on call bedrooms available within the unit foot print.

- The consultant to patient ratio did not exceed the range of 1:8 – 1:15 and so met with the Intensive Care Society standard.
- There were two consultant led multi-disciplinary ward rounds held every day.
- There was a consultant to consultant hand over each day between 8.30am and 9am.
- When participating in the duty rota for critical care (including out of hours) consultants were not responsible for delivering other services within the hospital.
- In addition to the consultant there were always two trainee doctors on call and one resident on the unit.
- There were two trainee doctor handovers per day.
- The consultants' office base was also situated within the unit which made access to advice and support more easily available.

Major incident awareness and training

- Major incident and business continuity policies and protocols were in place and readily available.
- We were told, during a staff focus group, about a recent road traffic accident which had resulted in the major incident plan being initiated.

Are critical care services effective?

Good

The unit continued to collect and submit data for the intensive care national audit and research centre (ICNARC) for validation, so it was able to benchmark its performance against comparable units. This data showed that patient outcomes were generally within the expected ranges when compared with similar units nationally. The exception had been for delayed and out of hours discharges, where the unit's performance had been slightly worse than the England average. However, these markers had recently shown an improvement and the numbers of delayed and out of hours discharges were reducing month on month. Care was delivered in line with evidence- based, best practice guidance, such as NICE guidance. There was a commitment to clinical audit and evaluation.

The trust was also part of the Cheshire and Merseyside Critical Care Network and so worked with other stakeholders (acute trusts and clinical commissioning groups) with a commitment to sharing and promoting best practice in critical care services.

Evidence-based care and treatment

- The unit used a combination of national and best practice guidance to determine the care they delivered. These included guidance from the Intensive Care Society and the National Institute for Health and Care Excellence (NICE).
- The unit demonstrated continuous patient data contributions to the intensive care national audit and research centre. This meant the care delivered and mortality outcomes for patients were benchmarked against similar units nationally.
- The unit was also subject to an annual peer review by the Cheshire and Merseyside Critical Care Network (CMCCNN). The purpose of the review was to demonstrate evidence at unit level of the range of standards applicable to critical care as outlined in their service specification.
- Following the last CMCCN review in 2015, the unit fully achieved most of the specification requirements. The draft report, received following the visit, showed that the unit performed better than the CMCCN average for most of the specification requirements with recommendations made for the following;
  - Ensure appropriate use of critical care capacity specifically in relation to delayed discharges.
  - Increase the nurse establishment to ensure additional supernumerary staff in accordance with the Intensive Care Society standard for critical care units with more than 10 beds.
  - Ensure all nursing staff at band 6 or above hold a post registration qualification in critical care.
  - Ensure that respiratory physiotherapy is available 24/7.
  - Increase the practice educator hours.
- The draft 2015 CMCCN report also showed that when peer reviewed against other CMCCN units, performance was better than average for all indicators with the exception of compliance with ventilator care bundles and ensuring all nursing documentation incorporated network and national guidance.
- There was a designated quality and audit nurse in post who managed the wide ranging unit audit program.

Audit results were displayed on an audit noticeboard and audit outcomes were also presented and disseminated in accordance with the unit's audit calendar. For example, in July 2015 there was a presentation of the Whiston medical emergency team audit and in March 2015, the results of an audit on the use of total parental nutrition was presented and published.

- On-going audit activity included infection, prevention and control, ventilator care bundles, skin care bundles, tracheostomy care and matching Michigan. (Matching Michigan is originally an American model used to reduce the incidence of central venous catheter related infections. It has been adopted by over 97% of acute hospitals in the UK).
- There was a range of local policies, procedures and standard operating protocols in place which were easily accessible via the trust wide intranet.

Pain relief

- There was access to the pain management team for support and guidance during the week.
- As part of their individual care plan all patients in critical care were assessed in respect of their pain management. This included observing for the signs and symptoms of pain. Staff utilised a pain scoring tool and analgesic ladder.
- We found that epidurals and patient controlled analgesia systems were used in accordance with trust guidelines.

Nutrition and hydration

- Guidelines were in place for initiating nutritional support for all patients on admission to ensure adequate nutrition and hydration. Nutritional assessments were undertaken within six hours of admission. This was corroborated in four out of the four sets of records we looked at.
- Nutritional risk scores were updated and recorded appropriately in the patient's notes.
- There was strict fluid balance monitoring for patients, which included hourly and daily totals of input and output.
- Patients were weighed weekly to assist in calculating their malnutrition risk score. (The critical care beds included weight monitoring functionality).
- The unit had recently carried out an audit into the provision of total parenteral nutrition (TPN), which showed that TPN prescribing was in accordance with NICE guidance though the prescribing of pabrinex was below that expected in patients with a high risk of malnutrition. A re-audit on the use of pabrinex was planned. (Pabrinex is an intravenous vitamin supplement).
- There was access to a dietetic service and the dietician attended the ward rounds.

Patient outcomes

- The results from ICNARC showed that patient outcomes and mortality were generally within the expected ranges when compared with similar units nationally.
- The most recently available and validated ICNARC data showed the following result examples;
  - Unit acquired MRSA and C.difficile were better than similar units.
  - Patients were not transferred out of the unit for non-clinical reasons.
  - The ICNARC (2013) model mortality ratio was 1:18 for the period January to March 2015, when compared with all other NHS adult critical care units.
  - The mortality ratio for the same period using the APACHE 2 (2013) model was 1:05. (APACHE stands for acute physiology and chronic health evaluation and is a severity score and mortality estimation tool developed in the USA.)
- The hospital provided a 24/7 critical care outreach function provided by the nursing membership of the medical emergency team.

Competent staff

- The critical care unit had a designated clinical nurse educator in post.
- Staff described a thorough induction programme for new starters to the unit, in addition to the corporate trust induction training. This included each new starter being assigned a mentor and undergoing a six week supernumerary period, which could be extended if necessary. This included a weekly study day and an introduction to the Step one critical care competencies. Step one competencies have been designed to provide the core competencies required to look after an adult critical care patient. New staff were able to take one year to work through the competencies before being considered for further post registration critical care courses.

- The unit provided a placement of usually 12 weeks for student nurses in their third year. We spoke with one student nurse during our inspection who reported that they felt well supported and had been able to spend most of their time on the unit working with their mentor.
- All nursing staff were subject to an annual check of their registration with the Nursing and Midwifery Council.
- Nursing staff received an annual appraisal. The latest figures showed that 92% of nursing staff (bands 1-7) had received an appraisal in the last 12 months. Trainee medical staff stated that they were well supported and also had an annual appraisal. A revalidation process was in place with good opportunities for training.
- More than 50% of the registered nursing staff had completed a post registration qualification in critical care.
- All registered nurses supplied by an agency or bank were able to provide documentary evidence of their competence to practice within a critical care environment.
- Heath care assistants had completed extended skills competencies, which allowed them to prepare ventilators for use. They were also involved in the training and development of new nurses in this skill.

Multidisciplinary working

- There was a multi-disciplinary ward round held every day with a second consultant led ward round held later in the day.
- We attended a nursing shift handover meeting, where basic patient care information was printed for each nurse. A 'bedside' handover was also completed between the nurses changing shift.
- Members of the medical emergency team attended the medical and nursing handovers in the morning to familiarise themselves with the likely activity during the day. For example, they would be notified of any potential discharges that would require follow up on the ward.
- There were daily bed management meetings held in the trust to discuss activity. We were told that critical care did not always attend unless they had specific issues. Staff felt that moves out of critical care were not always judged as a priority by the wider hospital as patients were considered to already be in a place of safety.
- There was a weekly (Friday) multi-disciplinary team meeting held on the unit.

Seven-day services

- A consultant intensivist was available seven days a week including out of hours.
- The physiotherapy team also provided a seven day a week service to the critical care unit during the day with an on call service out of hours.
- We understand that dietetic and pharmacy services were available Monday to Friday and via on-call at weekends.
- Imaging and diagnostic services were provided during the working week and then via on-call out of hours and at the weekend.
- Consultant staff described during interview that there were never any problems obtaining diagnostics or laboratory support out of hours.

Access to information

- The critical care unit used a paper based record system alongside a clinical information system that recorded physiological parameters directly from the equipment monitoring the patients as well as fluid and drug administration. Whilst recording ventilator settings and blood pressure for example, the nurse had to physically validate the recordings each time they were measured.
- There were two paper based records for each patient, one for medical notes and one for nursing notes, which were accessible at the patient's bedside. This enabled consistency and continuity of record keeping whilst the patient was on the unit, supporting staff to deliver effective care.
- The critical care unit used a different prescription chart to the rest of the hospital so when patients were discharged to the wards then a new ward prescription chart was transcribed.
- On discharge from critical care a discharge summary was created for the nursing and medical teams taking over the patients' care

Consent and Mental Capacity Act

- The staff we spoke with demonstrated understanding of the issues around consent and capacity for patients in critical care. We spoke with two nursing staff that had direct experience of following the deprivation of liberty process including the completion of relevant documentation. Staff did articulate that if they were unsure in any circumstances they would seek guidance from senior staff or from the safeguarding lead.

- Written guidance on deprivation of liberty was available at every bedside.
- Records showed that 95% of nurses within the medical care group had received training in mental capacity as part of their mandatory training.
- In terms of the management of delirium, there was an assessment of mental capacity recorded in the patient record. This was called the confusion assessment method for ICU (CAMICU) and was used in conjunction with the Richmond agitation Scale, which measures the agitation or sedation level of a patient. The care plans we looked at stated that the CAMICU should be completed once a shift but this was not always evident in the four sets of patient records that we examined.
- Sedation breaks were implemented where appropriate. (A Sedation break where the patient's sedative infusion is stopped to allow them to wake has been shown to reduce mortality and the risk of developing ventilator related complications. The sedative is then re-started if the patient becomes agitated, in pain or in respiratory distress).

Are critical care services caring?

Good

Overall, we judged that the critical care service at Whiston Hospital was caring.

We saw people and their relatives being treated with understanding, compassion and respect. The review of written evidence demonstrated that the unit was good at involving patients, family and friends in all aspects of their care and treatment.

However, we did note that CCTV cameras were being used in the four bedded isolation bays. It was explained that they had been installed to enhance patient safety as a consequence of the design of the isolation rooms. We were concerned about the potential impact on patients' privacy and dignity and escalated these concerns during the inspection to senior staff. The trust acted promptly, ceased to use the cameras and increased the number of staff in the isolation area to allow for safer observation of patients.

Compassionate care

- We spoke with four relatives who told us that their loved ones were cared for in a kind and compassionate manner by staff. Our own observations supported this.
- We observed unconscious patients being communicated with by nursing and medical staff in a compassionate manner.
- Conversations regarding a patient's condition, prognosis, care and treatment options were sensitively managed. At the time of our visit there were two deaths on the unit. We saw that the patients and their relatives were treated with the utmost compassion.
- We saw that CCTV cameras were being used in the section of the unit where there were four isolation cubicles. The cameras had been installed five years ago when the unit opened. We were informed that the cameras were installed to enhance patient safety in the isolation rooms, where it was difficult to observe a patient unless staff were actually always in the room. There were occasions when staff needed to leave the patient's bedside; for example, to check a controlled drug or assist in turning. It was in these circumstances, we were told, that the desktop monitor at the nurses' station, which displayed the camera view from each of the four rooms, was turned on. Under these circumstances, it was potentially possible for anyone passing the nurses' station, either a member of staff or a member of the public, to see what was on the screen. We asked senior staff if there was any guidance or protocol for staff on the use of the CCTV cameras and whether consent was formally obtained from patients and/or their relatives. In the absence of any guidance surrounding the use of the cameras we raised our concerns with the senior team about the potential impact upon patients' privacy and dignity. The trust responded promptly and the cameras were turned off, pending a review of their ongoing use. Additional staff were then allocated to the isolation area to improve the level of observation afforded to patients.

Understanding and involvement of patients and those close to them

- Initial and on-going face to face meetings were implemented by nursing and medical staff to keep people informed about their relatives care and treatment plans.
- We received very positive feedback from patient's families especially with regard to being kept informed by the unit's nurses and doctors.

- We saw results from the on-going relative's survey displayed on the noticeboard in the waiting area outside the unit. There had been 10 completed questionnaires for the July to August 2015 period and the results were generally positive in terms of 'first impressions, environment, communication and support'. For example, 'if staff approached your relative's bed whilst you were there, did they introduce themselves and say what they were doing?' Answer – Never = 0 / Sometimes = 2 / Always = 7 and Not Answered = 1. The results of the relative's surveys were shared with the Cheshire and Merseyside Critical Care Network.
- We found that where necessary, additional face to face meetings were organised to ensure family members were kept informed and had the opportunity to have their questions answered.
- Language interpreters and sign language interpreters were available on the unit should they be required.

Emotional support

- The service actively promoted the use of patient diaries for those patients in critical care. Patient diaries are a simple but valuable tool in helping people come to terms with their critical illness experience. The diary is written for the patient by healthcare staff, family and friends. Research has shown that patient diaries often help the patient better understand and make sense of their time in critical care and help to prevent depression, anxiety and post-traumatic stress.
- Staff proudly informed us about the support they gave to relatives especially to those who had sadly been bereaved. Counselling support was available and an annual remembrance service was held. This service was so well supported that an external venue now had to be found to cater for the numbers of people who wished to attend.
- Relatives had access to a 24/7 chaplaincy service.
- There was a senior nurse for organ donation in post who worked closely with the critical care team in managing the sensitive issues relating to approaching families to discuss the possibilities of organ donation.

Are critical care services responsive?

Good

The facilities and premises were appropriate for the services that were delivered. The services were planned, delivered and co-ordinated to take account of people with complex needs.

Patients were able to access critical care when needed in a timely way although there were some issues with the numbers of patients who experienced a delayed discharge from critical care.

Patients and their relatives were supported in accessing the systems in place for raising concerns and complaints although the numbers of complaints in critical care were relatively low.

Service planning and delivery to meet the needs of local people

- There were a number of structured bed management meetings throughout the day. These were attended by representatives from all the specialties although critical care did not always attend. However, up to date daily patient status information was shared with bed managers so that potential delayed discharges could be minimised or avoided. The view of staff was that critical care patients within the hospital were not always considered a priority for movement as they were already in a place of safety.
- Once a decision had been made that the patient was ready for discharge, the design of the unit allowed patients to be moved within the unit itself to avoid any potential single sex breaches.
- There were no critical care beds on the St Helens Hospital site. So any patients on the St Helens site whose condition deteriorated and warranted admission to critical care would be managed in accordance with the urgent transfer of patients from St Helens Hospital to Whiston Hospital standard operating procedure. Anecdotally, we were informed that this was very infrequent.

Meeting people's individual needs

- Patients were being reviewed in person by a consultant within 12 hours of their admission.

- Care plans demonstrated that peoples' individual needs were taken into consideration before delivering care.
- Interpreting services were available within the hospital if required.
- There were facilities for relatives to stay on the unit if they wished to.
- We spoke with relatives whose family member had a learning disability. They were full of praise for the way that the staff took the time to communicate with their loved one.
- Staff received training in the management of patients living with dementia.
- Once discharged from critical care, patients were followed up by the outreach team. The latest available ICNARC data showed that the unit was performing better than similar trusts for early and late readmissions to critical care.
- Staff were aware of the real issues of sensory deprivation for patients in a critical care environment and its impact upon sleep deprivation. So care was taken for example, to mark the difference between day and night by lowering the lights at night, trying to be quiet and not disturb patients uneccessarily.

Access and flow

- The critical care unit had a clear written operational policy for admission and discharge. There was also a Handover of Care policy, which provided staff with a clear framework which enabled staff to safely transfer patients both internally and externally.
- During interviews with staff we were told that generally there was no problem accessing a critical care bed when needed. This was supported by the fact that admission took place within four hours of making the decision to admit and then patients were seen by a consultant within 12 hours of admission. The unit did take patients on occasions from the respiratory wards for bi-level positive airway pressure treatment. This is a non-invasive form of positive pressure ventilation. In addition patients were also admitted on occasions for renal dialysis.
- Critical care bed occupancy was similar to the England average for the period May 2013 to March 2015.
- From the results of the most recent ICNARC data the unit was performing better than comparable trusts for the numbers of early and late readmissions.
- The exceptions had been in the numbers of reported delayed and out of hours discharges. The delays experienced by patients were predominantly less than 24 hours although a small number were delayed for longer. In three cases we saw that discharge was delayed by up six and seven days. We were informed that these longer delays were due to specific complex patient issues, which meant finding a suitable and appropriate step down bed on the wards was made more difficult.
- We saw that the most recent ICNARC data (January to March 2015) showed there was an improving trend in both delayed and out of hours discharges so that performance was more in line with similar units. We reviewed evidence that recent meetings with the trust bed management team had clarified the understanding that patients were not to be discharged from the unit after 9pm unless the unit was full and there was an urgent need to admit a level 3 patient.
- For the period April 2014 to March 2015, out of 829 admissions, 315 patient's discharge was delayed by less than four hours and 163 by more than four hours. Forty five of those delayed discharges were eventually discharged out of hours. More recently the figures for delayed and out of hours discharges had improved and are now comparable with similar units. This improvement has been attributed to team work, improved communication between departments and bed managers, a tightening up of the discharge process and more accurate data collection. Measures also included the development of a discharge dashboard, which highlights potential four and 24 hour breaches. This is shared with bed managers every morning so that delays can be highlighted and escalated.

Learning from complaints and concerns

- There was a formal policy for managing concerns and complaints, which was last reviewed in June 2015. Staff were aware of the policy and how to access it for reference.
- An easy read guide detailing how to make a complaint, comment or suggestion was available in the relatives' waiting room and around the hospital.
- Critical care received a low level of complaints. In total five complaints had been received since January 2015. Most related to communication between staff and relatives and lessons were learned and disseminated. For example, the need for staff to keep family members appraised of all aspects of care and all reviews that take place.

Are critical care services well-led?

Good

There was an effective governance structure in place which ensured that all risks to the service were captured and discussed. The framework also enabled the dissemination of shared learning and service improvements. We saw committed and capable clinical leaders and managers at unit and care group level that had a clear understanding of the risks to the service. The risk register identified the key risks within the service and the actions taken to mitigate them.

The staff we spoke with felt happy with the level of engagement with senior staff on the unit and felt confident that they could discuss any concerns that they might have and that they would be listened to. We heard from both medical and nursing staff that they felt the unit was well run and that senior staff and peers were supportive.

There was clear clinical leadership at unit level for both medical and nursing staff.

Vision and strategy for this service

- Staff were able to articulate the trust's vision, which was to provide five star patient care based on based on the building blocks of safety, care, communications, systems and pathways. Posters displaying the vision and supporting aims and values were displayed all around the hospital site.
- The unit was purpose built and only five years old. The environment had been developed to actually care for and manage 20 patients although only 14 were currently commissioned. This allowed for expansion in the future if the demand increased and funding was available.
- We did not secure any other evidence to illustrate specific critical care vision and strategy.

Governance, risk management and quality measurement

- There was an effective governance structure in place which ensured that all risks to the service were captured and discussed. The framework also enabled the dissemination of shared learning and service improvements.
- The risks inherent with the delivery of safe care were understood and identified on the unit's risk register, which was up to date.
- The service measured itself against both the Intensive Care Society core standards and the Cheshire and Merseyside Critical Care Network service specifications. Peer review showed consistently better performance when measured against specification requirements than most other units in the network.
- The service demonstrated a dedicated focus on understanding and addressing the risk to patient care.

Leadership of service

- There was clear nursing and medical leadership with the skills, integrity, capacity and capability to lead the service effectively.
- We saw that senior medical and nurse leaders were committed to providing a safe service for their patients.
- The organisational chart for the critical care unit showed that nurses were in specific lead roles such as quality and audit, practice education and rehabilitation

Culture within the service

- Staff were encouraged to report incidents and raise concerns.
- Staff were open, honest and happy to tell us what it was like to work in critical care.
- There was evidence of collaborative working and positive relationships with other departments within the hospital.

Public engagement

- The critical care unit engaged in an on-going relatives' questionnaire process to gain feedback on the service being provided. The results of which were collated, analysed and presented. The results were displayed in the relatives' waiting area.
- There was some helpful basic information about the critical care unit displayed on the trust's website. It included information about who the senior staff were, alongside visiting times and signposts to other supportive web site sources, such as cruse bereavement services and health talk on-line.

Staff engagement

- Staff were involved in the design and commissioning of the unit when it was opened five years ago.

- There were opportunities for critical care staff to be seconded to the medical emergency team for a 12 month period.

Innovation, improvement and sustainability

- The ICU was an active member of the Cheshire and Merseyside Critical Care Network. Membership of the network enabled the unit through collaborative working with commissioners, providers and users of critical care to focus on making improvements where they were required.
- There are plans from September/October 2015 to introduce a system that will electronically monitor early warning scores. This would allow the system to send automatic calls to the critical care outreach team when a patient's scores indicated the need for an urgent response and so improve the care to patients.
- The outreach team had also recently taken on the role of vascular access practitioners. Nurse practitioners use their clinical expertise to lead practice, facilitate change and monitor the effectiveness of interventions to prevent complications.

Maternity and gynaecology

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

Information about the service

Whiston Hospital in Knowsley provided care and treatment for maternity and gynaecology patients in the St Helens and Knowsley area. The maternity services comprised outpatient clinics, a foetal monitoring unit, an early pregnancy unit, a ward for post-natal and ante-natal care with 37 beds and a delivery suite with 14 single rooms. There were two dedicated obstetric theatres. Community midwifery services were provided by midwives employed by the trust. For gynaecology patients there was a dedicated ward.

We visited the maternity department during the announced inspection between August 18 and 20 and again at an unannounced inspection on Saturday 5 September 2015. During our visits we spoke with 28 staff and ten patients. We observed care and treatment to assess if patients had positive outcomes and looked at the care and treatment records for 12 patients. We reviewed information provided by the trust and gathered further information during and after our visit. We compared their performance against national data.

The service was led by a clinical director with a head of midwifery professional lead.

Summary of findings

The maternity and gynaecology services at Whiston Hospital required improvement in the safe, responsive and well led domains.

There was a system for learning from incidents and improving practice, however, it was felt that this was not as effective as it needed to be. Equipment had not been adequately monitored, medicine storage was unsafely managed in three areas and the guidelines for detecting deterioration in patients were not followed.

There were some shortfalls in the midwifery staffing; however actions were in place to address this.

There were issues with the access and flow of patients through the unit with particular effect on the delivery suite. Patients had limited choices for the birth of their baby due to a dominant medical model of care. There was a lack of leadership for the service and no vision or strategy for future developments. There was a risk management system in the maternity service however this was not robust and required development.

The service was good in the caring and effective domain.

Patients spoke highly of the care they received and the information they were given. There was good support for bereaved patients and those with complex needs. The policies and procedures in the service met national guidance and were regularly reviewed. Practices were

audited and changes made if required. There was good infant feeding support and initiatives and patient outcomes were similar to the England average in most measures.

Are maternity and gynaecology services safe?

Requires improvement

Maternity services at Whiston hospital required improvement in terms of being safe.

A serious incident occurred in April 2015. The review of this incident identified contributing factors and areas for improvement. However at the time of our inspections the learning from this incident had not been shared with staff nor the required actions taken and a second similar incident occurred in August 2015. This was under investigation at the time of our inspection.

Equipment including that required in an emergency had not been thoroughly checked at the required intervals to ensure safe working. In three separate areas of the maternity unit there was unsafe storage of medicines. This was brought to managers' attention at the announced inspection and action had been taken to rectify this at the unannounced inspection. Guidelines for the assessment of deteriorating patients were not always followed. Midwifery staffing did not comply with recognised recommendations; however actions were in place to address this.

There were examples of duty of candour being followed (being open and honest with patients when things go wrong). All areas were visibly clean, tidy and any actions were taken to improve identified shortfalls in infection prevention and control. Systems were in place to protect vulnerable patients. The majority of staff were up to date with their mandatory and specific midwifery skills training. Medical staffing met the needs of the patients including providing safe levels of medical staff out of hours.

Incidents

- A serious incident occurred in April 2015 concerning assessment of cardiotogography (CTG) monitoring. The review of this incident identified contributing factors and areas for improvement. However at the time of our inspections the learning from this incident had not been shared with staff and actions identified had not been completed. A second serious incident with similar circumstances had occurred. This meant the system for learning from incidents and taking necessary actions to

prevent recurrence were insufficient. At the unannounced inspection additional training for staff was planned to address one of the actions required from the first serious incident review.

- The investigation by the supervisor of midwives into the incident in April had not been completed four months after the incident. The supervisor of midwives audit in September 2014 rated the time taken for supervisors to complete investigations as a high risk as less than 50% had been completed within the 45 day target. This risk remained the same at the time of the inspection.
- There was a list displayed of what constituted an incident which should be reported. Staff told us the system was easy to use and they were encouraged to report incidents.
- The midwife with a lead role in risk management completed four reviews of incidents weekly. These were multi-disciplinary reviews and specific incidents would be chosen to aid learning and improve practice.
- A risk management group met monthly and reviewed the number of incidents and any themes and trends. Individual incidents were discussed and further actions agreed if necessary. Attendance at these meetings was by the managers of various wards and departments within the obstetrics and gynaecology service. There was no record of how these incidents and learning was shared with other colleagues and we saw examples of where learning had not been shared and actions not taken.
- There was a matrix used which graded the incidents on level of harm and appropriate care provision. In the information provided by the trust there were no incidents graded as a near miss and 94% of incidents in May 2015 were graded as low or very low. This meant the severity of potential risk or the timeliness of the response was not included in the grading mechanism.
- Medical staff and midwives told us the mechanism for receiving formal feedback from clinical incidents was poor. This consisted of presentations at monthly ward meetings and information in the maternity and gynaecology newsletter. The July meeting had been cancelled due to staff shortages. The information in the June 2015 newsletter was three months old which meant there was a delay in sharing any learning. These informal mechanisms meant feedback from incidents may not be shared with all necessary staff.
- In the obstetric theatres feedback from incident investigations with learnings for staff were displayed. We found that practices had changed as a result of incidents and near misses.
- Obstetrics and gynaecology morbidity was discussed at the clinical governance and audit meetings. Cases were presented and lessons learnt discussed with actions taken or planned and agreed by the clinicians present. We did not see any evidence in the minutes of these meetings that the serious incident that occurred in April had been discussed.
- Staff understood their responsibilities under the duty of candour and we saw this had been followed in a recent incident.
- One patient told us the consultant had discussed with them how their induction of labour could have been better managed. They said this gave them confidence in the service. They said they would return to the hospital with any subsequent pregnancy.

Safety thermometer

- Information about harm free care was displayed in the entrance to the gynaecology ward. This showed there had been no safety incidents in the past month.
- The maternity specific safety thermometer had been in use for the past two months; however this information was not displayed and it was not used to assess performance.

Cleanliness, infection control and hygiene

- All areas of the maternity wards and units were visibly clean and tidy. Patients commented that the areas were very clean.
- Staff on the wards and departments were seen to use the hand gel provided and wash their hands between caring for patients. Staff used personal protective equipment appropriately. There were plentiful supplies provided in appropriate places on the units.
- The latest infection prevention and control audits showed the delivery suite and the gynaecology ward were compliant with the trusts' policies and procedures with a score of 96%. The maternity ward the overall score was 91% which resulted in actions being identified in order for the ward to meet the required standard of compliance.

Environment and equipment

Maternity and gynaecology

- The maternity services were situated on the second floor of the hospital and all the various wards and departments, including the women's outpatient department, were on this floor. This meant it was easy for patients to move between the departments without needing to go through the hospital.
- The obstetric theatres and the special care baby unit were situated directly off the delivery suite which meant they could be quickly accessed in an emergency.
- The bereavement rooms on the delivery suite contained the medical equipment present in the other delivery rooms and contained no additional homely furniture or decoration. There was no other non-clinical environment for a patient and family to spend time following the death of their baby. Additional finance had been secured to provide some wall art and soft furnishings to help provide a more suitable environment in the future.
- All the single rooms had an en-suite bathroom with toilet and shower. This provided privacy and dignity for the patients in these areas. For patients in the ward areas there were bathrooms and toilets at the end of each bay area.
- There was no signage on the doors in the delivery suite which indicated if a room was in use. We saw staff had to ask each other if a patient was in a room prior to entry.
- There was sufficient medical and monitoring equipment in each patient area which meant staff did not have to leave their patient to find the equipment they required. Community midwives had all the equipment they required and it was well maintained.
- The adult and infant resuscitation equipment had checklists which consisted of a signature and date. There was no record of what specific equipment had been checked or how this had been completed for example switching on a machine to check it was in working order.
- One resuscitaire had no signature to indicate it had been checked on two consecutive days in August and we found one soiled oxygen mask in another area. This indicated the checks had not been performed sufficiently on that equipment.
- Safety monitoring checks on some equipment in theatre had not been completed as required. Examples we saw were the room temperatures had not been recorded five times and the temperature of the medicines fridge six times in the past 20 days.
- Equipment was well maintained and if issues were reported repairs were completed quickly.
- Portable appliances had been tested as necessary.

Medicines

- The controlled drugs stock including epidural infusions was checked twice daily and this was recorded. We observed this check to be accurately completed.
- In one of the obstetric operating theatres there was an open trolley which contained a variety of medicines including those used by the anaesthetist and fluids for infusion. We were told this had been brought to the attention of the pharmacist and lockable cupboards had been purchased but not put in place. This did not meet with safe storage of medicines guidance. This was brought to managers at the trusts attention at the announced inspection. At the unannounced inspection these medicines had been placed in a locked trolley which was secured to the wall.
- There was no record these medicines were checked regularly and we found one vial of medicine was out of date. This meant there was no satisfactory monitoring of the medicines held in this theatre. At the unannounced inspection a daily checklist of the contents of the locked trolley was in use.
- There was unsafe and incorrect storage of medicines on the maternity and gynaecology wards. On the maternity ward intravenous fluid was stored in an unlocked cupboard in an unlocked room and on the gynaecology ward there were loose strips of medicines in the portable medicine trolley and the locked cupboards in the treatment rooms. This was brought to managers at the trusts attention at the announced inspection. At the unannounced inspection medicines were seen to be stored securely. The community midwives medicines were safely stored. The Entonox for community use was transported via taxi and a risk assessment for this procedure could not be produced.
- In one theatre there was a temporary fridge used for refrigerated medicines. There were no recorded checks of the temperature of this fridge or checks of the stock held in it. This did not meet with the trust's safe management of medicines policy.
- The medicine charts we saw on all wards had been fully completed.
- There were no medicines available on the foetal monitoring assessment unit. This meant if a patient

required medicines for pain relief or high blood pressure, for example, these would be accessed from another ward in the unit. This would cause a delay and mean a staff member would need to leave the unit.

Records

- There were two patient record systems in place which led to information being stored in different ways and places. One system was handwritten notes and the other was computerised records. This meant it was unclear how and where specific notes were recorded and stored.
- The medical records contained multiple documents which resulted in bulky notes which were comprehensive but the filing of specific records was unclear. Between January and April 2015 three incidents of patient records being misfiled had been reported. We found a medicine administration chart for one patient filed in other patients' records.
- There were bi-monthly audits of patient records completed in order to assess the accuracy of record keeping. Feedback was provided to staff in the monthly newsletter.
- On the gynaecology ward the fluid intake and output charts we saw had not been accurately completed. For one patient, who had a catheter in place and had required a bladder scan, there were two output entries over a 24 hour period, the intake column was blank and there was no recorded total. This meant there was no accurate record of this patient's fluid balance.
- In the ward areas the medical notes were kept in trolleys in or around the nurses' administration base. These trolleys were not locked and in some areas, including the foetal monitoring assessment unit, were stored in an area accessible to patients and their relatives. This meant these records were not securely stored.
- There were difficulties with the connectivity of the computerised midwifery records for the community midwives. This resulted in them using both a paper and computer system which increased the risk of inaccurate record keeping and a delay in transfer of computer accessible records to the IT system. This was on the maternity risk register and had been identified at the time of implementation of the computer records in 2012 with action ongoing to resolve the issue.
- The baby health record "red book" was provided to new mother's either prior to them leaving the ward or by the community midwives.

Safeguarding

- 89% of midwives were up to date with the safeguarding training.
- Staff were aware of their responsibilities to protect patients and new-born babies if there were concerns for their safety. There were examples of effective joint working with other agencies to ensure the safety of both the patient and their baby.
- The community midwives could access other health records if they had concerns, such as accident and emergency records. They were aware of the process of reporting concerns and had 100% attendance at safeguarding meetings for patients in their care.
- There was a highly visible recording system to ensure any concerns identified were easily accessible to staff.
- Some staff we spoke with were aware of their responsibilities to identify and report any concerns about female genital mutilation. However the senior midwifery staff were unsure if there was a policy about this. The policy was found on the intranet but staff were unaware of its content.
- The lead midwife for safeguarding was on sick leave at the time of the inspection. Midwives told us there was no cover for this post at a focus group. There was in fact cover for this post, but when discussed midwives were not aware of this.
- The security system included buzzer entry to each ward and staff verbally and visually identified the visitor. A baby tagging system was in place which was linked to the hospital security system and included doors automatically locking when triggered by a sensor.
- The security on the delivery suite included a reception desk which was attended by a receptionist during the day. We were told a security guard was at this desk during the night.

Mandatory training

- 95% of midwives and medical staff on the maternity units were up to date with their mandatory training. This included fire safety, health and safety, equality and diversity, information governance, infection control, resuscitation and the safeguarding of adults and children.
- 99% of midwives and obstetric medical staff were up to date with their maternity skills and drills training. This was updated every year.

- The induction of new doctors consisted of one day induction into the trust and one day for departmental induction.
- There was 50% compliance with the skills and drills training by the consultant anaesthetists. It was documented in the CNST report of March 2014 that only one of thirteen anaesthetists had completed this training. Whilst there has been a significant improvement since that report there remain 50% of anaesthetists who are not up to date with this maternity specific training.

Assessing and responding to patient risk

- We looked at nine patient records for women during labour. For six patients the trust's policy "guideline for performing intermittent auscultation and a cardiotocograph (CTG) during the antepartum, intrapartum period" had not been followed.

This stated that there must be documentation that each practitioner caring for a woman had sought the opinion of a colleague (midwife or doctor) to systematically review the trace with them as a minimum hourly (fresh eyes approach). The findings should be documented on the sticker which should be placed in the hospital records and signed by both practitioners. In five of the six records there were no stickers present and in the other only one signature was recorded. This meant the assessment used to detect deterioration in the physical wellbeing of an unborn baby was not carried out in accordance with national guidance effectively.

- In one record the trusts' guideline for foetal blood sampling had not been followed which resulted in lack of detection of risks to the unborn baby.
- The maternal early warning scores (MEWS) were used for recording the vital signs of patients. Where these indicated deterioration in their condition medical assistance was accessed quickly if required.
- We observed one theatre team undertaking the 'five steps to safer surgery' procedures. This included the use of the World Health Organization checklist which had been adapted for obstetric procedures. The theatre staff completed safety checks before, during and after surgery and demonstrated a good understanding of the 'five steps to safer surgery' procedures.
- The staff who assisted the obstetric surgeons during operations were qualified operating department personnel who had completed the appropriate training.
- Operating theatre personnel had completed additional training to assist them with team working. This included human factors training and learning from never events.
- Although there was no doctor assigned to the care of patients on the foetal monitoring unit midwives told us medical staff were responsive to any deterioration in the patient's condition and attended the unit when required.
- The venous thrombo-embolism risk assessments were completed on line and a patient could not be discharged unless they were completed. There was an alerting system if the assessment was not done within 48 hours of admission.
- There was a high dependency unit on the delivery suite for maternal patients who required a higher level of treatment due to their medical condition. 4% of midwives had completed specific training in maternal critical or high dependency care. On the shifts when none of these midwives were working, staff told us they would ask the anaesthetist to support them in meeting the needs of patients in that unit. This meant patients may receive care from midwives who had not received specific training for their additional needs or had their competence to do so assessed.
- There was a clear pathway for the management of patients whose scans showed anomalies. This included referral to the screening specialist midwife and if necessary the foetal medicine specialist. The pathway included a three day referral for further assessment and development of a plan of care, including the involvement of other specialist centres if applicable.
- On the gynaecology ward two hourly intentional rounding was carried out and recorded. Where necessary vital signs were assessed and actions taken if required.

Midwifery staffing

- Maternity staffing did not comply with the Royal College of Obstetrics and Gynaecologists recommendations of the safer childbirth staffing standards. This was identified on the maternity risk register and had been reviewed annually and proposals for improvement presented to the executive team since 2013. This had been reviewed by the board in June 2015 with resulting agreement to recruit five midwives and five midwife support assistants. This would mean there were 1.8 full time equivalent posts which remained vacant.

- The staffing numbers had been assessed using the birth rate plus assessment tool in 2011. It was anticipated there would be a reassessment in October 2015.
- At the current time an acuity tool on delivery suite was in use that ward staff completed to assess the required versus the actual midwife numbers based on the needs of the patients at hourly intervals throughout the day.
- Incident reports for January to April 2015 showed 13 occasions when there were shortages of staff with most leading to the escalation policy being implemented. On two occasions elective caesarean sections were cancelled due to the low staff numbers.
- When the midwife staff numbers on the ward and delivery suite were below those required to meet the needs of the patients the escalation policy was put into action. We were told the most usual staff to provide additional support were the community midwives, especially at night. Specialist midwives, such as the risk midwife, would also provide support if required. There were two midwives on call from the community; If the midwives did come in at night they were given a rest period before they returned to work in the community.
- Information provided by the trust showed that in July 2015 community midwives had been deployed to the maternity ward on three occasions
- The ratio of midwifery staffing to births was worse than the England average at 1:32 versus 1:28 from March 2015 to May 2015.
- The service was not using the midwifery red flag system to highlight and review staffing concerns. This meant they were not following the recommendations of the National Institute for Care Excellence guidance “Safe midwifery staffing for maternity settings”.
- Most midwives told us they rarely had their allocated break times which included when they were working a 13 hour shift. There was an acceptance that this was usual practice although the band 7 midwives were concerned that staff should have a break to ensure their own needs were met.
- The band 7 midwives who were shift leaders on the delivery suite did not work in a supernumerary capacity. This meant they were responsible for the care of women and were not able to oversee the running of the delivery suite or offer the support less experienced midwives may need. Some midwives from all bands told us they were concerned about this as it made them feel less supported.
- The midwifery matrons visited the maternity unit at 8am every day to assess the staffing of the various units. They then were part of the trust staff briefing where any shortages of staff and plans for cover were discussed. This meant there was an assessment of staff numbers completed on a daily basis.
- We were told the majority of time when there were midwife shortages on the wards this was due to sickness. The current sickness level for the maternity ward and the delivery suite was 5.6% of total staff. One to one meetings took place with staff that had been off sick on their return to work and sickness was part of the manager’s discussions at their monthly meetings.
- There had been recent changes to the midwifery working practices at the trust. This included rotation of staff between the wards and from day shifts to night shifts. Staff had been consulted about this change and had the opportunity to have one to one discussions with managers where necessary. To date there had been no review of the impact of this change on staff sickness or morale and we were given conflicting views as to the resulting effect.
- No agency midwives were used. Staff worked extra hours or changed their work pattern to fill vacancies.
- The community midwives did rotate to inpatient wards for a two week period every three months. This meant they had the opportunity to renew their skills which they may not be using in the community.
- At times there were insufficient qualified nurses on the gynaecology ward to meet the needs of the patients. On one day of the inspection there were two qualified nurses, one health care assistant and two student nurses on duty for seventeen patients with five patients being admitted for day case surgery. The escalation procedure was used on this day and additional staff came in to work. The shortage of staff was due to one part time vacancy and one maternity leave vacancy. Recruitment processes were underway.
- There were low levels absence due to sickness amongst the community midwives with this being around 0.04%
- We observed two midwife handovers on the delivery suite. These took place with all staff coming onto a shift present at the information board which contained the current patient’s status. This was a verbal handover with some staff making their own notes. Whilst the necessary information was provided to staff during these handovers the area was busy with other staff, patients were being added or taken from the board quickly or

added to a separate board for patients awaiting triage. This process was chaotic with some confusion about which rooms patients occupied, their current medical status and known additional admissions. Due to this staff may not receive all the vital information they require as soon as possible.

- The handover of information at the shift change on the maternity ward included all the staff coming onto shift. They received records of the current medical status of patients and babies accommodated on the ward.
- The boards for recording the staffing numbers on the wards were not completed. On one area only one shift of the day was completed and on the other the number of midwives required reflected the number on the rota and not the established agreed number required. This meant the information displayed did not provide an accurate picture of the staffing on the wards.
- There was one qualified nursery nurse who worked 30 hours a week and supported new parents.

Medical staffing

- There were 60 hours per week consultant cover for the maternity services which was adequate for the number of births at the unit.
- One specific consultant was on call for 60 hours one week at a time on a rotation of one week in nine. They were in the hospital Monday to Friday 8am-6pm and Saturday and Sunday 9am-2pm. For the remainder of the week they were on call within 30 minutes of reaching the hospital.
- There were ten middle grade doctors on the medical rota which represented 14% of the medical staffing. This was more than the England average at 8%.
- Locum usage was low and was mainly junior staff who had worked at the trust previously.
- The junior doctors told us they felt very well supported by the more senior medical personnel.
- The senior house officer provided medical cover for the obstetric ward, the gynaecology ward and accident and emergency. There was also an extra doctor of this grade on the maternity unit on Saturday and Sunday 9am-2pm. This meant there was additional medical cover available as on call support.
- There was a dedicated consultant anaesthetist available 24 hours a day for the obstetric theatres. There was a middle grade anaesthetist available out of hours; however the consultant on call could be contacted and would attend if required.
- Medical staff conducted a handover at shift changes which consisted of detailed information being provided to the oncoming doctors.
- On the gynaecology ward staff reported having a daily ward round for their patients, including at the weekends. They also had a ward round by a consultant to see any patients who were not gynaecology patients but were accommodated on that ward. They told us they had never had any issues with getting timely medical assistance when required.

Major incident awareness and training

- Staff were aware there was a major incident policy and knew how to access it should they be required to do so. Simulation exercises took place every year.

Are maternity and gynaecology services effective?

Good

Maternity and gynaecology services at Whiston hospital were good in terms of effectiveness.

The policies and procedures reflected national guidance, were up to date and available for staff. Audits were carried out and changes made when necessary to improve practice. Patients received pain relief of their choice in a timely way. There was extensive support to encourage and assist breast feeding which had resulted in the attainment of a nationally recognised award. The outcomes for patients were in line with the England average on most of the compared measures. Where they were worse this had been investigated and actions taken.

There were good examples of multi-disciplinary working between all professionals. There was no seven day working for maternity services outpatient department, foetal monitoring assessment unit or the early pregnancy unit. Out of hours all patients attended the ward or the delivery suite. There was sufficient medical cover out of hours. Doctors and midwives had access to the information they required and all staff had an understanding of the mental capacity act and how it may affect their work.

Evidence-based care and treatment

- There was a guideline group which met monthly to review and update guidelines. There was clinical involvement in this group and a strict sign off process to ensure compliance with the latest national guidance.
- The policies and procedures were available in paper format and electronically n the clinical areas. Those we saw were up to date based on current national guidance and had been reviewed in the past three to six months.
- When policies were updated this was communicated to staff, including the community midwives, via the maternity and gynaecology monthly newsletter. It was then the responsibility of the individual to read and understand these changes
- World Health Organisation checklist audits were carried out in the theatres and the results displayed on the theatre notice board. Any issues raised were discussed with the individuals and groups for future learning
- The antenatal, caesarean section and post-natal care policies and practices were in line with the relevant NICE guidance.
- There was an annual audit programme which consisted of clinical audits. These were presented at the bi-monthly audit meetings, findings discussed and recommendations made where necessary.
- Audits were carried out in response to recognised changes in practice or concerns. This included an audit in July 2015 into the induction of labour when it was recognised the rates had increased. The recommendations included review of the current policy and changes in practice.
- Midwives who were completing a leadership programme carried out an audit as part of that programme. They were supported by the managers and the medical staff to complete this.
- In March 2014 the trust's maternity services had been assessed against the clinical negligence scheme for trusts criteria and had gained level three, the highest level.

Pain relief

- Patients told us they had received adequate pain relief at the time they required it and did not have to wait.
- Epidural pain relief was available for patients who wanted to use this option. Midwives reported prompt response from the medical staff when this was required unless they were busy with an emergency.
- There was one birthing pool on the delivery suite. We were told this was primarily used for pain relief in labour as there were no baths or portable pools to provide this in an alternative setting.
- There was a pain assessment recorded as part of the observations of patients. Those we saw on both the maternity unit and the gynaecology ward had been completed and when necessary pain relief had been offered.

Nutrition and hydration

- Light meals, snacks and drinks were available from the ward staff 24 hours a day. For patients with a longer length of stay meals could be ordered from the catering department.
- The trust had achieved baby friendly status level three. Stage three was the final stage of assessing the implementation of the baby friendly standards. This was part of the UNICEF UK baby friendly initiative and the assessment was carried out in May 2014. The initiative worked to ensure a high standard of care for pregnant women and breastfeeding mothers and babies.
- Information received from the trust showed the number of patients initiating breast feeding met or exceeded the trusts target of 51.8% in 12 out of 13 months between May 2014 and May 2015. The numbers of patients breast feeding on leaving hospital was below the trust's target in four of those months. Midwives of all levels were aware of this and were focused on increasing the breast feeding rates. Information about the assistance patients required with breast feeding was included in the staff handover.
- There were three staff in the infant feeding team including an infant feeding specialist midwife. They saw as many patients as possible whilst they were in hospital and assisted patients and colleagues in the special care baby unit if required.
- There was a drop in clinic every Friday at which 15 to 20 women attended for peer support and professional advice if required. There was a peer support group with patients able to contact someone seven days per week. Patient feedback from this group was extremely positive and patients said that they would not have continued to breast feed without support from the drop in clinic.
- Should any patient have concerns about breast feeding a daily telephone call or one to one support was offered from the community midwives or in the clinic.

- All professional and support staff who had contact with pregnant women received training in breast feeding management from the infant feeding support team. This was included in doctor's ongoing professional development plan.

Patient outcomes

- The outcomes for patients were recorded on the maternity dashboard. This included caesarean section rates, instrumental deliveries and post-partum haemorrhage rates. There were no targets recorded on this dashboard therefore it was not possible to understand if the trust was performing better or worse than expected.
- Maternal readmissions were discussed at the monthly risk management meetings. In July of the 22 readmissions recorded, two were maternal readmissions with the others being paediatric. The reasons for all readmission were identified and actions taken to prevent recurrence where possible.
- The trust performed below the national neonatal audit programme standard for four of the five questions. 86% of babies had their temperature taken within an hour of birth against the target of 98 to 100% and 30% received their mother's milk when discharged from the neonatal unit against the target of 58%. An action plan had been developed and the trust' latest audit showed improvements being made in this area.
- The induction of labour rates had been recognised as higher than the England average at 31.2% as oppose to 25%. An audit was carried out and recommendations made to change practice with an action plan in place in July to reduce the rates and was due to be implemented.
- There had been six admissions to the intensive care unit between May 2014 and May 2015. There had been no admissions in the past six months which was a reduction on the previous six months.
- The number of babies admitted to the special care baby unit had remained static and higher than expected. The reasons had been investigated as part of the maternal readmission audit. Some actions had been introduced to reduce these admissions such as infant feeding clinics and others including senior medical support in this clinic were planned.

Competent staff

- Midwives told us they could not always attend additional training due to work commitments on the unit. This included training for new records when they were introduced, such as the pressure ulcer assessment.
- Midwives received their one to one supervisions by their allocated supervisor of midwives. They said the support they received was good and consistent.
- The preceptorship for newly qualified midwives was thorough and included a rotation across all the maternity departments but did not include experience in the community. This meant newly qualified staff were well supported; however would not have the opportunity to be supported in their learning in the community setting
- The local supervising authority had completed an audit of the trust in September 2014. The number of supervisors to midwives was one to twelve which was acceptable. The role of the supervisor is to protect the public through monitoring the practices of midwives to ensure the mothers and babies receive good quality safe care. At that September audit all four areas were met with improvements required in one area.

Multidisciplinary working

- Patients accommodated on the gynaecology ward who were under the care of doctors from other surgical specialisms were seen daily by a consultant from that specialism. For the medical patients there was one specific consultant who saw them daily. Nursing staff on this ward felt well supported by the medical teams from other specialities.
- There was a guideline for the care of patients with a high body mass index this included multi-disciplinary working with midwives, doctors and other specialists as appropriate including dieticians.
- There were multi-disciplinary ante-natal clinics which included appropriate clinical support for patients with diabetes and specialist support for patients with substance misuse issues. Both midwives and doctors reported an excellent working relationship with an open culture where both felt able to discuss any concerns about clinical care. Midwives reported that out of hours they could get support and advice promptly from the doctors in the hospital and the consultant on call.

- The community midwives said they had good communication, both verbally and in writing, with the hospital midwives and doctors. They could call on the specialist midwives should they require any additional support with specific issues.
- The midwives discussed how they worked with the physiotherapists in the ante natal phase to educate and support patients with their pain management.
- Where patients were transferred between hospital sites in the area we saw transfer documentation accompanied the patient both to and from the hospital. Should a patient be transferred from this trust they were accompanied by a midwife to ensure a safe transfer and this assisted with the handover of care.
- When a baby was transferred to the special care baby unit a recorded assessment which included treatment to date accompanied them.

Seven-day services

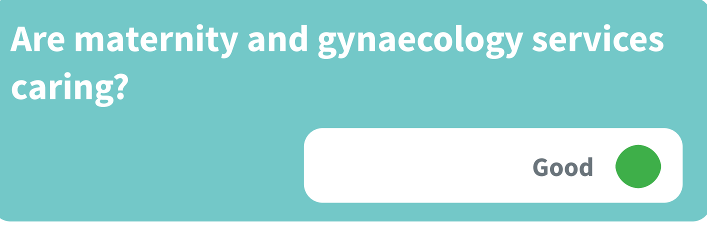
- The medical staff, including consultants were available out of hours and provided a responsive seven day service.
- The additional women's services, such as the outpatient department and the foetal monitoring assessment unit were not open in the evenings or at weekends. During these times patients were seen on the delivery suite for ante natal care and the maternity ward for postnatal care.
- The early pregnancy unit was a part time service. This was open two full days and three mornings per week with no service at weekends or evenings. The midwives on this unit had been trained to complete scans however outside of these hours scans would be performed in the accident and emergency department.
- The gynaecology ward had no scheduled operations during the weekend. They did admit patients who had either attended the accident and emergency department or been referred by their general practitioner.
- There was a team of operating department personnel available to work in the obstetric theatre 24 hours per day, seven days a week.

Access to information

- There were medical, orthopaedic and surgical plastics patients on the gynaecology ward at the time of our inspection. Nursing staff told us they had sufficient information about these patients to meet their needs, including their individual plans of care.
- If a patient was transferred from another hospital a copy of their notes accompanied them to the maternity department.
- Doctors told us they always had access to the information they required. If a patient from another area was admitted in an emergency the information staff required was present in their hand held notes.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Consent forms we saw had been accurately completed and signed.
- Staff had an understanding of the deprivation of liberty safeguards and their role and responsibility with regards to the care of a patient who may lack mental capacity.
- Nursing staff on the gynaecology ward said they requested assistance from the medical wards for patients who may lack capacity and have behaviours which put themselves or others at risk on a busy surgical ward. They recognised the need to provide additional support to patients who lacked mental capacity.



Maternity and gynaecology services at Whiston hospital were good in terms of being caring.

The feedback from patients and their supporters was positive in terms of the caring, patient and supportive attitude of the staff on both the maternity unit and the gynaecology ward. Staff were sensitive to the dignity and privacy issues which could occur in this service and managed these well. Patients and their supporters told us how they had been involved in making decisions about their own care and given clear information throughout their pregnancy.

Maternity and gynaecology

There was good support for bereaved parents with one midwife being the pivotal person in leading this within the service. There were other specialist midwives who offered additional emotional support to patients and guidance to staff.

Compassionate care

- Patients told us the care they had received was "excellent" and midwives were kind, supportive and accessible.
- In the single rooms staff closed the curtain present inside the door to provide additional privacy for patients when the door was opened.
- Patients who required a termination of pregnancy due to foetal abnormalities received sensitive care in a timely manner. Two single rooms were used to accommodate these patients on the gynaecology ward which meant they did not share an environment with pregnant women or babies.
- The trust is consistently above the England average for the friends and family test, the trust repeatedly scores 100% for patients who would recommend across all four categories particularly in the antenatal, birth and postnatal community provision categories.
- We heard staff giving advice and support to patients over the telephone in a sensitive and respectful manner. They took time to explain, advise and listen to the patient's concerns.
- The trust scores about the same as other trusts for 15 out of 17 indicators in the maternity survey, the trust performed better than other trusts for cleanliness on the maternity unit.

Understanding and involvement of patients and those close to them

- Patients told us they had been involved in their care including discussions about pain relief, modes of delivery and available support. They received comprehensive information at the antenatal stage about their pregnancy, how to access the support available and the role of the supervisor of midwives.
- We saw patients supporters were actively involved and welcomed to be part of the birthing process if they wished.
- Medical staff discussed any concerns patients had with them and their supporter as appropriate. They made sure patients were kept informed of any issues with their pregnancy providing information in a sensitive manner.

Emotional support

- There was a midwife with a lead role in supporting bereaved parents. They provided a very high level of one to one support which included where appropriate provision of support prior to labour, one to one support in labour, post-natal debrief session with the consultant and a follow up telephone call with the offer of ongoing face to face meetings. Patients could also discuss their next pregnancy and have support from this midwife if they wished.
- There was a bereavement care plan for any patients who had suffered the loss of a child. This contained detailed information for staff that were caring for that patient. An emotional support checklist was included and there was input from the supervisor of midwives.
- The bereavement midwife was also a trained counsellor who would see patients in this capacity. Patients would be signposted to appropriate external counselling services if required.
- There was a perinatal mental health midwife who provided additional support for any patients requiring additional psychological support through their pregnancy. They also provided advice and support to other midwives as appropriate.
- The gynaecology oncology nurse specialist position was vacant at the time of the inspection, with the replacement appointee due to commence in post in the next two months. The previous post holder had secured an internal promotion and was available for advice where necessary during this period.

Are maternity and gynaecology services responsive?

Requires improvement

Maternity and gynaecology services at Whiston hospital required improvement in terms of being responsive

There were limited choices for patients to plan the delivery of their baby and facilitate normality in childbirth. The system of triage for patients impacted on the work of the

delivery suite and the ability of staff to provide individual care. There were times when there were no areas available for assessment and triage because women were in active labour within those areas.

There was good support for patients with complex physical and mental health needs. Additional services and support were available for patients with specific communication needs. There was some learning from complaints shared with staff however there was no formal sharing or follow up discussion.

Service planning and delivery to meet the needs of local people

- There was one birthing pool available on the unit. Midwives told us the number of deliveries in water was low although this had not been audited. There was no strategy for encouraging the use of the birthing pool or for having portable pools available for other areas of the delivery suite or use by community midwives. This meant if a patient wanted to deliver in water they had limited opportunity to do so.
- The percentage of home births compared hospital births was low between May 2014 and May 2015. There were 24 unplanned home births in the same period. Midwives were aware of this and individually encouraged home births; however there was no strategy in place for doing so.
- We observed that patients were not offered a real choice of where to give birth. One example of this was a midwife telling a patient where she presumed she would be having her baby and not offering other choices such as a home birth.
- The trust record keeping audit in May 2015 had found birth plans were not being completed for all women which meant their wishes for labour were not always documented.
- There was no midwifery led unit which meant low risk patients did not have the choice of this option for delivery of their baby. This does not meet NICE guidance CG 190 “intrapartum care: care of healthy women and their babies during childbirth.”
- There was no strategy for the development of services to meet the normality in childbirth vision of the Royal College of Midwives.
- Midwives said they did their best to deliver one to one care during labour and would always stay with a patient during birth. We saw that midwives were allocated one patient who was in active labour; however they could also be responsible for several other patients who would need to be reallocated during active labour. This meant there could be inconsistency of delivery of care when the delivery suite was at full capacity.

Access and flow

- Bed occupancy rates were higher than the England average from July 2014 to December 2015 with the rates ranging from 73-88 % compared to 56 to 60% nationally. This meant the maternity services were running at a higher than usual capacity and there were no plans in place to manage this.
- There was a telephone triage system on the delivery suite. There was no specific staff member allocated to take the calls; however we saw that anyone available did so promptly. These calls and the actions taken or advice given were recorded.
- In May 2015 an audit of ‘triage attendance to delivery suite’ had been “abandoned” due to “no progress with the triage service”. This showed there was recognition that a triage service may be required however there had been no commitment to develop this.
- There was one ward of 37 beds where both antenatal and postnatal patients were accommodated. The numbers of patients in each category were flexible depending on the needs of the service at the time. This meant patients could always be accommodated with the change of status of a room or bay from antenatal to postnatal care.
- The foetal monitoring assessment unit was open for ante-natal patients from 9am to 5pm Monday to Friday. Midwives told us this was not long enough as during the hours it was closed these patients were accommodated on the maternity ward or delivery suite.
- GP’s could refer patients to the foetal monitoring unit or patients could self –refer. Appointments were booked by telephone triage on the delivery suite. It was recorded there should be no more than 20 appointments per day, however we saw regularly that some appointments were pre-booked with little or no capacity for those patients who self-referred or who were referred by the GP. Patients were kept waiting and the staff stayed on this area until all the patients had been seen which was frequently later than 5pm.
- We were told by a midwife manager that four patients were booked daily for induction of labour. However we saw that six patients had been booked on one of the

days during our inspection. This meant there was additional capacity required on both the delivery suite and the ward to accommodate these patients. The increase in numbers was not mirrored with an increase in capacity of beds or an increase in staff. This meant on these days patients may be admitted into the two rooms on the delivery suite which were allocated for initial examination, or the bereavement rooms. They would then not be available for their allocated purpose should that be required.

- Four patients were booked for elective caesarean sections on Mondays and Thursdays with two every other day. On the days additional patients were booked additional staff were on duty when possible
- There were no cancellations of surgical procedures such as elective caesarean sections, due to shortage of beds on the obstetric unit.
- 9.3% of midwives were trained to complete the new-born infant physical examinations and there was a lack of paediatric doctors to complete these. This led to delays in discharge. One example was a patient who delivered their baby at 8.30am and was not discharged until 9pm due to waiting for the check to be done. This meant that room on the delivery suite was unnecessarily occupied. There was one bay of four beds unoccupied on the gynaecology ward. This was planned to be opened as a hyperemesis unit.
- The gynaecology ward was used for patients from other medical specialities which led to a shortage of beds for gynaecology patients at times; however this had not led to any cancelled operations.
- There was an efficient process for the admission and discharge of patients who required medical management of a miscarriage. They were admitted by the doctor and their medicines prescribed by them. The process was then nurse led including patient discharge. This negated the need to wait for the availability of a doctor and improved the timeliness of the procedure.
- Some patients in the women's' outpatient department had waited up to two hours to see a midwife or doctor with another wait for blood tests.

Meeting people's individual needs

- Managers described how they would use additional resources for patients with a learning disability which were included in a clear pathway of antenatal and post-natal care. This included input from the specialist mental health midwife, flexibility about admission to the unit and the ability to have additional informal support if required.
- There is a small team led by a specialist midwife who support women with substance misuse issues. These midwives meet women in the community and hospital setting. They supported patients with education in a group and on a one to one basis. They worked with other local agencies to support patients and ensure unborn babies were protected. They had also provided additional training for midwife colleagues
- On the gynaecology ward staff said they were concerned about the provision of care for some patients living with dementia. They were unsure if there was a lead dementia nurse specialist to support them with the care of patients however had asked the psychiatric liaison nurse for extra help when required. This meant there was a lack of clarity about how best to support patients with dementia on this ward.
- We did not see any written information in any other language than English. Staff told us they could request information in other languages if required.
- There was easy access to a translation service for both inpatients and those in the community. This could be face to face or via the telephone as required.
- There was information for staff about how to obtain additional support for any patients who were hearing or sight impaired.
- The infant feeding co-ordinator discussed how additional support would be accessed to aid a patient's understanding of breast feeding. This included for patients with communication difficulties or those whose first language was not English.

Learning from complaints and concerns

- Midwives told us they would deal with complaints informally if possible to aid timely resolution for the patient. They were aware of the complaints procedure and would advise patients how to complain officially if they wished to do so.
- There were leaflets and posters informing patients how to complain in all the ward and unit areas.
- Lessons learnt from complaints were included in the monthly newsletter. This provided basic information of

what additional action was required to prevent recurrence. There was no formal sharing of this information to discuss and check staff understanding of actions required by them.

- There was information regarding the correct duty of candour procedure on display in the staff areas.

Are maternity and gynaecology services well-led?

Requires improvement

Maternity and gynaecology services at Whiston hospital required improvement in terms of being well led.

There was no vision and strategy for the maternity services. Discussions about the future were focused on providing a good enough service for the increase in births at the unit. Midwifery managers and medical staff felt involved in the development of the service; however midwives did not and felt there was a lack of consultation with them regarding the future of the service.

There was a lack of visible leadership of the service and no encouragement for innovation. The culture was one of openness with regard to clinical care; however there was a lack of transparency regarding the management of the service.

Vision and strategy for this service

- The leadership team for midwifery services was unable to tell us the future vision and strategy for the maternity services. They said they were "looking to develop a strategy in the future as not everything sits within a risk framework." The band seven and eight midwives did not know the future vision or strategy for the maternity services. We were told there was no five year strategy. They were aware of the current issues and the work ongoing to address them, but were not aware of any plans for the future of the service.
- The main issue in midwifery services was increasing the operational staffing numbers and grades to ensure they were adequate for an anticipated growth to over 4000 births per year. However there was no consideration given to the appointment of a consultant midwife a key issue in the management structure of a unit providing for over 4000 births per year.
- There had been no discussions involving the whole medical team about the impact of an increase in the number of births on anaesthesia services.
- There was recognition that the service provided a medical model of care which did not meet the normality agenda. Skills such as hypnobirthing and homeopathy were identified as areas which the head of midwifery would like to develop; however there were no plans in place to achieve this at the time of our inspection.

Governance, risk management and quality measurement

- There were four risks on the maternity risk register. The dates that these risks had been added to the risk register were available on datix but not evident in the reports circulated.
- One of the risks about staffing levels had been identified when the trust moved to the new hospital building in 2010 and this had resulted in regular staffing reviews.
- The low number of identified risks and the timescales were discussed with the lead for the service. They were aware that some areas of risk may not have been identified and that there may be risks within maternity services which had not been addressed.
- We saw and were told by staff of all grades in maternity departments that the current system to access the service was inefficient. There was no single triage point which caused delays for some women in being seen and bed capacity concerns in the delivery suite. Staff had highlighted these concerns but there were no plans for change.

Leadership of service

- Midwives of all bands and medical staff told us they did not see the person in charge of the maternity services on the delivery suite or the maternity ward. They could contact them and they were approachable but they were not visible on the unit.
- There had been some changes to the leadership of the maternity services and interim matrons were in post. Ward managers told us they received good support from these managers and those above.
- The managers felt supported by the executive team and saw the board members at relevant times such as during the local supervisory authority audits.
- There was a leadership programme in place for band 6 midwives to complete a leadership development programme in readiness for them taking a band 7 role.

There was also a development programme in place for the band 7 staff to enhance their role with the introduction of increased management responsibilities. Midwives were appreciative of the opportunity to complete this and enthusiastic about their leadership development.

Culture within the service

- There was a culture of open discussion about clinical care and concerns between the midwives and the medical staff. A lack of barriers to this openness were described such as respecting clinical judgement and a healthy approach to challenging each other.
- We heard some concerns about their being a lack of transparency about the management of the service. These included a lack of sharing of information by the higher management team and a lack of opportunity to discuss and understand the strategic objectives of the service.

Public engagement

- There was no maternity services liaison committee as the previous group was disbanded when the responsibility for it was given to the primary care trust. There were no plans to reinstate this group.
- There was patient representation at the labour ward forum and the infant feeding groups.
- There was an informal feedback sessions when the "supervisor of the week" spoke to five women about their experience. They said these comments were used during discussions about continuing service provision.

Staff engagement

- Band seven and eight midwives felt included in the management of the maternity services. They could contact the executive team to present ideas for service development.
- The band five and six midwives did not feel included in the service and had no formal mechanism for providing feedback or presenting ideas for change. One midwife had developed and ran an informal meeting where midwives could attend and share their ideas; however this had been introduced outside of the formal management mechanism for consultation.
- Midwives told us there was a lack of consultation about changes made on the maternity unit. One example was the introduction of a policy to allow partners to remain in the unit with the mothers. Midwives were not consulted about this and it resulted in safety concerns due to them sleeping on the floors in the bay areas. This had now ceased.
- The change in work patterns for the midwives to include rotation between day and night shifts as well as between the delivery suite and the maternity wards had commenced in October 2014. There had been no review or evaluation since it began and staff were unaware of any mechanism for them being included in monitoring the outcome of the changes.
- There was a staff survey completed however the view of midwives was that nothing happened as a result of the survey. This meant the outcomes of staff engagement were not communicated clearly to staff.
- It was not always clear in which capacity those supervisors of midwives who were also managers were acting when supporting staff and attending meetings. This was documented in the Local Supervising Authority September 2014 annual report in terms of ensuring independent attendance at meetings. Staff told us this could cause concerns of a conflict when they were having supervisor support.

Innovation, improvement and sustainability

- There was a lack of encouragement of innovation in the maternity services. Where ideas had progressed to actions this was due to the enthusiasm of individuals and them giving their own time to the project. Example of these were a senior midwife had planned to complete an audit of patient triage due to recognition by the midwives that the current system was inefficient and led to multiple admissions onto the delivery suite and a bereavement midwife who ran an' air and share' support group.
- Discussions with midwives and medical staff focused on how to keep providing a service with the pressures of increased capacity. There was no discussion about future development of the service other than increasing the numbers of births at the unit.
- There were actions for improvement identified in reports from agencies such as the local supervising authority and CNST which had not been embedded in practice 12 months later. Examples were investigations by supervisors of midwives being completed within 45 days which was still outstanding and anaesthetists completing skills and drills training.

Services for children and young people

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

Information about the service

The St Helens and Knowsley Trust neonatal and children and young people service is situated at Whiston hospital. The trust provides a 15-cot neonatal unit situated on level 2 in close proximity to the labour ward, two in-patient wards 3F and 4F, a children's observation unit based on 4F and outpatient clinics run at both Whiston and St Helens hospitals. The trust provides an acute community nurse team.

Each year the trust serves approximately 4,500 children and young people as in-patients and day cases; 12,000 children as out-patients and 18,000 children in the Emergency Department.

General practitioners have access to a same-day second opinion from a paediatrician and children can be seen on the same day through referral to the Children's Observation Unit (CHOBs) via the hospital switchboard. Parents or carers are able to stay with their children 24 hours a day.

All neonatal nurses are trained in neonatal intensive care and the unit operates as part of a regional neonatal managed clinical network to ensure best outcomes for babies.

Summary of findings

Treatment and care were delivered in accordance with best practice and recognised national guidelines.

Children, young people and their families were respected and valued as individuals. Feedback from those who used the service was positive. Staff were compassionate, caring and provided effective care to children, young people and their families. Transition and acute community nursing support was comprehensive and made a positive impact.

The staff worked well with other teams and worked hard to provide a service to meet the needs of a child or young people who present to the hospital. Processes were in place to provide an initial or long term service to any child or young person brought to Whiston hospital.

Staff liked working within the children and young people directorate and said they felt valued by senior managers. Certificates and plaques on display showed the trust actively showed appreciation of staff by organising special events, awards and ceremonies.

There was a good track record of lessons learnt and improvements when things went wrong. This was supported by staff working in an open and honest culture with a desire to get things right.

Children, young people and their families were not provided with regular opportunities to comment about

the services provided. The trust was in the process of sourcing a system to help them gain an understanding of how children and young people felt about the care provided.

We spent time on the neonatal unit, the children's wards and outpatient departments. We also attended an outpatient clinic,

We talked with 29 children, young people or their parents. We recorded contact with 20 members of staff from the areas we visited including the clinical director, matron and ward manager for the service; the foetal monitoring co-ordinator, consultants, junior doctors, ward sisters, trained nurses, health care assistants and ward clerks. This number also included student nurses.

We reviewed the care pathways of four babies on the neonatal unit and 16 care pathways for children and young people on the wards.

Are services for children and young people safe?

Good

The trust monitored incidents and had processes for feeding back to staff so that lessons could be learnt. We saw evidence that changes were made following learning. Reported drug errors were very low.

The areas inspected were visibly clean and tidy and the trust regularly audited hygiene and cleanliness, monitoring performance over time. Checklists for cleaning were in place. Methicillin-resistant Staphylococcus Aureus (MRSA) and Clostridium Difficile (C.Difficile) rates were very low.

Safeguarding was managed by a central team who had good links with the other services. Staff were clear about processes and who to approach with queries.

Mandatory training was just below the trust target but staff members we spoke to were able to tell us what training they were due to complete and how to find out what training was outstanding.

Patient clinical risk was managed on wards through a paediatric early warning score system (PEWS). The neonatal unit has not yet adopted this tool but was due to implement an electronic version of the system within weeks. The use of blood pressure monitoring was limited in all areas.

The service had seen challenges in nurse and medical staffing. Nurses' recruitment had suffered due to a large intake of staff by another local Trust. This had since been rectified and staff were due to start employment. There was a pre-planned joining of the two wards at weekends throughout the summer to maximise the use of resources.

Medical staffing of middle grade doctors was eight which was lower than the target of 10. Locums filled the posts along with extra cover in the Emergency Department.

There were some elements of concern. The service had a designated pharmacist but drugs such as Gaviscon were not always locked away. This was immediately rectified on the day of inspection as the Gaviscon was transferred to a locked cupboard. Sluice rooms did not have locks on the

doors. And breast milk and baby food was not stored securely, however this was rectified on the day of inspection as the room where the breast milk and baby food was stored was immediately locked.

Incidents

- We talked with approximately 20 members of staff and they were familiar with the trust's electronic reporting system. They knew how to report incidents and who to escalate concerns to.
- Some incidents were automatically reportable such as readmissions of babies under 28 days old, pharmacy prescription errors and admissions of children following a suicide attempt.
- Drug errors were scored to determine what action was required.
- Reporting an incident produced an acknowledgement email to confirm it has been submitted, and an outcome email to tell staff when the incident had been reviewed, what risk score had been applied and action taken. Incident outcomes were also circulated at recorded meetings.
- There was evidence that lessons were learned from incidents and actions taken to limit reoccurrence. For example, following an attempted suicide, curtains and locks on bathroom doors were removed from rooms that would be used for high risk patients and so reducing the risk of self-harm.
- Whilst learning was shared within the division, we found no evidence that learning from incidents was shared with other services within the trust.
- The trust reported that no never events had occurred within the last twelve months.
- Mortality meetings were held in the form of critical reviews for any deaths involving children. The service linked with maternity services to ensure a multi-disciplinary approach to review and learning.
- The trust used the Patient Safety Thermometer to record the frequency of pressure ulcers, urinary tract infections or falls on children's wards. The falls element also included 'bumps'. No pressure ulcers, urinary tract infection, falls or bumps recorded between March 2014 and March 2015.

Cleanliness, infection control and hygiene

- The trust reported that no incidents of Methicillin-resistant Staphylococcus Aureus (MRSA) and Clostridium Difficile (C.Difficile) had occurred within services within the last twelve months.
- The areas we inspected were visibly clean and tidy.
- Staff practised hand hygiene by using alcohol gel and gloves. The trust audited hand hygiene on ward 3F in February 2015 and rated staff as fully compliant in hand hygiene practice. However, we saw clinical staff using hand gel before, or after seeing a patient, rather than at both times.
- The audit gave an overall compliance score of 94% and showed improvements from the previous year. Cleaning needs were highlighted following swab testing of areas such as a sharps tray and telephones, which were addressed in an action plan.
- Infection control audits were also completed with action plans produced when required. Staff showed us where the audit results were stored. The neonatal unit showed 100% compliance with infection control practice.
- A procedure was in place for the prevention of Legionella disease and staff were able to explain the process. A technician visited areas on a monthly basis to check the water system and that staff were adhering to the procedure.
- In all areas we found cleaning products stored on shelves in unlocked rooms. These should be locked away to limit unauthorised access. This was rectified on the day of inspection as the cleaning products were immediately transferred to a locked cupboard.
- Toys in the outpatient department were cleaned daily and we saw that checklists for cleaning toys were in place.
- We observed meal times and saw that hand wipes were not provided and children were not encouraged to wash their hands before eating.

Environment and equipment

- Wards comprised of individual rooms and 4 bed bays. Two bays had ceiling hoists which could be moved from bed to bed.
- Nursing staff confirmed that boys and girls aged above eleven or twelve were placed in separate bays.
- The neonatal unit had funding for 15 cot spaces, two of which included high dependency care. There were five isolation rooms, two of which had monitoring equipment linked to the nurses' station.

- The line of sight in the neonatal unit meant side rooms could not be viewed at all times. The trust stated steps were taken to ensure two alarms were in place for very sick babies been treated in these areas. Two of the side rooms also had monitors wired up to the nurse's station so that babies could be monitored from there.
- We observed staff using clinical equipment competently on the neonatal unit.
- Ward 4F housed a stabilisation room where very sick children could be cared for if required. The room was locked and daily checks took place to ensure good stock levels and that equipment was clean and fit for purpose. A medicine trolley was found to be locked securely.
- A child friendly 'hatch' was used between two utility rooms, easing the process of obtaining urine samples from children. Here, staff would stand on one side and the child and carer would go on the other. Staff would then encourage the child to 'leave a surprise' in the hatch for them.
- On ward 4F, a room storing breast milk was unlocked which could pose a risk that milk could be tampered with. Cleaning and sanitisation products as well as medications were also found to be in unlocked rooms and therefore accessible to the public. This was rectified on the day of inspection as the breast milk room was immediately locked and all cleaning products and medications were immediately transferred to locked cupboards.
- The wards also had a dressing room and a phlebotomy room where children could be cared for in a less intimidating environment. Play specialists helped children who were anxious.
- The kitchens for parent use were well equipped and visibly clean and tidy
- There were no 'in-use' signs on outpatient consultation rooms and so privacy could be compromised by people entering the room unexpectedly.
- During one of our visits, the waiting room was very busy with no available seating and a number of people standing.

Medicines

- The service had a designated pharmacist.
- Medicines were stored in all areas. We checked the drugs on the neonatal unit and found that these were checked daily with drug counts corresponded with drug book entries.
- On ward 4F we found a cylinder of Entonox (a pain relieving gas) which was connected and ready for use in an unlocked room. This created the risk that the drug could be misused. This was rectified on the day of inspection as the gas cylinder was immediately transferred to a clinical room with a digital lock.
- Drugs that require storage below certain temperatures were stored in fridges and daily checklists were in place to monitor fridge temperatures. In the neonatal unit, not all entries were complete and in one drugs fridge we found food and drinks were being stored. When staff were informed they took immediate action and removed the items.
- We saw instructions written on white boards to ensure staff could calculate and document the dosage of emergency medicine for children based on their weight.

Records

- We reviewed 20 records on the wards and the neonatal unit.
- Records were accurate and clear. Medical notes did not always include signatures but nursing notes did. Parental responsibility and management plans were included as well as clearly prescribed medication.
- We also found that immunisations were not routinely recorded. Capturing this information can help identify overdue immunisations.
- Many of the records we reviewed showed that blood pressure readings, and falls risk assessments were not recorded routinely.
- On the neonatal unit we found patient records were readily available to staff.
- We checked 4 neonatal admission documents which showed a clear plan about the management of each baby
- The services produced their own quarterly review of record keeping which identified concerns (such as documenting discussions with parents) and action plans for improvement. The reviews demonstrated consistent improvement in record keeping over time.

Safeguarding

- The trust employed a team to manage safeguarding.
- A clear written process was in place for admitting children and young people with mental health needs, and was also linked with relevant legislation.

- The service used an electronic document management system which allowed staff to raise a 'red alert' for children with safeguarding concerns.
- We saw evidence that safeguarding was managed in the clinic environment. For example, in the outpatient department we saw signs reminding visitors that they could not take photographs or film audio or video whilst in the waiting area.
- When we visited the neonatal unit, staff asked us for identification which supported the view that safeguarding was actively managed within the service.
- The trust did not have a restraint policy for children with mental health needs. However, general training had been implemented and was being provided for relevant staff.
- The on call structure meant that a member of staff with enhanced safeguarding training was always available should advice be required.

Mandatory training

- The trust aim was for 85% of staff to be up to date with mandatory training.
- Figures for August 2015 showed that 82% of staff on ward 4F had completed mandatory training. For ward 3F and the neonatal unit the figures were 86% and 83% respectively which showed that the service was just below target in this area.
- The service employed a clinical educator who was responsible for ensuring staff were appropriately trained for their roles.
- Reminders were sent to staff by email from their line manager who was able to review completed and outstanding training for staff.
- Staff providing any care for children or young people completed level two safeguarding training and qualified nursing staff and consultants completed level three this met best practice guidance from the royal colleges.
- The level three training had been ratified by the local safeguarding children's board. We reviewed the training package which was comprehensive, covering a variety of topics such as domestic and honour based abuse and female genital mutilation.
- Underpinning factors were also covered such as legal frameworks and record keeping.
- A ward manager was the trust trainer for paediatric life support and staff training was updated every 4 years in accordance with the Resuscitation Council (UK) guidelines. Paediatric basic life support training was completed annually. Shift leaders were trained in advanced paediatric life support.

Assessing and responding to patient risk

- Staff on wards 3F and 4F used an early warning score system to monitor children under their care. This was not the case of the neonatal unit. However the neonatal unit were due to implement an electronic early warning score system in September.
- Deteriorating children were managed in specialised rooms on wards 4F (stabilisation room) and 3F (high dependency beds). These areas were well stocked and checked daily.
- There were clear processes for transferring children or babies who became seriously unwell and there were good links with local networks of care.
- Some children were given open access to children wards and protocols were in place so that they attended accident an emergency if they were very ill. These children had a flag on the hospital patient electronic data system to identify them to hospital staff.
- Despite there being a clear process ward staff stated that sometimes children were brought directly to them without prior warning. To manage this risk the service had a stabilisation room on ward 4F where they could be cared for, and there were two high dependency beds on ward 3F.
- The trust had a policy for missing persons and a checklist for children who absconded from wards which included contacting security and checking CCTV and escalating the issue to senior staff and external agencies such as social services and the police. The trust did not use a 'lock down' process for wards on these occasions which would limit people entering and leaving the ward or unit.

Nursing staffing

- Nursing staff on Ward 3F told us there was no acuity tool in place to calculate the numbers of nursing staff required to care for children on the ward. Instead they used historical figures which had been used since the ward first opened. These were based on the requirement for cover of a number of areas within the

ward, plus one nurse in charge. This equated to a requirement for four paediatric trained nurses on Ward 4F and five trained staff on Ward 3F. Healthcare assistants and nursery nurses were also employed.

- The service had recorded issues recruiting nursing staff on the risk register and explained that a neighbouring trust had recruited a large number of staff which had impacted on availability. This was confirmed by a manager who reported that there were 9 nursing vacancies following staff retirement and long term sickness. The trust had responded to this by running recruitment open days and the posts had been recruited to.
- There was a pre-planned joining of the two wards at weekends throughout the summer to maximise the use of resources. This meant one ward was used instead of two and staff could be pooled onto one ward and maintain appropriate levels.
- At the time of our inspection there was a vacancy for a housekeeper and in the meantime the housekeeper duties were being fulfilled by healthcare assistants and the rest of the team.
- We observed staffing rotas on the neonatal unit and found that staffing levels and skill mix met the standards set by the British Association of Perinatal Medicine (BAPM).
- Ward 3F had two high dependency beds which were staffed according to guidelines.
- Staff involved in training told us that whilst all new staff complete an induction it would be beneficial to train staff for one full day annually. They told us it was difficult due to the constraints of staffing and in particular accessing staff who work at night.
- We observed the process of handing over details when shifts changed which took approximately 10 minutes. This was effective, and followed a clear process. Staff gathered around a whiteboard to update and receive details on patients being cared for by senior nurses. On the neonatal unit, plans were made during handover, for accepting potential babies. On Ward 4F staff discussed family circumstances and the character and mood of children staying on the unit as well as clinical details.
- The services ran with a shift leader on units and wards. There were clear guidelines in place for staff to follow should the shift leader not be present, for example through sickness.
- We observed staff deal with short notice sickness for a night shift on ward 4F by swapping a member of staff from a day shift to cover the night instead.
- Nurses were confident that senior management were always ready to come to assist clinically if required.
- All senior nursing staff on the neonatal unit were able to source agency staff to meet minimum staffing level requirements if required. We saw evidence of this on both the neonatal unit and ward 3F during our inspection.
- Nursing staff reported being able to escalate staffing issues at any time of the day or night to ward managers, the bed manager, colleagues in A&E or the on call consultant**.**

Medical staffing

- Consultant staff reported shortfall in middle grade doctor staffing. 10 middle grade doctors were required but the service only currently employed 8. The two remaining vacancies were filled by locum doctors and through extra staffing in A&E.
- We observed the handover of details from one shift to another on the neonatal unit which were comprehensive. For example, written details about each baby was circulated to medical staff; babies due for delivery or with particular problems (such as suspected sepsis or jaundice) were discussed as well as babies who might require transfer to another hospital. Discussion also took place about general work required during the shift.
- During one handover, specialist complex needs nurse was present to ensure medical staff had knowledge of a child with complex needs.

Major incident awareness and training

- A Major Incident Plan was in place which made reference to children as a vulnerable group and explained how children would be cared for in the event of a major incident being declared. A separate Paediatric Emergency Plan had also been developed.
- Winter planning took place during August for vaccinating babies with chronic lung disease from September against respiratory syncytial virus in the winter months.
- The trust had a policy in place for offering support to local children's hospitals and children with conditions who are supported but living at home, should a child related pandemic occur.

Services for children and young people

Are services for children and young people effective?

Good

The trust participated in national, regional and local audits. Reports confirmed appropriate steps were taken by the trust in response to the results of audits. Care and treatment was planned and delivered in line with evidence-based guidance, standards and best practice. This was regularly monitored and reviewed. The individual needs of children and young people were assessed and care and treatment was planned to meet those needs. Pain was adequately assessed and managed and consent to treatment was obtained appropriately.

The trust provided community nursing, consultant paediatricians and access to diagnostics seven days a week. Multidisciplinary working was well developed within the service and extended to other services including schools, tertiary hospitals and general practitioners.

Evidence-based care and treatment

- The paediatric clinical governance and management committee met once a month and monitored all aspects of the trust's performance in the provision of services for children and young people. This included the use of evidence-based care and treatment.
- The information and reports from April, May, June and July 2015 included details about participation in national and local audits and adherence to National Institute for Health and Care Excellence (NICE) and other clinical guidance.
- There were 15 chapters of written policies and clinical guidelines for children and young people services which were accessed through the hospital intranet.
- There were 12 chapters of neonatal policies available on the neonatal unit.
- We reviewed compliance with best practice guidance through case tracking, observations and discussion with staff and relatives.
- Policies and procedures reviewed included, newly diagnosed diabetic discharge plan; febrile child policy; and the paediatric early warning score (PEWS) policy and guidance.
- Records confirmed that diabetic discharge plans were followed. The trusts internal audit of care provided to the febrile child confirmed best practice guidance was followed.
- We noted inconsistent compliance with best practice guidance related to the monitoring of vital signs on wards 3F, 4F and the children observation ward because blood pressures were not consistently measured in keeping with the trusts policy.
- The trust had introduced the paediatric early warning score (PEWS) to measure the results of vital sign observations taken by nurses and doctors. The trusts PEWS charts required the temperature, heart rate, respiratory rate, level of consciousness and blood pressure to be recorded and scored to help identify whether a child's health was deteriorating.
- We looked at the case notes for four children following surgery and found that baseline blood pressure readings had not been taken and neither was their blood pressures checked after surgery.
- The trust policy was for the PEWS to be completed for all children admitted to the hospital including those for elective surgery. Admission forms for all areas requested the blood pressure measurements for children and babies. The royal college of nursing (RCN) best practice publication 'Standards for assessing, measuring and monitoring vital signs in infants, children and young people' recommends vital signs, including blood pressure, should be recorded for all children on attendance to hospital and following surgery.

Pain relief

- Acute pain management guidelines were available to staff and pain specialist nurses were employed.
- Paediatric pain assessment charts were used and seen in the nursing documentation we reviewed.
- Pain relief was reviewed for effectiveness and changed if necessary.
- We witnessed pain relief being discussed.
- Robust assessments using different formats depending on the age and communication skills of the child or young person were in use.
- Blood was taken by appointment and a tiered system of pain control provided.

Nutrition and hydration

- Young people told us there was a choice of food and drinks available throughout the day.

- The menu offered a choice of meals and snacks and the children and young people chose their meals each day.
- Meals were managed and served by the housekeeping staff and nurses did not have an oversight of the meals provided or consumed.
- This is not in keeping with the nursing and midwifery council (NMC) code of conduct which specifies nurses must have some responsibility for food and nutrition. 'The fundamentals of care include, but are not limited to, nutrition, hydration…includes making sure that those receiving care have adequate access to nutrition and hydration, and making sure that you provide help to those who are not able to feed themselves or drink fluid unaided.' NMC March 2015.
- On the neonatal unit staff maintained a record of fluids provided which allowed staff to monitor the baby's nutrition and hydration status.
- Comfortable chairs and facilities were provided for mothers who wanted to express breast milk for their babies on the neonatal unit.
- The trust provided donated breast milk for babies whose mothers could not express milk.
- Baby feed was not always stored securely for example on the neonatal unit we saw mothers freely accessing the baby milk fridge. This issue was rectified by staff immediately. However we also saw occasions when milk was locked up and mothers provided with baby milk on request.

Patient outcomes

- The principle meeting to which all groups reported was the monthly 'Paediatric clinical governance and management committee' meeting. These were attended by senior clinicians from each of the children and young people departments and provided an oversight of the audits and other activities for all children and young people services including the neonatal unit.
- Review of the April, May, June and July 2015 minutes from this meeting showed that all aspects of governance for the service was discussed and reviewed.
- The trust participated in the Royal College of paediatric and child health (RCPCH) national neonatal audit programme (NNAP). The most recently published report for 2013 showed the trust scored 100% for retinopathy scans for premature babies which was better than the national average of 94%.
- The trust scored 86% for checking the temperature of premature babies within an hour of birth which was worse than the national average of 89%.
- The neonatal unit met their quarter 1 commissioning for quality and innovation (CQUIN) targets set by NHS England. This measurement was based on the trusts regular submission of data for the NNAP.
- January 2014 to January 2015 the trust participated in a national epilepsy audit and found they underperformed in some aspects of care in relation to providing sufficient information to children and their families. Minutes of the paediatric epilepsy meeting held on Monday 20th July 2015 highlighted broad plans to improve outcomes in response to this epilepsy audit. This involved a re-audit using the 'Children and Young People's epilepsy service' performance indicators. This audit identified specific areas of strength and weaknesses and a detailed action plan to address each area was developed. Progress will be reviewed in September 2015.
- Discussion with the epilepsy nurse confirmed the trust had already achieved some of the planned outcomes such as improving access to outpatient appointments, better documentation and additional guidance for children, young people and their parents.
- The trust participated in the national paediatric diabetes peer review in June 2014 and scored 0.5% worse than the England average for ensuring children with diabetes consistently maintained the safest blood sugar level. The paediatric diabetes action plan was detailed with robust systems to promote change. Systems included clear description of expected change, timescales and staff identified to take responsibility for leading the improvements. The plan had been reviewed in October 2014 and May 2015.
- Changes included updating staff training, updating the diabetic care plans and proformas, a clinical psychologist was employed and changes made diabetic clinic out-patient appointments were managed.
- Discussion with ward and outpatient staff about the diabetes audit confirmed this information and proposed changes were understood by the relevant staff. Observation and case tracking confirmed guidance developed as a result of the diabetes audit were put into practice.
- The minutes for the 100th paediatric clinical governance and management committee meeting on 17th June 2015 discussed the progress of the diabetes action plan and approved a date to commence a re-audit.

- Readmission rates within 28 days of discharge January 2014 - December 2014 was worse than expected. Actual readmissions were 611 and the expected number was 375. Initial findings identified babies discharged from maternity were returning to the baby ward due to possible jaundice. The trust was reviewing the care and treatment of these babies to enable assessment and treatment in the community.
- The trusts 2015–16 audit plan included participation in national and local audit programs, review of national institute for clinical and social care excellence (NICE) and other best practice guidance.

Competent staff

- A comprehensive preceptorship program was in place which included demonstrating practical skills and completion of a work book. Newly qualified nurses said they felt well supported.
- The trust employed a nurse educator for the children and young people directorate who worked directly on wards 3F and 4F.
- Weekly seminars and training on neonatal and paediatric topics were presented. Topics included bronchiolitis, diabetes and failure to thrive.
- Specialist staff members, expert in their field, were employed in all areas; roles included advanced nurse practitioners, specialist nurses, paediatricians and therapists.
- Nursing staff reported they were well supervised and data from the trust confirmed 98% of nursing and midwifery staff received supervision April 2014 - April 2015.

Multidisciplinary working

- There were examples of team working across other departments and disciplines including the children and adolescent mental health services (CAMHS); diagnostic services and community nurses employed by partner trusts.
- The directorate developed a self-harm pathway which included referral to 5 Boroughs child and adolescent mental health services (CAMHS).
- There was effective liaison with the tertiary hospital, child protection and safeguarding teams.
- There were clear pathways for referring babies, children and young people to tertiary specialist hospitals such as Liverpool Women's and Alder Hey hospitals.
- We saw that the service level agreement with a neonatal ambulance service for transferring sick and deteriorating babies and children to tertiary hospital was effective.
- The trusts community nursing team provided an effective bridge between the hospital and community based services. Service level agreements and care pathways included a handover period between this team and community based teams provided by other trusts.
- The service demonstrated flexibility by ensuring this process was in place for children outside the local region when required.
- There were clear protocols for supporting children and young people through transition into adult services. The transition was arranged in three stages 12-14 years; 14-15 years and 15-19 years.
- The transition policy identified that some young people attended school until aged 21, in these circumstances the transition process could be extended until then.
- Staff and patients g
- ave examples of flexibility within the processes outlined in the policy.

Seven-day services

- There was consultant paediatrician presence 7 days a week. Paediatric ward rounds occurred seven days a week.
- The out of hour's consultant telephone on call service ran from 9pm to 9am.
- 24 hour, seven days a week paediatric imaging and diagnostics was provided through sharing images electronically with on call paediatric imaging specialists out of hours.
- The community hospital nurses provided 7 days a week service 7am to 10 pm.

Access to information

- Clinical and nursing notes were mostly paper records and these were accessible throughout the day and night.
- The discharge planning protocol and check list included confirmation when general practitioners were informed of outcomes.
- Mothers were encouraged to use the red baby communication book on the neonatal unit.

Services for children and young people

- The policy for admission to the children's observation unit included giving general practitioners the opportunity to discuss concerns and treatment plans with the consultant of the week 9am to 7pm on week days.

Consent

- 20 members of staff told us they obtained consent from children, young people and their parents / carers prior to commencing care or treatment. Staff were aware of the principles of Gillick competence and the Fraser guidelines used to help assess whether a child had the maturity to make their own decisions and to understand the implications of those decisions. Staff used these where appropriate.
- We saw from records that consent was obtained from parents for each child or young person.
- 29 children and young people or their parents were spoken with and told us doctors, nurses and allied health professionals explained procedures fully before asking for consent forms to be signed.
- The children we spoke to during this inspection also told us the doctors had explained things to them directly in a way they could understand.
- Consent for surgery forms had been signed by parents.
- There was evidence application of Gillick competency assessment was fully understood by staff.
- Discussion with staff indicted staff needed additional instructions to help them understand how the mental capacity act 1995 applied to young people over 16 years of age.

Are services for children and young people caring?

Outstanding

The care was person centred and children and young people were treated as individuals and as part of a family. The trust was generous in their dealings with children and young people and their families.

Staff were both creative and flexible to ensure care met the needs of individual children and young people. Feedback from children, young people and parents was exceptionally positive.

Staff were passionate about delivering high quality care and went above and beyond their usual duties to ensure children and young people experienced high quality care

Staff were skilled in communicating with children and young people and kept them informed of what was happening and involved in their care. Staff were committed to working in partnership with children, young people and their families.

Compassionate care

- Children, young people and their parents spoke highly of the service received.
- During our inspection we observed excellent caring, respectful and compassionate interactions between staff, children, young people and their families, particularly in the outpatient clinics.
- Carers were supported to remain with children and put-up beds were provided to facilitate this as required.
- All staff spoken with were passionate about listening to the child or parent and working in a compassionate and caring way.
- We observed nurses providing tender care and treatment to babies whose parents were not readily available; interactions included cuddling and soothing conversation.
- We observed nurses, health care assistants, play workers and doctor's play with children in order to put them at ease or distract while carrying out procedures or interviewing parents.
- Privacy curtains were used to make sure the dignity of children was maintained and nurses and health care assistants acted as chaperones when doctors completed full physical examinations for babies at outpatient clinics.
- The wards and units for the service were child friendly environments, with pictures on the walls and windows. There were play rooms with toys suitable for children of varying ages.
- There was also an area for parents to make hot drinks free of charge and watch television.

Understanding and involvement of patients and those close to them

- Staff were committed to encouraging the involvement children, young people and their families in planning and delivering care and described different methods of providing information and promoting effective communication.
- Policies and procedures instructed staff to involve children and their nearest relatives in decisions about care and treatment. An example was the 'failure to thrive' procedure in which staff are instructed to specifically assess the primary carers ability to provide basic care, maintain safety, provide emotional warmth and stimulation and give guidance to their child. Additional support would be put in place if problems were identified.
- Staff confirmed patient and or parent involvement by recording conversations in the daily and clinical records.
- We witnessed staff explaining care, treatment and processes in simple easy to understand terms to parents, children and young people. Doctors and nurses used leaflets to help explain conditions and treatment to parents and children.
- We observed the expectations of children and parents being discussed during the handover of shifts between clinical and nursing staff.
- Children and young people were treated as individuals and positive relations developed. Staff were accessible and parents and young people told us they knew the name of the nurses, doctors, consultants and allied health professionals providing their care. Patients also told us they were known to doctors and nurses by sight.
- Every patient and parent spoken with described receiving a flexible, individualised service and many described instances when adjustments were made to help the child feel at ease with their plan of care.
- Carers described instances when the staff took the needs of siblings into account as well as those of the patient.
- Parents who remained with their children were provided with vouchers to use in the hospital canteen.

Emotional support

- We witnessed eight staff taking time to sit and speak with parents, children and young people and specialist nurses said they had received training to support children and parents coping with long term conditions such as diabetes and epilepsy.
- The trust had a service level agreement with a local hospice in relation to 24 hour emotional support for children with life limiting illnesses and their parents.
- Children and young people were referred to specialist support groups as appropriate and events were held to provide support for children with cystic fibrosis, diabetes and epilepsy.
- Children were treated with sensitivity for example separate rooms were available for CAMHS patients and appointments were extended to meet the needs of the young people. In addition a CAMHS specialist was available and would travel between Whiston and St. Helens hospital if required.
- Patients described been able to have extra face to face or telephone appointments with the specialist nurses if needed.
- Parents described sensitive care when their consultant changed because the original consultant mentored the new consultant and so the change-over felt seamless.
- An example of outstanding emotional and educational support is the annual residential activity weekend provided by the trusts children and young people's diabetes team and funded by the local support group and families run by the team. The weekend was staffed by the team and children and young people with diabetes and coeliac disease attended. The residential have been taking place since 1992.

Are services for children and young people responsive?

Good

The service was planned and delivered to be flexible enough to meet the individual needs of children, young people and their families. Services were tailored made with the specific needs and preferences of children and young people in mind.

The trust had made tremendous efforts to provide a safe and effective service to children and young people who required mental health services. The trust had also been a pioneer in providing an acute community nursing service for children.

Access to services was timely and the service responded appropriately to individuals when complaints and concerns were raised.

Services for children and young people

Service planning and delivery to meet the needs of local people

- The service participated in the national neonatal parent survey completed October 2013 – September 2014 (published March 2015) and devised a service action plan in response to the results. Services developed included the purchase of five dedicated breast feeding chairs and breast pumps for use on the neonatal unit. The infant feeding policy was also revised and a visit from the infant feeding team was increased to daily. Future plans include providing a communal sitting room for parents.
- The trust scored average when compared to England scores in most areas of the children survey completed in 2014. However the answers had been provided by the parents or guardians and not the children. The trust is to introduce a questionnaire or survey which will be more attractive and accessible to children and young people.
- There is an open access policy to ward 4F / 3F for children with long-term or life limiting illnesses. This ensures the needs for this group and their families can be met at all times.
- The trust reviewed the provision for children and adolescents with mental health needs and negotiated a service more tailored to meet the needs of this population. The service design included involving the trusts health and safety manager in developing an environmental checklist. Side rooms were checked and modified to reduce the risk of self harm; a part-time children and adolescent mental health service (CAMHS) nurse specialist was employed; a clear policy for referral to the specialist CAMHS team was developed and a service level agreement accessing the CAMHS urgent response team within 6 hours of admission 24 hours a day 7 days a week was negotiated.
- The service for CAMHS is on the paediatric risk register. Particular concerns continue to be raised through the electronic reporting system and plans reviewed to promote continued improvement in response.
- The provision is under continual multidisciplinary review and consultations have included taking advice from the trusts solicitors.
- A change in the commissioning of the service has meant a delay in replacing the nurse specialist when this person resigned their post. However the remaining service and the trusts efforts to respond to children and young people with a mental health need is exemplary.
- The trusts acute children's community nursing team (CNNT) provision based at Whiston hospital was an exemplary service demonstrating the trusts response to the needs of children and young people. This service ensured continuity of care and an integrated service between the hospital provisions, community based nursing teams, tertiary hospitals and school when required.
- The role of the CNNT service was highlighted in a number of paediatric and neonatal reports and standard operational procedures, demonstrating the value of this hard working team in relation to protecting children and promoting the delivery of safe and effective integrated care. One example included the safeguarding children activity report 2015 which identified the CNNT's role in admitting vulnerable children to hospital in keeping with the trusts 'Vulnerable infant' standard operating procedure.

Access and flow

- The outpatient clinic times included appointments after school and initial appointments were longer than usual.
- Admission processes were easy to understand and staff repeatedly said they never turned a child away and we saw protocols for transporting children to another local district general hospital as a part of the escalation policy.
- Systems were in place to ensure services were always delivered. We reviewed the trusts quarterly incident reports from January to July 2015 and no children and young people services, wards, outpatient clinics or other provision were reported as closed or cancelled during this time.
- Approximately 99% of children and young people attended an outpatient's appointment within 18 weeks of referral.

Meeting people's individual needs

- Policies and processes were in place for supporting the needs of children with learning disabilities and different learning abilities. Staff described their experiences of providing a flexible service in keeping with the policies and aim of the trust to enable timely and equal access to all.
- The trust subscribed to a language line to access translation services. Staff had ready access to the service which could be accessed immediately by phone or booked in advance.

- Parents told us they had used this service.
- The trust did not always use the translation service if a relative could translate. This is not best practice in relation to safeguarding and confidentiality.
- The trust offered choice and flexibility in relation to children and young people services. Choices included whether to be admitted on to a children's or adults ward and where to attend outpatient appointments. The choices available to children and young people and their carers meant individual needs were met.

Learning from complaints and concerns

- Staff were aware of complaints made and the learning as a result. Staff were keen to say there were very few formal complaints because the majority were dealt with informally.
- Records and reports provided evidence that informal complaints and concerns were always thoroughly investigated and the ward manager and other relevant staff would meet with the complainant to discuss each concern.
- Records also showed that complaints were reviewed individually and ideas for preventing a similar concern provided. This information was shared through team meetings and the paediatric directorate newsletter.
- An easy read format of the trusts complaints and concerns leaflet was available in the waiting areas of wards 3F and 4F.
- Staff would direct complainants to the patient advice and liaison service (PALS) if necessary. The PALS concerns and complaint audit recorded 23 complaints for the year 2014/2015 and, at the time of the inspection visit, nine complaints for 2015/2016 all were resolved informally.
- The Paediatric Department has processes in place for reviewing all complaints so as to identify themes and to share and learn from them.

Are services for children and young people well-led?

Good

The senior clinical and nursing leadership provided vision about the development of the children and young people service. All staff were committed to providing high quality care in line with the service strategy. The culture of the service was enabling and all the staff worked well together to achieve a common goal of high quality person centred care for children and young people using the service.

Individual staff were proud to work for the trust, enjoyed their jobs and felt valued and supported by senior managers. Senior managers took an interest in the staff and were accessible.

The trust needs to do more to enable children and young people to give formal feedback about the service and so influence service development. The trust also needs to make sure the opinion of staff in the neonatal and children and young people directorate is harnessed to ensure their ideas are considered.

Vision and strategy for this service

- The trust has developed the vision and strategy document 'Charter of Care 2014 -2017 for neonates, children and young people' this dovetailed into the trusts overall strategy and philosophy and is in accordance with the 6 C's outlined in the chief nursing officer for England in the national nursing strategy 2012. The 6 C's are: care, compassion, competence, commitment, courage and communication.
- Nursing, medical and allied health professional staff were knowledgeable about the strategy.

Governance, risk management and quality measurement

- There was a trust wide and a neonatal, children and young people risk register in place.
- The risk register was reviewed by the most senior executive medical, nursing and corporate executives monthly.
- The clinical director was aware of the actions taken to mitigate the risks at ward level and named the nurses directly responsible for day to day management at ward and unit level.

Leadership of service

- Staff stated leadership was visible and the clinical director and director of nursing spent time on wards 3F and 4F. We were told however that the director of nursing rarely spent time on the neonatal unit.
- The matron's office was situated adjacent to ward 3F.

Services for children and young people

- Staff described an open door policy in respect of communication with senior managers. This was facilitated with the clinical director and directorate manager through weekly one to one drop-ins.
- Non-Executive Directors had completed fact finding visits and attended nurses meetings.
- Staff said they had confidence in the abilities and philosophy of the executives and senior management team.

Culture within the service

- All staff said they liked working at the trust and there was effective team and interdepartmental working.
- Staff felt appreciated by the senior management team.
- We met staff who had worked at either St Helens or Whiston hospital for a long time, some as many as 40 years.
- These staff were open minded and concerned about ensuring a modern up to date paediatric service was provided.
- Staff were willing to adopt new practices to achieve continued professional development and enhance their knowledge and expertise.

Public engagement

- The trust supported the completion of the patient led assessment of the care environment (PLACE) which is based on the patient's perception and experience.
- Opportunities for informal comments from patients and visitors were not seen.
- Children and young people gave direct feedback about services, this was mostly informal. The exception been a formal feedback requested from children who went on the diabetic service weekend away.
- The clinical director and senior managers were in the process of sourcing a child friendly survey for children and young people using the service.

Staff engagement

- Staff felt able to express their opinions and raise concerns through unit and trust-wide forums.
- Staff completed the annual NHS staff survey however the result had not been broken down into directorates so the opinions of staff in the neonatal, children and young people service were not highlighted.

Innovation, improvement and sustainability

- The service recognised the need to provide robust succession plans and this was included on the risk register for the directorate.
- This was the area of concern identified by both recently employed and long standing staff ward and neonatal nurses. They felt skills of experienced staff had not been fully reviewed and so work place learning was not as valued as it could be.
- The senior managers and executives talked about the plans for future improvements including shared-approach pathways between different disciplines and ensuring a planned approach to introducing best practice care pathways.
- This reflected information in the trusts charter of care for neonates, children and young people 2014-2017.
- This charter could be improved if monthly or quarterly goals were set.

End of life care

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

Information about the service

We visited Whiston Hospital as part of our announced inspection on 18, 19 and 20 August 2015 where patients with end of life (EOL) care needs were nursed on the general wards.

We did not visit St Helen's Hospital to look at EOL care as the hospital deals with acute oncology and outpatients and is managed by the acute oncology team rather than the palliative/EOL service. Inpatient care for EOL is predominately delivered and managed at Whiston Hospital.

On the 18 August we met with the specialist palliative care team (SPCT) leader and the EOL care facilitator to gain an overview of the palliative and EOL service. The clinical team provides specialist advice and support as requested for patients on the general wards and in addition the EOL team advise, educate and provide a supportive role. The nursing team gain advice and support from the community consultant in palliative medicine for Knowsley, St Helen's and Halton and from the community consultant in palliative medicine and the hospice's associate specialist in palliative medicine.

There were 1553 deaths across the two hospital sites, Whiston Hospital (WH) and St Helens Hospital in 2014.

From April 2014 -July 2015, 1,109 patients had been referred to the specialist palliative care team.

During this inspection we visited 12 inpatient wards; wards 1A (general medicine), 1B (acute medical), 1D (cardiology). Wards 2B, 2C (respiratory), 2D (endocrinology/general medicine), 3C (trauma & orthopaedics), 4A, 4C (general surgery), 5A, 5B, 5C (care of the elderly) and A & E where EOL care may be provided. In addition we attended a multi-disciplinary meeting held at Willow Brook Hospice, visited the spiritual centre, bereavement office, the discharge lounge, hospital mortuary and the viewing room.

We observed care, looked at records for 12 people and spoke with eight patients, nine relatives and 36 staff across all disciplines, including doctors, nurses and health care professionals. We also spoke with members of the management team, porters, domestic staff, chaplains, bereavement team, engagement officer, patient advisory liaison service (PALS) and mortuary staff.

We also spoke with members of the hospital specialist palliative care team (SPCT) including the clinical lead for palliative care, the palliative care consultant based at Willowbrook Hospice, the end of life care coordinator and three clinical nurse specialist nurses from the SPCT. In addition we 'shadowed' a SPC nurse who provided treatment and symptom control for patients, support and advice for staff, patients and their relatives at the hospital.

We looked at appropriate policies and procedures as part of our inspection of this service. We received comments from people who contacted us to tell us about their experiences, and we reviewed performance information about the trust.

End of life care

Summary of findings

We gave the end of life care (EOL) services at Whiston Hospital an overall rating of good.

The palliative and end of life patient journey was supported by a strong Nurse led Specialist Palliative Care Team that worked closely with the ward based staff. There had recently been board approval to appoint a specialist consultant with recruitment underway.

We found that staff were committed to providing a good quality service that was delivered with compassion and dignity.

Staff were clear about their commitment to providing care that ensured patients ended their life in a dignified way in their preferred place of care. There were good systems in place for rapid discharge so that patients could return to their preferred place of care at short notice.

Patients were involved in their care, supported to make informed decisions and were provided with appropriate emotional support at a difficult time for patients and those close to them.

The trust had acted on the Department of Health's National End of Life Strategy recommendations and was introducing the amber care bundle which encouraged talking openly about people's wishes and putting plans in place should the person die.

The service had a work programme in place and wished to develop this into a future strategy for the service. The trust had a board member with a specific lead for EOL care to ensure scrutiny and challenge regarding performance at a senior level.

Staff spoke positively about the support they were given by senior staff and management.

Systems were in place to prevent patients suffering avoidable harm. Incidents were reported by staff appropriately, they were investigated, lessons were learnt and improvements made to the service as a result.

Patients' medication was well managed with the pharmacy team responding to requests promptly so patients received effective symptom control in a timely way.

End of life care

Are end of life care services safe?

Good

Staff were encouraged to report incidents and they were knowledgeable about the incident-reporting process. Learning from incidents took place within the SPC team at meetings and for staff at ward level.

Anticipatory end of life care medication was prescribed appropriately. Training for equipment used specifically by the SPC team; for example the use of syringe drivers was part of mandatory training.

Following the recent new recruitment of a clinical nurse specialist the staffing level for the SPC team was sufficient to meet the needs of patients.

There was a palliative consultant medical staffing vacancy which was recorded on the trust risk register; The trust confirmed recruitment was underway at the time of our inspection.

Staff were clearly aware of their role and responsibilities in relation to safeguarding.

Training was provided by the end of life care facilitator and via electronic educational packages. Some concern was raised about the need for an additional educator to assist in rolling out the amber care project across the trust which supports staff in the identification of patients who may require intervention at the end of life.

Out of the twelve DNACPR forms reviewed at Whiston Hospital eight had been completed appropriately. We saw some clear record keeping on the forms and in patients' notes of the reason why the decisions were made, with involvement of the patient or a family member and the involvement of an appropriate clinician. Some of the shortfalls we noted included; documentation not countersigned by a consultant, gaps in timing between junior doctor and consultant's signature and no use of an identity stamp.

There was currently no joined-up system for information sharing. The clinical network group had plans in place to address this; however there was no specific date for the introduction of the electronic palliative care co-ordination systems.

Incidents

- Staff were encouraged to report incidents and they were knowledgeable about the incident-reporting process.
- Staff spoke with us regarding a serious incident that had very recently been reported in relation to a patient and the use of bed rails. We spoke with the ward sister and the relatives of this patient who were still visibly distressed regarding this issue. Relatives advised us they had been given feedback in an open and honest way. Another incident reported on the trust datix system had been an error regarding opiate prescribing for a patient. In response to this incident there had been increased monitoring of prescribed medications checked by pharmacists and an increase in displaying the anticipatory medications on the mouse mats as a reminder and prompt for staff.
- Any serious incidents would be discussed at ward meetings and these would be raised at the EOL steering group and business team meetings where safety was a standing agenda item.
- Mortuary staff would complete an incident form if they had any concerns regarding either the moving and handling or presentation of a deceased patient or regarding correct identification procedures. We were made aware that following an incident around the transfer of a bariatric patient to the mortuary, a new mortuary vehicle with moving and handling equipment had recently been purchased to improve this service.
- Staff working in the mortuary service gave us an example where practice had changed as a result of learning from incidents of harm or risk of harm being reported and investigated. Staff had stopped using the top storage shelf in the fridges due to the risk of patients' bodily fluids leaking and for safe handling /access of patients by staff.
- Staff reported they received feedback and were alerted to any themes from incidents. Minutes from the EOL steering group showed incidents were recorded and discussed for any learning to be shared.
- Medical staff we spoke with demonstrated an understanding of their individual responsibilities in relation to the duty of candour and an awareness of the trusts policy to be open and candid with patients and families about incidents. This involved medical staff being supported to be open and honest with patients and apologise when things go wrong.

Medicines

- The service had performed within the England average national for the prescription of medicines for the five key symptoms at the end of life. (National Care of the dying audit 2014)
- Anticipatory end of life care medication was prescribed appropriately and nursing staff reported that EOL medication was well managed with the pharmacy team responding to requests promptly so patients received effective symptom control in a timely way.
- Four of the six specialist nurses were nurse prescribers where they are granted supplementary and extended prescription rights to assist medical personnel relating to patients who are receiving palliative or EOL care. This was good practice as it enabled nurses to give symptomatic relief without delay. We reviewed eight medication administration record charts in a number of wards we visited and found appropriate prescribing.
- Staff were aware of how to use the syringe drivers effectively. This included checking the needle site, battery and volume of infusion remaining in the syringe. The use of syringe drivers was supported by regular and on-going staff training. We observed a staff member changing the syringe driver on Ward 3C and saw that staff followed the policy and managed controlled drugs in accordance with the controlled drugs in accordance with the controlled drugs regulations 2013.
- Medical staff followed the trust's clinical guidelines on anticipatory medication prescribing. In addition they were provided with advice and support from the specialist nurses. Information was included in a handbook on prescribing guidelines, on mouse mats and laminated sheets that staff confirmed were useful.
- In 2011, the National Patient Safety Agency recommended that a particular range of syringe drivers should be removed by the end of 2015. Alternative syringe drivers were provided in accordance with this guidance. Staff reported syringe drivers could be secured from the equipment store when required.
- A pharmacist for EOL and Parkinson's disease described how they reviewed the medication charts and tended to add in the safety factors around prescribing prioritised medication for EOL patients who were being discharged at short notice. The pharmacist confirmed they had been in receipt of training on the ICCR and on EOL medication.

Records

- The service used paper based patient records. The hospice had an electronic note system however this was only available as read only in the hospital.
- Work has been undertaken by the trust following the review of the Liverpool Care Pathway and the decision to withdraw it in July 2014. The 'individual care and communication record for the patient who is dying and those important to them' (ICCR) was the tool used to support the multi-disciplinary team. This was piloted from January 2015, feedback forms were analysed and following some amendments was implemented across the trust.
- Of the nine patient records we looked at, the documentation was accurate, legible, signed and dated. A new junior doctor confirmed the SPC team member had showed them the ICCR and stated that the SPC team were good at completing the documentation.
- The records were structured and legible and were accurately maintained. The records included a daily review, pain relief and the patients preferred place of care. Records confirmed staff involved and updated relatives where possible.
- The patient's spiritual needs were also recorded and the documentation provided staff with prompts to ensure that patients and those close to them were involved in care planning.
- We observed patients were nursed on appropriate pressure relieving mattresses in line with their clearly recorded risk assessment. Four mattresses we checked were appropriate to meet patients' needs.
- The trust had a 'do not attempt cardio pulmonary resuscitation' policy which was available to staff on the intranet. The trust acknowledged some concerns around patients being followed up in the community when discharged. We found eight out of twelve DNACPR forms at Whiston hospital had been completed appropriately. We saw some clear record keeping on the forms and in patients' notes of the reason why the decisions were made, with involvement of the patient or a family member and the involvement of an appropriate clinician.
- The shortfalls we noted included; documentation not countersigned by a consultant, lack of recording of formal mental capacity assessments within the medical notes, gaps in timing between junior doctor and consultant's signature and no use of an identity stamp.

Medical staff were able to describe the procedures for DNACPR forms. Relatives of patients at the end of life told us their relatives' resuscitation status had been explained to them prior to completion of the DNACPR.
- The trust acknowledged the need to ensure training was ongoing to ensure staff were consistent in completing these forms.
- We found patients' records were stored securely on wards to maintain confidentiality and appropriate access.
- A paper based recording system was in place in the mortuary to record patients admitted, kept appropriately and to record the deceased being taken from the mortuary by undertakers.
- We found that SPCT contact with patients and relatives was clearly documented in the case notes. We found examples of decision making being clearly documented including details of progress with fast-track and continuing care referrals.
- Staff in the mortuary service kept accurate records on paper and electronically. Records showed that patients were admitted correctly and that deceased bodies were located appropriatley.
- Undertakers signed release forms before removing bodies from the mortuary.
- Mortuary policies and procedures included 'procedure for care of the deceased', 'disinfection policy' and a policy for viewing the deceased. This included respecting people's privacy and dignity and meeting their faith requirements. Records showed equipment was well maintained and serviced.
- Staff had guidance on how to reduce the risk of infection when caring for people after death. They kept records of mortuary fridge operating temperatures.

Safeguarding

- Policies and procedures were accessible to staff electronically for safeguarding vulnerable adults and children.
- Staff received mandatory training in safeguarding children and vulnerable adults that included aspects of the Mental Capacity Act 2005 and Deprivation of Liberty safeguards. Staff we spoke with confirmed they had attended mandatory safeguarding training for both vulnerable adults and children.
- Staff were knowledgeable about their role and responsibilities regarding the safeguarding of vulnerable adults and were aware of the process for reporting safeguarding concerns and allegations of abuse. Staff told us they felt confident and supported to raise concerns or to make safeguarding referrals as necessary.

Mandatory training

- Staff in the SPC team were up to date with their mandatory training that was part of an annual rolling programme. Mandatory staff training included the use of syringe drivers as part of an intravenous drugs course for qualified nursing staff.
- Staff training and education for managing the care of patients at the end of life had been provided on an ongoing basis by the SPC team who were training staff in the 'individual care and communication record for the patient who is dying and those important to them' (ICCR).
- Training related to 'one chance to get it right' and included a classroom and interactive session. This training had recently been extended to social workers, occupational therapists, physiotherapists and hospital porters.
- Electronic educational packages for DNACPR, communication skills, palliative care and oncology were readily available. This training was mandatory for junior doctors and band 5 nurses caring for oncology patients. There was currently no data on the uptake of the electronic training. There was some concern raised by the SPC team, doctors and ward staff that training in EOL should be mandatory throughout the trust and was not.
- Medical staff who were new to working at the trust were identified at induction as requiring EOL training and the medical staff we spoke with confirmed this.
- Staff providing end of life support reported to us that a business case was being put forward to employ an additional facilitator to continue training and take the lead for the implementation t of the amber care bundle.
- This project supports staff in the identification of patients who may require intervention at the end of life. The post of a facilitator who was implementing the amber project has ceased and not yet been replaced.

Assessing and responding to patient risk

- Staff used an early warning scores system to alert nursing and medical staff that the patient's condition

had deteriorated. Patients' documentation would be transferred to a care of the dying care plan when the recognition was the patient was expected to die within hours or a few days.

- Ward staff had contact details for the SPC team and confirmed the team responded promptly when needed.

Nursing staffing

- Staffing for EOL care was the responsibility of all the staff and not restricted to the specialist palliative care team. The SPC team included a lead nurse, four whole time equivalent clinical nurse specialists and an end of life facilitator and administrative support. Staff told us their workload was manageable.
- Ward staff told us they always prioritised care for a patient who was EOL and did what they could to ensure a staff member was with them at all times.
- The wards had two or three link nurses for EOL care who were responsible for some additional teaching on the wards particularly around the use of the ICCR and providing support as and when needed.
- There was a preceptorship development programme for newly qualified. Four nurses we spoke with confirmed they had received training in the ICCR and felt they had received some good training in relation to end of life care.

Medical staffing

- The trust's own specialist consultant in palliative medicine was seconded to another role at the time of inspection. We had concerns there was limited medical input to the specialist palliative care team. Cover was provided by the community consultant in palliative medicine for St Helen's, Knowsley and Halton who provided five sessions per week at the hospital. In addition the hospice's associate specialist provided two sessions per week. We were told this was not always sufficient and the palliative care service would benefit from a full-time consultant.
- We raised this matter with the trust at the time of our inspection, the trust confirmed that the appointment of an additional consultant had received board approval and recruitment was due to commence.
- The trust had recorded on the risk register the concerns regarding the lack of a palliative medical consultant that had an impact on the progress of improving the quality of EOL care at Whiston Hospital.
- The SPC team had a daily handover which was chaired by the assistant medical director at Willowbrook Hospice to discuss patients and caseloads whereby patients referred to the SPC team were given a plan which can then be communicated to the patients.
- A specialist palliative care telephone advice line for out of hours was provided by the local hospice. This was answered by a nurse and referred to a consultant if required.
- Three junior doctors who were new to the trust told us they had undertaken a formal induction. They had completed ICCR training and were feeling well supported in their roles. They found the aide memoires provided by the trust regarding recognising the dying and prescribing guidelines useful tools specific to EOL care for patients.

Major incident awareness and training

- There was a trust major incident plan which listed key risks that could affect the provision of care and treatment.
- Staff received mandatory training in fire and health and safety where they were also instructions and guidance to follow in the event of a major incident.
- The mortuary team had a major incident policy. The senior technician for the mortuary talked with us about these arrangements and the actions that would be taken in such circumstances.
- A senior mortuary technician confirmed the arrangements and actions that would be taken if there was a surge in demand for refrigerated mortuary space. The service had arrangements in place for additional storage of deceased patients should this be required.

Are end of life care services effective?

Good

The service had replaced the Liverpool care pathway for the dying patient that was removed nationally in 2014. A replacement advanced care plan had been agreed via the network group. Training in respect of the new tool was being delivered across the trust.

End of life care

The service contributed to the national care of the dying audit hospitals to compare end of life care provision with that of other healthcare providers. There was evidence to show that action had been taken to improve the service as a result of the last audit.

Staff were clear about the trust's definition of EOL care and were aware of the support available from the SPC team.

Staff were aware and able to access support from the local hospice out of hours. The SPC team confirmed they were supported effectively and they had an annual appraisal.

Since 2014 the hospital had committed to the implementation of the amber care bundle. The care bundle was aimed at encouraging patients and families to continue with treatment in the hope of a recovery, while talking openly about people's wishes and putting plans in place should the person die.

Following a review of the DNACPR forms we found staffs understanding of assessing people's capacity to make decisions about their care and treatment varied.

The service supported patients to be discharged to their preferred place of care either through fast track discharges to their home, a nursing home or hospice.

The SPC team currently met a 24 hour response times to see, treat or agree a treatment plan with patients over a seven days week.

Evidence-based care and treatment

- Care and treatment was provided was provided by the SPC team were working in accordance with NICE (national institute for health and care excellence) guidance and evidence based practice.
- The service and the specialist palliative care team had acted on the Department of Health's national end of life strategy recommendations. The amber care bundle had been introduced. The amber care bundle is a simple approach used in hospitals when doctors are uncertain whether a patient may recover and are concerned that they may only have a few months left to live. It encourages staff, patients and families to continue with treatment in the hope of a recovery, while talking openly about people's wishes and putting plans in place should the person die.
- The amber care bundle has been in place for two years and was currently being used on five wards with plans for additional training to ensure staff understood the differences between patients who were appropriate for the amber care bundle and patients who were at the end of life. 42 patients had been supported by the amber care bundle since March 2015.
- In NCDAH 2013-14 the service had achieved four out of seven organisational key performance indicators. We saw evidence that action plans to secure improvement had been implemented for the three KPI's which were not achieved. The service was making progress in the implementation of the action plan.
- At the time of this inspection the EOL facilitator told us that five wards were currently using the amber care bundle, there were plans to roll this out to additional wards over the next 12 months, however the facilitators post had ceased and there were currently no plans to replace this position.
- The new advanced care plan the 'individual care and communication record for the patient who is dying and those important to them' (ICCR) was the replacement advanced care plan which was agreed via a cross organisational group and training was being delivered. The care plan included a section to ensure patients' spiritual needs were assessed and recorded in line with NICE guidance for EOL care.
- The palliative care clinical nurse specialists had access to current, relevant literature and used evidence-based research to underpin their clinical practice. All staff in the SPC team undertook within their role some responsibility for the training and the development of staff.
- We saw clear guidance displayed on the information boards of wards on the model the trust were using in caring for patients relating to end of life care.

Pain relief

- Providing effective pain relief for patients receiving EOL care was a critical part of the SPCT's role. In 2013-14 SPC staff had attended courses in symptom control and non-medical prescribing to ensure patient's received appropriate advice.
- Following a pharmacy department opioid audit in 2013-14 a leaflet has been developed providing patients with more information about opioids in palliative care. This leaflet supported NICE CG 140 (opioids in palliative care), "When offering pain treatment with strong opioids to a patient with advanced and progressive disease "Provide verbal and written information on strong opioid treatment to patients and carers".

End of life care

- The NCDAH in 2014 showed that clinical protocols for the prescription of medications prescribed for the five key symptoms that may develop at the end of life were in keeping with the English national average.
- Appropriate medication was available for the ward staff to use and we saw that anticipatory prescribing was managed well. This was then clearly recorded in the notes and on the 16 medication charts we looked at. The patients and relatives we spoke with told us their or their relative's pain relief was managed well.
- The new care plan included a 'pain core care plan' which prompted staff to seek medical or specialist palliative care if patients' pain remains uncontrolled or side effects problematic.
- Doctors we spoke with were aware of the practice guidance available to them and were able and confident in contacting the SPCT for advice.

Nutrition and hydration

- Care plans included an assessment for oral nutrition and hydration and indicated patients should eat and drink normally for as long as possible despite this need reducing as people approached the end of their life. A mandatory core care plan was included with interventions for staff to appropriately support patients with eating and drinking. We saw evidence of patients nutrition and hydration needs having been discussed with patient and those close to them so that dietary preferences could be met.
- The advanced care plan includes clear guidance that patients should not be denied food and oral fluids. On the wards we visited we observed patients had ready access to fluids.
- We observed a patient who was provided with subcutaneous fluids to maintain an optimum level of hydration and comfort for them.
- The care plan included principles to guide the staff in their ongoing assessment; including ensuring regular mouth care was given, considering thickened fluids and involving those close to the patient in decision making.
- Patients we spoke with were positive about the availability and choice of suitable and nutritious food and drink and access to regular hot and cold drinks.
- The SPC nurse specialists had access to speech and language support for patients at end of life care as required. In addition the team were able to access to support from dieticians. Patients' records demonstrated that end of life patients' hydration and nutritional needs were considered and met.

Patient outcomes

- At the time of this inspection the trust were in the process of completing round five of NCDAH. The actions taken as a result of the 2013-14 NCDAH audit were monitored to demonstrate service improvement.
- The service was not currently working towards the gold standard framework. This is an independent accreditation for end of life care.
- The new 'individual care and communication record for the dying person' care plan had been introduced in a phased roll out, trust wide following a pilot phase to replace the Liverpool care pathway with effect from January 2015. In the weeks of its availability care plans had been used. A baseline audit of its use was piloted from January 2015 and evaluated against its use in 20 cases. A further audit was planned to assess its effectiveness.
- The service supported patients to be discharged to their preferred place of care either through fast track discharges to their home, a nursing home or hospice. Fully supported rapid discharges could be arranged in 6 hours.
- The SPC team provided guidance and support as required. The patient and those close to them were involved in the discharge planning process to facilitate a reduced length of stay and enable the patient to be cared for in a place of their choice.
- Monitoring of the discharge pathways was undertaken to evaluate the effectiveness of fast track discharge of patients known to their preferred place of care.
- The SPC team were auditing their service to assess compliance with good practice standards. A retrospective case note audit to establish if early referral to and assessment from the hospital SPC team had an impact on the length of stay in hospital had been completed in 2015. In addition other retrospective audits included an audit of triage referrals, discharge back to ward team and a response to referral audit. The response to referral audit for 2014 showed that out of 1084 referrals to the SPCT, 100% of patients whose notes had been audited were seen within 24 hours.
- The SPCT received emails twice a day to 'alert' the team about a patient who has been admitted whom they may

have seen previously. This supported the SPC to be able to provide continuity of care. Patients in the community were put on a ‘hospital alert’ system when it was thought appropriate.
- Patients identified as requiring EOLC received input from specialist respiratory, lung or gastro-intestinal nurses as necessary.

Competent staff

- Staff in the SPC team had an annual appraisal which they told us worked well and as a small team they had the opportunity to raise and discuss any problems with each other. At the time of the inspection 77% of staff had completed their appraisal.
- The specialist palliative care team were well qualified and attended relevant courses to extend and update their knowledge and skills. Staff confirmed team education and training was provided by the medical staff, for example weekly meetings were held which included reflective practice and learning.
- Training had been delivered in ward areas by the EOL facilitator and the specialist team. Ward staff spoke enthusiastically about the training in the new care plan they had received and how this supported them to provide good EOL care.
- Although wards had ‘link ‘palliative /EOL nurses we did not have evidence of how effective this role was and how these staff were trained and supported to carry out this role. Comments from a number of staff were about link nurses being unable to regularly attend the meetings due to the demands on their time on the wards.
- Staff within the SPC team had the opportunity of monthly clinical supervision to support them in their role, however this was not mandatory. All staff had received an appraisal in the last 12 months.
- Ward staff confirmed the SPC nurses came to the wards upon request and provided support as necessary to EOL patients.
- There was an effective induction for new staff in the specialist team. The induction included a trust wide and role specific induction where they shadowed an experienced member of the team and spent time with the consultant at the hospice, in the community and at the hospital sites. In addition the SPC nurse observed the practice of the Whiston site specific clinical nurses, for example upper gastro-intestinal, lung and oncology specialist nurses. Staff confirmed their induction was a positive experience and they were supported by peers and management.
- We looked at the development plan for a new starter which included gaining experience in a number of areas for example; symptom management, pain, nausea and vomiting, palliative care emergencies.

Multidisciplinary working

- The trust showed commitment to improving and developing EOL care across St Helens and Knowsley and more widely to Cheshire and Merseyside via the EOL steering group.
- Multi-disciplinary team meetings were held to discuss patients’ individual care to coordinate and plan the care for patients at the end of life. The SPC care team held weekly MDTs. Attendance consisted of nursing, physiotherapy and occupational therapy staff, chaplain, medical staff from the hospital, community and hospices. Minutes confirmed this.
- In addition daily MDT meetings were held on the medical wards to discuss and manage patient risks and concerns. Patients at the EOL were included in this discussion so all disciplines could contribute to effective and consistent care for patients at the EOL. The nine care records we reviewed confirmed that wards held MDT meetings and agreed on plans for patients.
- The speech and language therapist and dieticians did not attend MDT meetings routinely however they were in frequent contact with the nurses to provide guidance and advice.
- We observed the weekly cross site MDT meeting at Willowbrook hospice where new patients referred to the team were discussed and their plan of care.
- Requests for input from the SPC team were made by the staff by phone or paper referral.
- The chaplains visited the wards daily and received referrals from staff for any specific requests. The chaplain would provide spiritual or general support as requested from the patient.
- The SPC team worked closely with respiratory, care of the elderly and stroke specialities. The team have strong relationships with cancer and non-cancer specialists and the acute oncology team.

End of life care

- There is not currently an electronic palliative care co-ordination system available but this is not implemented properly with all potential users and across all sites.

Seven-day services

- Ward staff told us the specialist palliative care team was a responsive, supportive service.
- The SPC team offered a seven day Monday-Friday 9am to 5pm service on the Whiston site. For advice out of hours there was a 24 hour telephone hospice hotline providing nurse and medical advice.
- The consultant worked across boundaries and is part of a seven day a week rota.
- Staff reported there were no issues in accessing diagnostic services which were available 24 hours a day, seven days a week.
- We spoke with a senior medical doctor who told us seven day working was effective and gave an example whereby joint working had resulted in the rapid discharge home for a patient recently over a weekend.

Access to information

- The hospital intranet provided information and guidance for staff. Information included guidance on referring patients, including those requiring symptom control, links to hospices and 'just in case drugs'. Staff felt this was a useful resource that was easy to access.
- Information and guidance was also available from the SPCT and the local hospice out of normal working hours.
- There was a pathway in place for the transfer of care from hospital to community services. The links with the hospice enhanced the relationship across the community.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards(DoLs)

- The trust had a consent policy in place. The policy included advanced decisions, lasting power of attorney, mental capacity guidance and the use of independent mental capacity advocates where necessary.
- For three of the DNACPR forms we saw, the record showed patients where a mental capacity decision was recorded on the form itself and in their notes. This included family involvement. In addition, a copy had been forwarded to the patient's GP.
- Ward staff confirmed they had attended training around the mental capacity act including DoLs and best interest decisions.
- The mortuary service had sound arrangements in place for obtaining consent for tissue removal after death.

Are end of life care services caring?

Good

End of life care services were provided by compassionate, caring staff. Staff at Whiston hospital were sensitive to the needs of patients who were approaching the EOL. Feedback from people who used the service was positive about the way people were treated. Patients received compassionate care and their privacy and dignity were respected and maintained.

The SPCT was committed to providing patients with sensitive, caring and bespoke care.

Patients and those close to them were positive about their interactions with the SPC team. Patients felt their individual needs were met in a professional, sensitive way.

Staff were observed spending time talking with patients and providing comfort and reassurance. Relatives and those close to the patient were encouraged to be involved in their loved ones care.

The staff recognised the importance of identifying patients approaching the end of life in a timely way so that that the patient and those close to them would have a more positive experience at a very difficult time.

There was a purpose built dedicated bereavement office providing a best practice service with regards to providing pre and post bereavement care.

The SPC team were committed and enthusiastic to improve EOL care.

Compassionate care

- Patients were treated with dignity, respect and compassion. Staff were caring and patient centred.
- Staff understood the need for sensitive communication for patients who were approaching the EOL.

- We observed patients on wards who looked well cared for and interactions between staff and patients were caring and respectful. We spoke with relatives of patients who spoke positively about the care of their relatives.
- Relatives spoken with confirmed they generally stayed in the side room with their relative and had been provided with a mattress or small bed.
- Staff demonstrated flexibility and kindness when meeting a person's wishes. Examples included; the staff had facilitated a relative to bring in a patient's pet cat prior to their death to provide comfort to them, prayer mats were provided for relatives in a side room to support their religious needs and a patient had found great satisfaction in having their hair washed despite being bed bound.
- Training in communication skills was provided to staff from the SPC team developed in response to NICE guidance. The SPC team had attended advanced communications training. We spoke with an experienced ward sister who told us how she took junior nurses with her when she had difficult conversations with patients and relatives to support their learning and development.
- On the wards we visited we saw where families were encouraged to participate in aspects of care of their loved one, for example, wiping their face and providing mouth care. On more than one occasion we alerted the nursing staff to attend to patients to make them more comfortable, we raised our concerns at the time with the nursing staff as to whether patients were being monitored frequently enough so staff were satisfied patients did not require a position change, mouth care or bedding change. Staff acted swiftly to the patients' needs on these occasions.
- Staff told us of the practical support they were able to provide for relatives, examples included normal visiting times being waived and car parking permits were provided for ease of access.
- Patients' records showed discussions of sensitive conversations had been held with patients and relatives.
- We visited the mortuary and the staff we spoke with demonstrated an exceptionally caring attitude to deceased patients and their relatives. There were two family rooms where relatives could view their deceased relative if they wished.
- A detailed procedure for care after death was documented in order to ensure that all spiritual and physical care was carried out to ensure in accordance with cultural and religious beliefs of the deceased and their family.
- Ward staff reported to us how respectful hospital porters were when caring for deceased patients before they were transferred to the mortuary. We saw that mortuary staff referred to the deceased in a respectful manner.
- There was a quiet room on most wards where sensitive conversations could be held and staff confirmed these were used to talk with relatives and patients.

Understanding and involvement of patients and those close to them

- Nursing and medical staff had regular conversations to keep people informed about their relatives care and condition.
- This was confirmed through conversations with relatives and recordings in patients' notes. Four patient's relatives told us they had been included in discussions and explanations about the progress of their loved ones.
- Staff were sensitive and supportive to patients and those close to them and recognised that this was a difficult time for patients and those close to them.
- Staff included patients and those close to them in the planning and delivery of care where it was safe to do so.
- Patients and their relatives felt involved in their care.
- The named consultant and nurse were written above patients' beds and relatives told us they had been given an opportunity to speak with them frequently.
- We observed staff speaking with patients living with dementia in a kind and sensitive way.
- A policy was in place to ensure potential tissue donors are identified and referred to the National referral centre. As part of EOL care healthcare professionals were identified as the point of contact for bereaved relatives about donation.
- The wards we visited did not use a coding system to discreetly identify patients who were EOL on their boards however this may be useful for visiting professionals.
- We spent time with the mortuary and bereavement staff. They explained the processes to support relatives following the death of a family member. This included help with registering a person's death. The bereavement office had a separate facility where relatives could grieve in private.

End of life care

- There were two 'family rooms' of different sizes for people to view their deceased. Although the situation had not arisen, neither of these rooms was wheelchair friendly. Staff spoke positively where they had supported a grieving family to 'celebrate 'the birthday of their loved one within the family viewing room.
- On the critical care unit, relatives were given a leaflet after the death of a loved one to explain procedures. Staff could take people's handprints as a keepsake. A rehabilitation nurse contacted relatives after bereavement to offer them support and the team organised an annual remembrance service.
- We observed porters transferring a deceased person from the ward to the mortuary in a dignified and respectful way, with an effective handling technique.

Emotional support

- Emotional support to patients and those close to them was provided by ward based staff and the SPC team.
- Staff provided patients and those close to them with emotional support in a sensitive and compassionate way.
- The hospital offered a comprehensive spiritual care service that provided spiritual support to patients and those close to them.
- The chaplaincy team was made up of ten people, Roman Catholic, Anglican or Free Church and covered a 24 hour service seven days a week providing support to patients, families and staff.
- The multi faith room was available for patients and those close to them as a place of quiet and reflection.
- The multi-faith room was used regularly for Friday prayers for the Muslim community.
- The volunteer service provided spiritual volunteers to support end of life patients as necessary. This demonstrated a caring and compassionate approach towards patient, relatives and staffs spiritual welfare.
- Chaplains accompanied families to the mortuary upon request to provide support at this difficult time.
- We spent time with the chaplain who informed us that they could call on spiritual leaders from other faiths as necessary to ensure patients religious wishes were adhered to.
- We spent time with the volunteer services manager. This service included specific volunteers to support the emotional needs of patients. Three patients we spoke with spoke favourably of the service provided.
- The 'national care of the dying 'audit (2014) reported that the trust was below the English average in access to information relating to death and dying. As part of this inspection we saw information including bereavement booklets were available to guide newly bereaved relatives. We looked at this and saw it did not contain the most up to date and accurate information, for example the viewing room was recorded as being a multi-faith room.
- Signposting for people to contact other support agencies was available on wards throughout the hospital, for example information about local hospices, cancer information guide, Marie Curie care.
- The bereavement office staff contacted each bereaved family and met them when they collected the death certificate and their loved ones possessions from the office. The office staff arranged an appointment at the register office for families to collect death certificates; this supported a better the experience for families at such a distressing time.

Are end of life care services responsive?

Good

EOL services were responsive to the needs of the local population and facilitated and supported a high standard of individualised palliative and EOL care to patients.

Although the strategy for this service had not been agreed or formalised there was direction and monitoring of the service in response to people's needs. The service aimed to improve and connect services to prevent patients having their care compromised with admissions and readmissions to hospital and recognised the patient's wishes and priorities.

The service was part of a clinical network, the network linked with other stakeholders specific to the EOL service.

The palliative and end of life patient journey was supported by the SPC team that worked closely with the ward based staff.

Patients relatives felt their loved ones received a good service in relation to end of life care. Patients could access advice, support and treatment 24 hours a day.

End of life care

The SPC team had a flexible referral process and ward staff told us the SPC team responded promptly to referrals. Patients' individual needs were met by ward staff and SPC team.

Services were planned to take account of the needs of different people. The trust had a rapid discharge service for discharge to a preferred place of care.

Bereavement services were well organised and responsive to people's needs.

The skills and commitment of the SPC teams provided support to ward staff in a responsive and timely way that met the individual needs of patients.

The team recognised their priorities as rolling out the amber care bundle across the wards, working with GP's in relation to recognising EOL, working with undergraduates and medical staff and nursing staff regarding the withdrawal of fluids and nutrition.

Service planning and delivery to meet the needs of local people

- The SPCT provided a timely and responsive service to patents. In almost all cases the Team responded to referrals in 24 hours. If the team were unable to make an assessment they would make contact with the ward staff to check if the patient's condition had deteriorated and whether urgent advice was necessary.
- The EOL facilitator did a daily ward round to speak with staff re concerns with any EOL or palliative care patients, review patients and offer staff support and informal training.
- The hospital provided a rapid discharge service for patients to be discharged to a preferred place of care (PPC). The SPC team supported the enhanced discharges where patients are discharged to a PPC in the last hours or days of life.
- In 2014 a retrospective study showed 30 patients were fast tracked to their PPC in six hours. There had been a significant increase in the number of patients referred specifically to the SPCT rapid discharge planning. The service was not currently auditing the PPC as the data base does not capture this information. The introduction of an electronic recording system was an agenda item at the steering group meeting and plans were being developed to capture this information in the future.
- The SPC team received referrals from 1109 patients from April 2014 to April 2015. Of these the majority (65%) of patients referred to the service in 2014/15 had a diagnosis of metastatic cancer, however the referrals from non-cancer patients had increased by 10% from the previous 12 months. This indicated the specialist services of the palliative care team were provided to an increasing number of non- cancer patients.
- There was a commitment to improving the service to provide efficient patient centred systems. From June to July 2015 the bereavement working group had audited the late notifications of hospital deaths and in August provided a report to show that 20% improvement had been made.
- Wards were looking to improve facilities for relatives; introducing some comfort measures for relatives of EOL patients as they were in the process of obtaining some additional beds for relatives to stay overnight. Relatives we spoke with told us they had struggled accessing a bed or mattress when they wanted to stay near their loved one.
- Four family rooms were available and relatives and friends were encouraged to stay overnight. We found the signage and contact details to access these rooms was difficult.
- Some contract funerals had been held for those people with no close family or who could not afford the cost of a funeral.

Meeting people's individual needs

- A decision making flow chart was readily available to aid staff in the 'identification of patients who are dying'. In addition, the amber care bundle was sometimes used as a signpost to ensure a holistic assessment was carried out to take account of people's individual needs.
- Care was then planned in an individualised way and in accordance with the personal needs of the patient and those close to them.
- Up to July 2015, 28 of the new individualised advanced care for the dying patient documents had been completed from April-July 2015.
- The hospital had a chapel and a multi-faith room which was accessible to patients, staff and visitors. Minutes of the EOL steering group confirmed plans to create a 'lit up tree' to encourage engagement with bereaved relatives.

End of life care

- Information about dementia was displayed on the ward notice boards, in addition the forget-me-not sticker scheme, a discrete flower symbol used as visual reminder to alert staff that patients living with dementia, may require more support and time due to their illness.
- We listened to a board round on one ward where the staff reviewed the patients and discussed the planning for the discharge for patients. Staff confirmed this was effective communication and enabled them to respond to the needs of individual patients.
- Mortuary staff demonstrated their awareness of and sensitivity to cultural and faith practices.
- Information leaflets were available on the wards we visited for patients about support services and the care they were receiving.

Access and flow

- Following referral the patient's needs were assessed and care planning was discussed with the staff clinically responsible for the patient's care. The SPCT would work alongside the patient's own doctors and nurses, whilst the overall care of the patient would remain with their own medical and nursing team.
- Three doctors told us they had made referrals to the SPC team via the telephone and had been given advice that supported the management of patients with difficult symptoms.
- Rapid discharge processes were in place in getting people to their preferred place of care prior to their death. Patients could be returned to their place of care with appropriate support within 6 hours.
- The trust database flagged when a patient known to the palliative care service was admitted to the emergency department. The SPC team were able to provide rapid intervention or advice and treatment and then returned to their preferred place of care.

Learning from complaints and concerns

- Relatives we spoke with knew how to raise concerns or make a complaint. The trust encouraged people who used services, those close to them or their representatives to provide feedback about their care. Information was available to inform patients and relatives about how to make a complaint.
- The team leader for SPC care would be made aware of any complaints about the specialist palliative care service. There were few complaints relating specifically to EOL care. Staff told us they tried to address any issues at local level before they became a concern.
- Any informal complaints would be dealt with on the wards. If necessary people would be advised to use the patient advice and liaison service (PALS).
- The PALS manager told us they met with patients and relatives to assist them in answering concerns or complaints. Relatives would be advised to discuss concerns with the ward manager and finally a formal complaint if concerns could not be resolved locally.
- One aspect of the bereavement officer's role is to identify family concerns and ensure these are resolved in a prompt and timely manner by the most appropriate professional.
- Any complaints relating to EOL were discussed at the strategy group and were used for multi-disciplinary teaching.
- A lesson learnt register was created by PALS and shared with staff teams involved following closure of a complaint.

Are end of life care services well-led?

Good

The service strived to improve the quality of life of patients and their families who face life threatening illness, by providing pain and symptom relief, spiritual and psychosocial support from diagnosis to the end of life.

The service was led by a strong and visible nursing team who provided good and timely support for both patients and staff.

It was evident that were committed to providing a high quality service to patients.

Leaders understood the challenges to provide good quality palliative and EOL care services across the trust and had plans in place to address them.

Staff were very positive about the direction and support the SPC team provided to them and to patients in their care.

Medical leadership was provided by a specialist consultant at the hospice who covered the community, hospital and

hospice. However, the service had recently secured board approval to appoint a specialist consultant to support and enhance service development going forward. Recruitment was underway at the time of our inspection.

Staff were clear about their commitment to ensure patients died with dignity in their preferred place of care.

The service was responding effectively to national initiatives and local demand in a prompt and timely manner.

Vision and strategy for this service

- The clinical director with responsibility for EOL care and the SPC team leader spoke to us passionately about the vision for the service. The lead nurse attended the Cheshire and Merseyside strategic clinical network that had a comprehensive work programme for 2014-16.
- The SPCT had a comprehensive work programme that they wished to develop in to an EOL care strategy.
- The work programme was based on the Cheshire and Merseyside citizens' charter that incorporated 12 key themes for EOL care and culminated in the vision that people in Cheshire and Merseyside were able to live well before dying with peace and dignity in the place of their choice.
- The work programme was aimed at improving and connecting services to prevent patients having their care compromised with admissions and readmissions to hospital.
- The SPC team had developed an implementation and education strategy to support clarity and focus regarding their objectives.

Governance, risk management and quality measurement

- There were systems in place to audit the quality of end of life services that were regularly monitored and reported from the wards to the board. The monitoring of complaints, incidents, audits and quality improvement projects were raised at board level.
- There was a clear line of reporting to the trust's chief executive and board members so issues within the service could be dealt with promptly and effectively.
- The service risk register included two risks identified, concerns about there being no palliative care consultant at Whiston Hospital and the vacancy for a palliative clinical nurse specialist. This nursing post had recently been filled.

Leadership of service

- The service was led by a stable and committed nurse team.
- The team provided effective direction and leadership within the EOL/Palliative care service.
- The SPC team were strong, visible and accessible. It was evident that were committed to providing a high quality service to patients and those close to them.
- Leaders understood the challenges to provide good quality palliative and EOL care services across the trust and had plans in place to address them.
- Staff were very positive about the direction and support the SPC team provided to them and to patients in their care.
- Medical leadership was provided by a specialist consultant at the hospice who covered the community, hospital and hospice. However, the service had recently secured board approval to appoint a specialist consultant to support and enhance service development going forward. Recruitment was underway at the time of our inspection.

Culture within the service

- The SPC nurses were passionate about their roles and told us how important end of life and palliative care was.
- Staff were proud of the work they did and were committed to doing the best for patients.
- Staff reported positive working relationships across all disciplines. There was a culture of sharing knowledge and expertise demonstrated through formal training and informal teaching opportunities.
- All staff we spoke with showed a positive attitude towards caring for patients at the end of life.
- The mortuary manager confirmed staff worked well together across disciplines and they had regular contact with pathology, porters, chaplains and bereavement staff to discuss and enhance the management of the service.
- Mortuary and bereavement staff understood that their roles and approach were an important part of the provision of good end of life care.

Public engagement

- The bereavement officer provided information packs to families when they came in to pick up death certificates which included an opportunity for feedback regarding the service.
- Patient surveys had been sent out for those who had been identified as being in the last twelve months of life and the returned information would be used to secure service improvement.
- The public had access to the minutes from the trust board meeting online which would help them understand about the hospital its performance.

Staff engagement

- Staff spoke favourably about the annual celebration of the achievements of the staff.
- Oncology and medical services received awards for recognition for their hard work at the 2014 event.
- The SPC team were actively engaged and supporting ward staff to use the ICCR.
- Staff were keen to support the wider implementation of the amber care bundle and improve patient experience as a result.

Innovation, improvement and sustainability

- The trust was working with the clinical commissioning groups to integrate and increase palliative care provision.
- The palliative care steering group were looking at joining the transform programme, a national programme that encourages hospital trusts to develop a strategic approach to reaching their aim to improve the quality of care.
- Improvement has been made for the provision for transferring bariatric patients to the mortuary on both sites.

Outpatients and diagnostic imaging

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

Information about the service

A range of outpatient and diagnostic services are provided at St Helens and Knowsley Hospitals NHS Trust. The trust holds on average 4163 clinics each month. The Trust has two hospitals where these services are offered Whiston and St Helens Hospitals. Whiston Hospital has an outpatients department located mainly on the ground level. In the twelve months prior to our inspection the trust offered 659,491 appointments, 234,725 of which were Whiston Hospital which was a 7% increase in demand compared to previous years.

The trust offers a combination of consultant and nurse-led clinics for a full range of specialities. The range of clinics included: burns and plastic surgery, dressing clinic, plastic surgery laser, medicine for older people, stroke, cardiology, dermatology, ear nose and throat (ENT), gastroenterology, urology, haematology, ophthalmology, oral surgery, orthodontics, pain management, diabetes, endocrinology, rheumatology and therapy services. There was also a phlebotomy service and a diagnostic imaging service. The trust provided a comprehensive range of diagnostic and interventional services to patients, including: general X-ray, CT Scanning, MRI scanning, and ultrasound.

The trust hosts the North West regional burns unit, with a plastic surgery day-case centre in the Holbrook Unit based in Whiston Hospital.

We visited several outpatient clinics at Whiston Hospital including: ENT, fracture clinic, cardiorespiratory, and therapy services. We also visited pathology, haematology, radiology and diagnostic imaging services.

During the visit we met with 53 staff including volunteers, nurses, technical and clerical staff, doctors and radiographers and other allied health professionals. We also spoke with 15 patients and two carers. We reviewed seven records, observed direct care in clinics and attended multidisciplinary meetings. We also offered special meetings for staff called focus groups and met with 28 staff.

Outpatients and diagnostic imaging

Summary of findings

Overall we found the services to be outstanding.

Cleanliness and hygiene was of a high standard throughout the hospital departments and staff followed good practice guidance in relation to the control and prevention of infection.

Staff were confident and competent regarding incident reporting and learning was used to improve practice.

The trust had electronic medical records that were easily accessible and readily available when patients visited the service. Information about a patient's treatment and care needs was obtained from relevant sources before clinic appointments to enable the service to meet the patient's individual needs. The electronic patient record enabled timely access to information and diagnostic test results during consultation that contributed to patients making fully informed decisions about their care and treatment.

Staff were aware of their role in safeguarding, a reporting process was in place, and staff knew how to escalate concerns regarding issues of abuse and neglect.

Patients attending the outpatient and diagnostic imaging departments received care and treatment that was evidence based and followed national guidance. Staff worked together in a multidisciplinary environment for the benefit of patients.

Staff were competent and supported by robust management systems to provide a good quality service to patients.

The service had been proactive in working towards providing seven days services within radiology and pathology services. The radiology department worked with external partners to provide twenty-four hour cover via a central hub with access to electronic imaging.

We observed many good examples of compassionate care with patients being treated in a highly respectful and considerate manner. The majority of patients said the staff had a good attitude, this was also reflected in a patient satisfaction survey.

We observed how staff interacted with patients in the outpatients and imaging departments. Reception staff were polite, friendly and helpful. We observed one staff member going out of her way to support a patient that had come from another department.

The radiology staff told us how they had supported a patient requiring several investigations and treatment by arranging all the treatment to be delivered at the same appointment in an attempt to reduce stress and discomfort.

There were examples of a clear pathway and assessment planning for patients with additional needs this to ensure they received appropriate support in a timely manner. This included the use of identifying the need for pre appointment visits to relevant departments to be arranged if required.

Leadership within the outpatient and diagnostic imaging service was very positive, visible and proactive. Managers had a strong focus on the needs of patients and the roles staff needed to play in delivering good care.

Managers had access to the trust electronic visual management information which allowed them view a range of information on how their own service was performing and to benchmark the service against others. This gave us assurance that the trust was proactive in monitoring the quality and governance of its services.

The outpatient and imaging services service had a clear vision regarding how they wanted to deliver services and develop the different sites to meet clinical need and demand.

The NHS friends and family test ranked the service as one of the highest in the country for extremely positive feedback received from patients.

The hospital had a range of forums to seek patients' feedback such as the "patient power" group.

Many of the departments we visited had awards on display and staff and patients were proud to show us what they had achieved. We saw many examples of national targets being shortened by internal targets to drive improvements throughout the service.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Incidents

- There were no never events (very serious, wholly preventable patient safety incidents that should not occur if the relevant preventative measures have been put into place) or serious incidents requiring investigation reported in outpatients and diagnostics for the period May 2014- April 2015. The service had a lower rate of incident reporting than the national average, however, all the staff we spoke with were confident and competent in incident reporting.
- The X-ray department had a duty to protect patients, visitors and staff from radiation by radiation safety laws, in particular the Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER). Eight incidents had been reported since December 2014 prior to our inspection.
- There was shared learning from incidents with a clear structure for sharing across the organisation including a “patient safety first” newsletter with specific safety alerts which was widely available for staff to read. The diagnostic imaging service had a record of all incidents reported and actions taken. We tracked an incident reported earlier this year which resulted in a patient receiving a higher dose of radiation than required. This had been reported and fully investigated and an issue with the machinery software was identified. We were able to review ongoing evidence that the trust had worked with national agencies and the manufacturer to learn from the incident and work to resolve the issues.
- We observed a change in practice following an incident relating to a delay in an abnormal X-ray finding being reported. Staff in the service were able to describe changes in practice which included a coordinator of the day (COD). In the event of a critical finding, an email alert was sent to the referrer and the COD. The COD is responsible for ensuring the email is read to reduce future delays in diagnostic reporting.
- Staff felt able to report incidents as there was a no blame culture in the organisation.
- Staff were aware of their responsibilities to be open with patients under the duty of candour regulations.

Cleanliness, infection control and hygiene

- The outpatient department was visibly clean throughout. Staff followed good practice guidance in relation to the control and prevention of infection.
- Staff were bare below the elbow in clinical areas as per NICE guidance on infection control.
- We looked at cleaning schedules throughout the outpatients and diagnostic imaging rooms. They were completed accurately.
- Clinic areas and departments were cleaned every morning and evening.
- Patient-led assessments of the care environment (PLACE) showed that the trust has achieved the best PLACE audits nationally for two consecutive years 2014 and 2015.
- Infection control training had been completed by 96.8 %staff, which was above the trust’s target of 95%.
- A patient survey was completed for two weeks in April 2015 receiving 394 responses. All patients said the clinic was clean, 99.7% (393) said the clinic was tidy and 80.7% (318) saw staff wash their hands or use hand gel.

Environment and equipment

- The hospital was newly opened in 2010 with purpose designed diagnostic and outpatient facilities.

The building had been specifically designed with one centralised building consisting of colour coded floors. The majority of outpatient and diagnostic services were easily accessible on the ground floor.

- Maintenance contracts were in place to ensure that specialist equipment in the outpatient and diagnostic imaging departments was serviced regularly and faults repaired quickly, for example the cardiorespiratory department equipment was serviced annually by the provider. Staff were trained to do routine maintenance and had a service contract if they are unable to resolve an issue.
- We examined the resuscitation trolleys located throughout the departments and found they were visibly clean and in good order, with all the required equipment available. We found that, in all areas except one outpatient area, the trolleys were checked daily with a more comprehensive weekly check.

- Staff confirmed that they had never been asked to use equipment they had not been trained to use. We reviewed a number of staff competency checklists completed demonstrating staff competence to use equipment.
- Regulations state that instructions must be visible to keep patients and staff safe in radiology departments. These are known as 'local rules'. We found theses were visible throughout the imaging services.
- There were processes in place for scheduled calibrations and quality checks of relevant equipment including blood gas machines.

Medicines

- There were clear systems in place for managing and dispensing medication to patients who attended the outpatient and diagnostic departments. Staff were aware of the processes and were able to show us evidence of in house training to administer medications such as eye drops.
- The limited amount of medication stored within the department was done so appropriately. Medicines were stored in locked cupboards and there were no controlled drugs or intravenous fluids held in the majority of outpatient departments. In the cardiology department controlled drugs were stored, administered and managed appropriately in line with trust policy.
- Lockable fridges were available for those drugs needing refrigeration; temperatures were recorded daily when the departments were open.
- Prescription pads were stored securely and appropriate use was monitored.

Records

- The department had adopted a paper light approach and utilised an electronic patient record system. As a result the service did not report any issues with availability of records or results being unavailable for patients. We noted that measures were in place to protect the access to the system to ensure privacy and confidentiality of information.
- A contingency plan was in place if the information technology system failed. We were informed by a junior member of staff and a senior manager that the system had not failed since being in place.
- Reception staff informed us that on occasions the booking system has planned down time. On such occasions they would use a paper system and then input information when the system is active to ensure that the patient appointments can go ahead.

Safeguarding

- Staff were aware of their roles and responsibilities and knew how to raise matters of concern appropriately. A staff member was able to describe how they had reported a safeguarding concern.
- Staff were trained in safeguarding as part of the mandatory training. Training statistics provided by the trust showed that 86% of diagnostic imaging staff and 96% outpatient staff had completed the required safeguarding training .This was above the trust target of 85%.
- Relevant policies and procedures were available electronically on the trust intranet for staff to refer to. Managers supported staff in escalating concerns in a timely and appropriate way.

Mandatory training

- The trust had a clear training needs analysis which identified mandatory training required which was role specific.
- Staff received mandatory training in areas such as infection prevention control, fire safety, moving and handling and safeguarding. Training was delivered either face to face or via e-learning. Staff were expected to keep themselves up to date with training as well as close monitoring by nominated staff throughout the service.
- Staff we spoke to said they were up to date with their mandatory training and told us they were supported to attend training. We observed the electronic service record dashboard, which recorded staff training figures, for general outpatients which identified 96% compliance. For diagnostic imaging staff the figure was 97%.

Assessing and responding to patient risk

- Reception staff were observed checking patients personal details when they entered the clinic providing a double check that they had the correct patient record.

Outpatients and diagnostic imaging

- There was a clear process to check the identity of patients in the outpatient and diagnostic imaging departments. This included a system for patients who were unable to confirm their own identity.
- Staff were trained in basic life support and had access to resuscitation equipment which was regularly checked and maintained
- The World Health Organisation surgical safety checklist for radiological interventions was in place in the imaging department. This is an accredited process by the National Patient Safety Agency and Royal College of Radiologists. The department have modified the checklist further and adopted a pause and check chart which provides an additional safety check prior to administering radiation.
- Staff had clear guidance to follow should a patient's condition deteriorate while they were in the outpatient department.
- Risk assessments were completed for patients who needed extra care during a procedure.

Nursing staffing

- Staff in the department worked across both hospital sites to meet the capacity and demands of the service. Flexibility of staff had resulted in low use of bank staff in general outpatients. Managers with responsibility for determining the correct staffing levels confirmed staffing levels and skill mix were determined by the number and nature of clinics running at any particular time.
- Managers were aware of the increase in activity and had carried out a recent workforce review. An action plan had been produced and was to taken to the trust executive team in the autumn for approval.
- Staffing levels were appropriate to meet the needs of patients. However there were specific examples of staffing pressures such as the specialist prosthetic service which was part of a nationwide shortage. Managers were proactive in managing staff shortages such as reviewing therapy staffing levels. This was done following the recent transfer of services into the service from another provider.

Medical staffing

- Medical consultants and other specialists arranged outpatient clinics directly with the outpatient department to meet the needs of their specialty.
- There was a robust arrangement for out of hours cover which the imaging service had implemented. This involved other providers managing the staffing levels and workload. This had reduced the need for locum cover.

Major incident awareness and training

- Staff were trained and able to describe their role and responsibilities should a major incident occur.
- The outpatient and diagnostic imaging service had been involved in an external organisation review of departmental major incident/business continuity plans and found to be compliant.
- A contingency plan was in place for staff to have access to patient information should the information technology system fail.

Are outpatient and diagnostic imaging services effective?

Patients attending the outpatient and diagnostic imaging departments received care that was evidence based and followed national guidance. Staff worked together in a multidisciplinary environment to meet patients' needs.

Staff were competent and supported to provide a good quality service to patients. Competency assessments were in place. Staff attended training to enable them to have the skills and knowledge to provide treatment and care.

The majority of staff we spoke with confirmed that they received one-to-one supervision/appraisal meetings with their managers on a monthly basis, which they found beneficial.

Information about patient's treatment and care needs were obtained from relevant sources before clinic appointments to enable the service to meet the patient's individual needs. Information was shared with GP's and other community services to improve continuity of care for the patient. The electronic patient record enabled timely access to information and diagnostic test results during consultation which contributed to patients making informed decisions about their care and treatment.

The service had been proactive in working towards seven days services. The trust operated twenty-four hour access for emergency care and diagnostics services.

Outpatients and diagnostic imaging

The radiology department worked with external partners to provide 24 hour cover via a central hub with access to electronic imaging, resulting in a timely review of images. There was 24 hour access for ECG tests and readings.

Evidence-based care and treatment

- Care and treatment was evidence-based and provided in line with best practice guidance. All the services we visited were able to show clear evidence of benchmarking themselves against national standards.
- We observed care being delivered that adhered to best practice including infection control, administration of radiation and the rapid access ear, nose and throat (ENT) clinic.
- Policies and procedures, assessment tools and pathways followed recognised and approved national guidelines. Staff were aware of how to access relevant policies and procedures via the Intranet for reference.
- Staff were given regular updates if and when guidance was reviewed or practice changed. The majority of staff worked across clinics on a rota basis, so they received all updates.

Pain relief

- Staff could access appropriate pain relief for patients within clinics and diagnostic imaging settings.
- Patients confirmed that pain relief was monitored for efficacy and changed to meet their needs where appropriate.
- Patients were given information about ambulatory procedures (minor procedures that can be performed in a clinic setting without the need for admission to a ward). They were offered a choice of pain relief for the procedure and appropriately supported with any symptoms afterwards.

Patient outcomes

- The service had key performance indicators for every service in line with national standards and targets. In every department we visited staff were aware of the target and the majority had set their own internal target.
- IRMER 2000 audits were conducted which showed that the service was complaint. Records of local audit demonstrated a high rate of compliance with good practice across the service including IRMER audits in the imaging department.
- The pathology service was compliant with the national clinical pathology accreditation scheme.
- The ratio to follow-up to new appointment rate at trust level for the St Helens and Whiston sites between January 2014 and December 2014 was higher than the England average.
- There was a clinical governance system in place and findings from clinical audits were reviewed at all levels of the trust.
- A range of local audits were carried out by different departments. This included general audits such as infection control.
- Minutes from team meeting showed that the audits were discussed by individual teams to share good practice and drive improvements. Patient outcome measures for the service had been published nationally including the regional burns team whose outcomes were above the national average and recognised as a regional centre.

Competent staff

- Staff were supported in their development through the appraisal process. We viewed the appraisal rates within outpatients and diagnostic imaging and found that the majority of staff had received a formal appraisal.
- There was evidence in a range of clinics and diagnostics imaging services that staff had met the competency requirements to operate equipment safely. Competency frameworks were in place these meant that staff undertook training and were assed in practice. Staff told us they were supported to access courses outside of the service to increase their knowledge to perform their role effectively. We saw evidence of role specific training being completed and then cascaded to other team members. The teams were skilled and knowledgeable about their specialist areas.
- We reviewed staff competency check lists completed and in date which showed staff were competent to operate specific medical equipment such as X-ray machines and other medical devices.
- All staff held the required professional registration and received notice when it was due to expire.
- Revalidation of doctors was routinely monitored through the specialist teams and at board level. The hospital had a good rate of validation, with all doctors being revalidated within the required time frame.
- The majority of staff we spoke with confirmed that they received one to one supervision meetings with their managers on a monthly basis which they found beneficial.

Outpatients and diagnostic imaging

Multidisciplinary working

- There were robust systems in place for working with external stakeholders. The services had close links with other provider organisations to share staffing and service planning.
- We saw examples of regular multidisciplinary team meetings held across a range of specialities and services such as imaging, rheumatology and ENT.
- Our observation of practice, review of records and discussion with staff confirmed effective multidisciplinary practices were in place.
- One manager in outpatients told us that calls from community staff were received advising outpatients of any special requirements for the patients so that plans to support them could be in place when they attended.
- Letters were sent from outpatients to GP's with a summary of the patients care. This ensured effective communication of care needs to support continuity for the patient.

Seven-day services

- The trust had been very proactive in working towards seven day services within the diagnostic imaging and pathology departments.
- The trust operated 24 hour access for emergency care and diagnostics services.
- The radiology department worked with external partners to provide 24 hour cover via a central hub which had access to electronic imaging.
- There was 24 hour access for ECG tests and readings.
- The outpatient clinics ran Monday to Friday, however patients had access to outpatient appointments at weekends on the St Helens hospital site.
- Seven day therapy services were implemented across medical patient pathways, with plans to extend across surgical pathways by April 2016

Access to information

- Patients were able to request copy of the dictation from their consultation to help understand information about their care.
- The imaging department had an electronic system that could be viewed from locations outside the hospital to enable prompt diagnosis.
- Information and test results were available at consultation via the electronic system
- Information was available to patients across a wide range of clinics including access to voluntary organisations
- No appointments had needed to be cancelled or rearranged in the last five years due to information not being available to the clinician.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We spoke with staff about the requirements of the Mental Capacity Act 2015 and found that they were aware of the requirements and were knowledgeable about how to ensure that people were treated appropriately.
- Before having a procedure undertaken in outpatients or diagnostic imaging services patient's consent was obtained verbally and recorded in their records. For biopsies or more invasive tests, consent for procedures was formally taken and discussed with the patient before starting the procedure. We saw evidence on the patient's records that consent had been gained in line with the trusts policies and procedures and paid due regard to issues of patient consent and capacity.

Are outpatient and diagnostic imaging services caring?

Outstanding

We rated the Outpatient and Diagnostic services outstanding for caring. Throughout outpatient and diagnostic services a caring culture was felt to be fully embedded wherever we visited.

Throughout our inspection we witnessed exemplary patient centred care being given. Services were delivered by caring, committed, and compassionate staff who treated people with dignity and respect. We observed many examples of compassionate care with patients being treated in a respectful and considerate manner. Patients said the staff had a very good attitude, and that they felt informed and involved in their care. These positive comments were reflected in a patient satisfaction survey completed in part of April 2015.

We observed how staff interacted with patients in the general outpatients and diagnostic imaging departments. Reception staff were polite, friendly and helpful. We found

many examples of staff and management working in partnership to constantly improve the patient experience. We observed one staff member going out of her way to support a patient who had come from another department.

Staff actively involved patients and those close to them in all aspects of their care and treatment. There were a range of support groups facilitated by the hospital that were available to patients and their families such as the diabetes support group. People were also encouraged to access the national support groups for a range of health conditions.

The trust had a number of clinical nurse specialists and lead nurses available for patients to talk with about their condition.

There was a strong, visible person centred culture and staff and management were committed to working in partnership to constantly improve the patient experience.

Compassionate care

- The privacy and dignity of patients was maintained throughout outpatient and diagnostic imaging services. Consultations were conducted in closed rooms which ensured that privacy and dignity was maintained. We observed many examples of compassionate care with patients being treated in a highly respectful and considerate manner. We spoke to eleven patients waiting in the outpatients department during one of our visits. All but one of the patients told us they had found the staff to have a good attitude and had found staff helpful, pleasant and approachable.
- A patient satisfaction survey was carried out during part of April 2015. The survey reported 394 responses were received. 100% of patients said they were treated with respect and courtesy.
- Reception staff were polite, friendly and helpful. We observed one staff member going out of her way to support a patient that arrived from another department. The staff member went back to the original department to gain more information and was observed keeping the patient informed. We observed a further three patients politely and helpfully being directed to the clinic areas.
- One patient told us that staff had “gone the extra mile.” When they had gone to St Helens Hospital for their appointment instead of Whiston by mistake the staff were most helpful. The staff rang Whiston Hospital outpatient department to explain the situation and the patient was reassured and asked to make their way to Whiston where the staff waited for them to arrive.
- We observed some instances where patients that attended clinic regularly had built good relationships with the staff that worked there.
- Staff could describe examples of how difficult messages were given to patients and those close to them both sensitively and privately.
- Chaperones were available to support patients during procedures if needed. Policies regarding chaperones were available on the intranet and in the office. Staff had received training for the role.

Understanding and involvement of patients and those close to them

- We found several examples of patients being involved in support groups. Staff actively supported patients to set up and manage support groups related to their condition.
- Patients received information about their care and treatment in a manner they understood and contributed to the development of a personalised care plan.
- Patients told us they were aware of their condition and that the doctors and nurses had explained this clearly to them. Patients told us they felt well informed about their care and treatment and could make informed choices.
- We noted that there were a number of posters available within the outpatient and imaging department areas with relevant information such as chaperoning and how to seek support.
- Each patient we spoke with was clear about what appointment they were attending for, what they were to expect and who they were going to see.
- There was evidence in the clinical notes that patients and their relatives were involved in making decisions about care and treatment.

Emotional support

- Staff told us about an occasion when a patient was attending the clinic but was known not to like large crowded places. They described how they had offered the patient a small side room to wait away from the other patients to ensure that they felt comfortable and supported.

- Staff understood that patients were at times emotional, anxious and worried. They provided reassurance and comfort in a personalised and compassionate way.
- The trust had a number of clinical nurse specialists and lead nurses available for patients to talk about their condition. For example diabetes nurses to talk with patients who had been referred for advice and support following the diagnosis of their condition.
- We found examples of access to local support and advisory groups to offer both practical advisory and emotional support to both patients and carers such as the diabetes support group.

Are outpatient and diagnostic imaging services responsive?

Good

The outpatient and diagnostic imaging services were responsive to patients' needs. Outpatient and diagnostic imaging services were offered at both Whiston and St Helens Hospitals to enable easier access for the population it serves. There was a free shuttle bus service for patients that ran between both sites.

Performance against national referral to treatment and cancer targets was very good. The trust was exceeding the national targets for referral to treatment. Clinics and diagnostic appointments were planned and arranged to meet both the needs of the patient and internal and national referral to treatment targets.

Referral to treatment percentage within 18 weeks for non-admitted and incomplete pathways were better than the England average and standard throughout the reporting period March 2014 to February 2015.

The number of patients waiting over six weeks for a diagnostic appointment was 2% better than the England average and was generally a zero return.

In order to improve the response time and access to timely treatment for a patient, if a critical or abnormal finding on an X-ray was seen designated radiology staff could book another follow up appointment with the appropriate specialist. This was seen as outstanding practice.

The radiology staff told us how they had supported a patient requiring several investigations and treatment by arranging all the treatment to be delivered at the same appointment in an attempt to reduce patients stress and discomfort. This was another example of very good practice.

There were systems in place to identify patients with a diagnosis of dementia to ensure they were appropriately supported when attending appointments. We saw examples of a clear pathway and assessment process to follow for patient with additional needs to ensure they received the appropriate support in a timely manner. This included the use of identifying the need for pre appointment visits to relevant departments to be arranged if required.

There was access to the loop system if any patients had hearing difficulties to improve the communication process.

There was evidence of learning from complaints and examples of how changes had been implemented following such complaints.

Interpreters could be arranged for patients whose first language was not English.

Service planning and delivery to meet the needs of local people

- Outpatient and diagnostic imaging services were offered at both Whiston and St Helens Hospitals to enable easier access for the population it serves. There was a free shuttle bus service for patients to that ran between both sites.
- The types and numbers of clinics offered in the outpatient department had increased to meet the demand in the area, and other services were being developed in response to patient feedback and consultation.
- Outpatient clinics were being offered several evenings a week for people to access outside their working hours
- There was no access to weekend outpatients however, once a month there were outpatients clinics held at the St Helens Hospital site.
- There had been a 7% increase in demand for the service and there were regular workforce and clinic reviews in place to plan to meet the demand.

Access and flow

- The outpatient department undertook 234,725 outpatient appointments during 2014/15.

Outpatients and diagnostic imaging

- Clinics and diagnostic appointments were planned and arranged to meet the needs of the patient. The trust met internal and national referral to treatment targets.
- Referral to treatment percentage within 18 weeks for non-admitted and incomplete pathways were better than the England average and standard throughout the reporting period March 2014 to February 2015.
- The trust was easily meeting the national six week target for patients waiting for a diagnostic appointment.
- The trust performed better than the England average during 2013/14 and 2014/15 for patients waiting less than 32 and 62 days for treatment. We found the trust was consistent with the England average for patients seen by a specialist within two weeks from 2013/14 to 2014/15.
- Waiting times for patients once they had arrived in the outpatient department was not routinely recorded however, we observed patients being seen within 20 minutes of their appointment time. Information provided by the trust from a patient survey carried out in April 2015 showed 261 patients out of 394 surveyed waited less than 20 minutes. Where there was a delay and clinics were running late patients told us they had been told by reception staff on arrival of the delay and the expected waiting time.
- In June to July 2015 a sample of 150,000 patients was taken who attended radiology they experienced an average waiting time of sixteen minutes from arrival to treatment.
- The did not attend rates (DNA) between January2014 to December 2014 were similar to the national average. The trust confirmed that this was being managed actively by the outpatient service utilising the patient contact call centre and use of mobile technology for follow-up appointments in an effort to engage with patients more effectively to ensure they attended their appointments.
- In a patient survey 90% stated they found it easy to find the clinic however a small percentage had stated that improving signs would make it easier.
- The radiology department had internal targets for providing reports following examination which was routinely being achieved. This meant that people had access to their reports in a timely manner to enhance the patient journey.

Meeting people's individual needs

- We were given examples by staff of how vulnerable or nervous patients were supported and adjustments were made to support their individual needs. One patient with complex needs who did not cope well in a crowded environment was offered a separate waiting area to alleviate any anxiety.
- The radiology staff told us how they had supported a patient requiring several investigations and treatment by arranging all the treatment to be delivered at the same appointment in an attempt to reduce patients stress and discomfort.
- In order to improve the response time and access to timely treatment for a patient, if a critical or abnormal finding on an X-ray was seen designated radiology staff could book another follow up appointment with the appropriate specialist .This was seen as outstanding practice by our specialist advisor.
- A language line was available if required and interpreters could be booked in advance if needed.
- There was access to the loop system if any patients had hearing difficulties to improve the communication process.
- There were systems in place to identify patients with a diagnosis of dementia to ensure they were appropriately supported when attending appointments. We saw examples of a clear pathway and assessment process to follow for patients with additional needs to ensure they received the appropriate support in a timely manner. This included the use of identifying the need for pre appointment visits to relevant departments if required.
- There were also water fountains, vending machines and an independent coffee house for refreshments.

Learning from complaints and concerns

- Complaints were handled in line with trust policy. Initial complaints were dealt with by the outpatient manager, who resolved them locally whenever possible.
- We found that Whiston Hospital had a low level of recorded complaints from August 2014 to July 2015.
- A total of 52 complaints were received with no complaints for radiology, rheumatology, sexual health and oral surgery.
- We saw evidence that changes were made following complaints investigations. A designated area for wheelchair users had been created following patient feedback about lack of room in the outpatient area.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services well-led?

Outstanding

Outpatient and diagnostic imaging was led by the outpatient and diagnostic imaging managers who reported directly to the executive team.

We found a clear and effective governance structure that promoted a high level of staff confidence. Risks were clearly identified and actioned appropriately ensuring a transparent audit trail.

Overwhelmingly staff we spoke to from a range of different roles and grades were aware of the trust's vision and values.

Staff had full confidence in both the trust executive leaders and local managers. They were very positive about support from their local managers and seeing the chief executive as very visibly and accessible. We observed that the outpatient and imaging services managers had a clear vision regarding how they wanted to deliver a service and develop the different sites to meet clinical need and demand.

Throughout the service the departments had their recognition awards on display and staff and patients were proud to show us what they had achieved.

The service had a very positive and proactive approach to internal improvement .We saw many examples of the trust setting higher internal targets than the national targets this would drive improvements throughout the service.

Within outpatients the hospital lead had a clear vision for the service to meet the increased demands and meet the clinical needs of patients.

The therapy staff had transferred into the trust in the last twelve months. Staff told us they felt welcomed to the trust although they were still undergoing a review of services and plans were in place to integrate the services within the trust. We did not see information on timescales for the review to be finalised.

Staff were proud of the work where they worked and the work they did; they worked well together and supported each other when the service was under pressure from increased demand.

We found managers of all levels from the different departments had access to the trusts electronic visual management information system which allowed them to have full information on how their own service was performing and benchmark against other services. This gave us assurance that the trust was proactive in monitoring the quality and governance of its services.

Managers had a strong focus on the needs of patients and the roles staff needed to play in delivering good care.

All the staff we spoke with were aware of the feedback from the NHS friends and family test. The trust was ranked one of the highest in the country for extremely positive feedback received from patients.

The trust had a range of forums to seek patients' feedback such as the "patient power" group.

The trust ranked in the top 100 places to work in the NHS in an external health journal.

Staff told us they were well supported with mandatory training, clinical supervision and staff appraisals.

Staff were positive about the annual staff awards event and told us that it was very popular and staff wanted to attend and be involved in the evening.

Vision and strategy for this service

- We spoke to a range of staff all of whom were aware of the trust's vision and values. The trust's vision and values were displayed throughout the hospital.
- Locally we observed that the outpatient and diagnostic imaging services had a clear vision regarding how they wanted to deliver a high quality service and develop the different sites to meet clinical need and demand.
- Within outpatients the hospital lead had a clear vision of how to deliver the service to meet the increased demands on the hospital and to develop the site to meet the clinical needs of patients.
- We observed that the imaging services had a clear vision regarding how they would develop the skills of staff to meet the increased clinical needs and demands on the service.

- The therapy staff had transferred into the trust in the last twelve months. Staff told us that they had felt welcomed to the trust although they were still undergoing a review of services plans were in place to better integrate the services with the trust.

Governance, risk management and quality measurement

- The division held regular governance meetings with senior managers. These were recorded and shared with staff. All departments we visited had systems in place for communicating issues regarding risk and quality. These included team meetings, newsletters and email briefings. The service had a number of governance lead posts such as in radiology which staff felt had a clear and positive role. Departmental risk registers were in place and staff who were involved in managing risk had a clear understanding in relation the to risks and the systems used to record and manage them both within the outpatient department and diagnostic imaging.
- Staff could tell us how risks were escalated and shared. One member of staff told us that there was a risk in terms of capacity in clinics but senior staff were aware of the problem and were trying to resolve the issue. This showed that risk was managed throughout the service and staff at all levels and staff were aware of the actions taken. We saw a demonstration of the electronic data management system which senior staff could access for real time information in relation to performance monitoring information. This showed that the service was able to measure current quality and performance data and retrospective information to identify tends and themes in detail for each department over a five year period.
- We found that a range of managers had access to the trust electronic visual management information which allowed them to have full information on how their own service was performing and to benchmark against other services. This gave us assurance that the trust was proactive in monitoring the quality and governance of its services. The radiology service had a clear governance structure with a focus on clinical effectiveness, patient experience, and patient safety.
- Regulations state that instructions must be visible to keep patients and staff safe in radiology departments. These are known as 'local rules'. We found theses were visible throughout the diagnostic imaging service.

Leadership of service

- The executive team were visible and approachable. Clinical directors and nurse managers worked closely with the executive team regarding the development and improvement of services.
- Leadership within the outpatient and diagnostic imaging service was very positive, visible and proactive. Managers had a strong focus on the needs of patients and the roles staff needed to play in delivering good care. They were visible and respected by their colleagues.
- We found several examples of strong individual leadership and examples of talent management to further meet the needs of the service such as the extended roles in the rapid access ENT clinic.
- Staff reported that the executive team were visible and we heard examples of regular communication and feedback. One staff member reported that they had given a presentation to members of the executive team in their department and felt that they understood the issues and challenges for their service.

Culture within the service

- There was an open and honest culture within the service. Staff we spoke with were candid throughout our inspection about their service and the areas where they wanted to do better.
- Throughout the service we found that staff thought of the two hospitals as one trust with one ethos.
- Staff were proud of their achievements and awards were on display in many of the departments such as in the rheumatology department where they had been nominated by an external organisation for a customer care award.
- The trust had clear behavioural standards "ACE" which included areas such as attitude communication and patient experiences. We found all the staff we spoke with were knowledgeable about the standards and we observed staff living these in practice.
- Staff were committed to supporting patients and their families. One staff member told us "everyone goes above and beyond, its excellent teamwork".
- We found that staff were well informed about how the trust was performing in all areas and were aware of the friends and family test results. The trust had been ranked one of the highest in the country for extremely positive feedback from patients.

Outpatients and diagnostic imaging

- The staff sickness rate was in line with the trust average overall trust target of 4.25%.

Public engagement

- The trust was proactive in seeking patient feedback within the outpatient services. We found feedback forms available in all the departments we visited seeking comments and suggestions for patients.
- All the staff we spoke with were aware of the feedback from the NHS friends and family test. The trust was ranked one of the highest in the country for extremely positive feedback received from patients.
- The trust had a range of forums to seek patients' feedback such as the "patient power" group and other condition specific groups such as the diabetes support group.
- Information was displayed on message boards throughout the outpatient and diagnostic imaging services to engage the public in messages about the service and to seek feedback.
- Locally we found that the services were proactive in seeking ways to improve the service. An example of this was the ENT rapid access clinic had ensured that staff had the advanced skills necessary to operate the clinics. Several patients told us that they had transferred from another provider to have care at the hospital because of the outstanding level of service they had received.
- There was a volunteer scheme in place and volunteers were contributing to the service by supporting, directing and assisting patients. The volunteers we spoke with were positive about their contribution and felt valued and supported by the wider staff team. We spoke to one volunteer who told us he would be happy for himself or a member of his family to be treated here.

Staff engagement

- The trust is ranked in the top 100 places to work in the NHS in an external health journal.
- Staff told us they were well supported with mandatory training, clinical supervision and staff appraisals.
- Staff were positive about the annual staff awards event and told us that it was very popular and staff wanted to attend and be involved in the evening.
- Many of the departments we visited had their awards on display and staff and patients were proud to show us what they had achieved.
- Staff felt engaged with changes and initiatives across the services. The culture within the outpatient and diagnostic imaging services was open and patient focused
- Individual teams told us that they had given presentations to the board and they had been to the department. The staff felt engaged and felt that although the service was busy and there were pressures on activity they felt that senior managers were aware of the issues and were trying to resolve them.

Innovation, improvement and sustainability

- Locally we found that the services were proactive in seeking ways to improve the service for patients such as the ENT rapid access clinic, this had ensured that staff had the advanced skills necessary to operate the clinics.
- Staff told us they were encouraged to share ideas about service improvements and spoke positively about how they were involved in service planning. The service had an "outpatient transformational" group to look at the patient journey into and through the service.
- The Trust has been supporting another Trust by sharing good practice regarding improving the experience of cancer patients, through the NHS Improving Quality division's buddy programme.
- We saw many examples of national targets being shortened by internal targets to drive improvements throughout the service.

Outstanding practice and areas for improvement

Outstanding practice

The trust had developed a pressure ulcer (PU) risk assessment tool used by the tissue viability nurses across the wards. This took into account the grade of the PU risk and a care plan was determined which included the equipment to be used for the patient. A pathway had been developed for the sourcing, using and returning the equipment such as mattresses and cushions. The system was working well and all staff were clear about their roles and responsibilities. The process included training, maintenance and a comprehensive audit programme. Ward staff felt this enabled them to prioritise and work more efficiently with patients with pressure ulcers and felt it enabled quicker recovery.

The additional needs pathway and coordinated approach to a patient with additional needs to reduce the need for repeat procedures was seen as outstanding in terms of enhancing the patient's experience.

Staff were passionate about delivering high quality care and went above and beyond their usual duties to ensure children and young people experienced high quality care (Services for Children and Young People).

During our inspection we observed excellent caring, respectful and compassionate interactions between staff, children, young people and their families, particularly in the outpatient clinics. (Services for Children and Young People).

We observed positive interactions when staff were seeking consent (Surgery).

In order to improve the response time and access to timely treatment for a patient, if a critical or abnormal finding on an X-ray was seen detected radiology staff could book another follow up appointment with the appropriate specialist.

Areas for improvement

Action the hospital MUST take to improve

- Compliance with four-hour emergency department wait time targets.
- Ambulance handover times.
- In ensuring the acuity of patients on the coronary care unit is assessed at all times to ensure there is the appropriate skill mix of staff and patient's privacy and dignity is maintained.
- The system in place to assess and improve the quality and safety of the services provided following a serious incident in maternity services. This must include actions to mitigate the risks relating to the health and safety of service users.
- Systems for the safe storage of medicines.

Action the hospital SHOULD take to improve

- Improve mandatory training and staff appraisal compliance in the Emergency Department.
- Review of training of the medicines policy in relation to the administration of regular medication via oral or intravenous routes.
- Ensure that the implementation of the care certificate is implemented across all services within the national timeframe.
- Ensure that all staff are applying the mental capacity act principals to the use of bedrails.
- Ensure that hazardous chemicals are stored appropriately in a locked cupboard when not in use.
- Develop an end of life strategy.
- Appoint a palliative care consultant.
- Discharge summaries should be sent to patients GPs when patients the have been seen by the trust SPC team
- Consider the provision of a fully functional electronic palliative care co-ordinating system across all relevant sites would enable service providers across boundaries to share information.
- Consider how the amber care bundle is to be rolled out as the facilitators post had ceased and there were currently no plans to replace this position.
- The trust should ensure that the use of CCTV cameras does not impact adversely upon patients' dignity and respect.

Outstanding practice and areas for improvement

- Ensure that all dialysate fluids are kept locked and only accessible to appropriate staff.
- Ensure that all equipment for use in the resuscitation of patients is in date and regularly checked.
- Consider the intensive care society standards for supernumerary staffing when calculating the nurse establishment.
- Ensure that the therapy review is concluded to facilitate the integration of therapies into the trust following their transfer from another provider.
- Continue to seek ways to work with other partners to lessen the impact of the national shortfall of prosthetic services.
- Ensure staff consistently follow trust policy and best practice in relation to completing vital sign observations for children and young people.
- Ensure nurses on wards 3F and 4F take an active part in managing meals and mealtimes.
- Ensure food and nutrition is always stored and accessed safely.
- Ensure staff receive training about when to consider the Mental Capacity Act for young people over 16 years old.
- Ensure a variety of opportunities are provided for children, young people and their parents to comments about the service.
- Consider promoting use of the translation service in all instances when a child or young person has English as a second language.
- Consider additional steps to ensure all children and young people departments provide relevant and required governance reports when expected.
- Consider analysing staff survey according to directorate so specific experiences and ideas are used to influence the development of the service neonatal, children and young people service.
- Consider setting target dates by which plans should be achieved so improvements can be measured.
- Make the development of robust succession plans for the neonatal unit and children's wards a priority involving staff in the planning and delivery process.
- Consider reviewing the environment of the neonatal unit alongside best practice for example the Health Building Note 09-03: Neonatal units department of health publication.
- Should ensure all midwives are competent in the assessment of CTG monitoring.