CareQuality Commission

Wirral University Teaching Hospital NHS Foundation Trust

Quality Report

Arrowe Park Road
Wirral
CH49 5PE
Tel: 0151 678 5111
Website: www.wuth.nhs.uk

Date of inspection visit: 15 – 18 and 24 September 2015
Date of publication: 10/03/2016

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Wirral University Hospitals NHS Foundation Trust (the trust) gained foundation status on 1 July 2007. The trust provides services for around 400,000 people across Wirral, Ellesmere Port, Neston, North Wales and the wider North West footprint with 855 beds trust-wide.

The trust manages two hospital sites;

Arrowe Park Hospital is the main site and provides a full range of hospital services including emergency care, critical care, a comprehensive range of elective and non-elective general medicine (including elderly care) and surgery, a neonatal unit, children and young people's services, maternity and gynaecology services and a range of outpatient and diagnostic imaging services. The majority of the trusts inpatient (749) beds located at Arrowe Park Hospital.

Clatterbridge Hospital provides a range of health care services including elective orthopaedic surgery (planned operations), specialist stroke and neuro-rehabilitation services, elderly care and dermatology treatments. The elective surgery and stroke rehabilitation wards each have a total of 20 beds. In addition, the hospital offers a variety of outpatient services for a full range of specialities including dermatology, podiatry, cardiac, plastics, phlebotomy, x-ray, and the Wirral Breast Centre. Magnetic Resonance Imaging (MRI) scanning appointments were available but delivered by an external provider.

We previously inspected this trust in May 2015 as part of a responsive unannounced inspection as a result of concerns regarding nurse staffing. We found that there were shortages of nursing staff on some medical wards in Arrowe Park Hospital and we told the trust it must address this important issue quickly. The trust responded positively to this inspection and when we carried out our comprehensive inspection on 16 – 18 September and 24 September 2015 (unannounced), we found that nurse staffing levels had improved, however further work was required to ensure that wards and departments were adequately staffed at all times.

Overall, we rated the trust as 'Requires Improvement'. We found that services were provided by dedicated, caring staff and patients were treated with dignity and respect. However, improvements were needed to ensure that services were safe, effective, responsive to people's needs and that services were well led.

Our key findings were as follows:

Vision and values

The trust had a vision 'to be the first choice healthcare partner to the communities we serve - from home to the provision of regional specialist services'.

The vision was underpinned by the PROUD values; Patient, Respect, Ownership, Unity and Dedication.

Staff were aware of and could articulate the organisational vision and values. There were examples of the trusts vision and values being put in to practice on display throughout the trust.

The trust was working with health partners in the locality, leading one of the national vanguard sites to develop new healthcare models. The new models of care sought to bring together GPs, community services, mental health and hospital services to re-shape services and support the improvement and integration of services for the benefit of patients.

Leadership and Culture

The trust was led and managed by a visible executive team. There had been recent changes within the senior team following the resignation of the Director of Finance, the Executive Director of Operations and the imminent retirement of the Director of Nursing (DON). The trust had plans in place to reappoint to these positions and had good interim plans in place until the appointments were made. The trust was planning to appoint a new Chief Operating Officer and Deputy Chief Executive early in 2016.

In addition, a new Director of Nursing had already been appointed and was working closely with the current DON to facilitate and ensure a smooth and seamless handover.

The senior team were known to staff and it was evident that in response to a disappointing staff survey (which indicated a disconnect between the senior team and frontline staff) they had made considerable efforts to

Summary of findings

engage and include staff in the change and improvement agenda. The trust had developed and implemented a Workforce and Organisational Development Strategy to support the securing of a healthy organisation and a sustainable and capable workforce. The Trust had also implemented a range of communication and inclusion initiatives to promote staff engagement and inclusion. The Listening in Action programme was an example of the trust hearing and responding to staff concerns and issues.

The trust was aware of the challenges it faced and the areas we have as identified as requiring improvement were known to the trust and plans were either in place or being developed to improve performance. For example, the trust was facing significant financial difficulties and had worked with our partner regulator Monitor to develop a recovery plan. At the time of our inspection the trust was making steady progress regarding the delivery of the plan and was delivering improvements within agreed targets and time frames.

However, we were concerned in respect of the lack of leadership and strategic approach in services for patients at the end of life. There was a draft three-year vision developed by the trust's end of life care committee. However, we found no evidence that this had been communicated to staff. There was no overarching monitoring of the quality of the service across the trust. We also found that the trust performed worse than the England average in the National Care of the Dying Audit, published in May 2014.

In the critical care service there was no clear, shared vision or strategy for the service. There was a governance structure in place although at times, it was unclear how risks were being, monitored, managed and reviewed.

However, we found that staff employed by the trust were proud of the work they did and demonstrated a commitment to providing patients with high quality services. Morale was improving and staff were aware of the challenges faced by the trust and the plans in place to address them. Staff were more positive about the visibility and accessibility of the senior team as well as the improvements in staffing made since our last inspection.

Although there was an improving culture in most areas, there were still some staff groups that felt the trust still had work to do to address their concerns and improve engagement. This was particularly evident in maternity services and in operating theatres.

Nurse Staffing

As previously indicated, the trust had made a positive response to the findings of our previous inspection and had worked hard to actively recruit additional nursing staff. As a result, nurse staffing had improved considerably since our inspection in May 2015. The nurse vacancy rates had reduced to 7.66%.The Trust had employed over 50 new nurses, however staff turnover, although reducing, meant that there were still 70 nurse vacancies across the trust in July 2015.

The trust was still recruiting nursing staff on a rolling programme and although improved, there were still times when the wards were not appropriately staffed. This was an area of concern both in Arrowe Park Hospital (in particular medical services) coupled with concerns regarding the number of nurses on duty during the night at the Clatterbridge Rehabilitation Centre (CRC) and ward 36 (both of these wards provided medical care) on the Clatterbridge site.

In addition, there was no recognised acuity tool used on the paediatric ward to determine staffing numbers. In maternity, the management of the electronic rostering system meant the skill mix on the delivery suite and antenatal/postnatal unit was unpredictable. Staff told us that the same staff could be rostered onto different units at the same time. In addition, midwives were also able to swap shifts without reference to shift leaders or the maternity matron and so skill mix and experience could not be guaranteed.

To manage and mitigate shortfalls in staffing and skill mix, matrons met each day to discuss nurse staffing levels across the divisions to ensure that staff and skills were appropriately deployed across all wards and departments. In addition nurse staffing concerns were escalated to managers for action. However, there were occasions when managers were unable to secure additional resources and wards were short staffed as a result. This was a particular issue in medical services.

Summary of findings

The staffing and skill mix on surgical wards and in theatre areas was sufficient, with some infrequent periods of reduced staffing as a result of unplanned absence.

Medical staffing

Medical treatment was delivered by skilled and committed medical staff.

The vacancy rate for medical staff at the time of our inspection was 12.4%. Vacancies, extra staffing over and above normal levels and additional ward rounds were supported by the use of locum /agency doctors. The total number of shifts covered by locum medical staff in medical services trust wide between April 2015 and September 2015 was 1,428.

In addition, the number of palliative care consultants was below the Association for Palliative Medicine of Great Britain and Ireland, and the National Council for Palliative Care guidance.

There were also medical vacancies across in the diagnostics and imaging services.

At Clatterbridge hospital there were sufficient numbers of suitably qualified medical staff during the daytime hours. However, there was only one junior or middle grade doctor on duty during the night and at weekends. There were no surgical doctors, anaesthetic or critical care support available on the Clatterbridge site after 8pm. If a patient's condition deteriorated the staff at the hospital would transfer the patient to the acute site, however there was no locally agreed protocol in place to support safe transfer of patients.

The trust was aware that the current vacancy position and the use of locum and agency doctors presented a (potential) risk to patient care and safety and were focused on appointing additional medical staff as a matter of priority. Nevertheless, we remained concerned that the lack of medical staff was having a negative effect on the timely care, treatment and review of patients in the care of the trust.

Mortality and Morbidity

The Summary Hospital-level Mortality Indicator (SHMI) is a set of data indicators which is used to measure mortality outcomes at trust level across the NHS in England using a standard and transparent methodology. The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated at the hospital. The risk score is the ratio between the actual and expected number of adverse outcomes. A score of 100 would mean that the number of adverse outcomes is as expected compared to England. A score of over 100 means more adverse (worse) outcomes than expected and a score of less than 100 means less adverse (better) outcomes than expected. Between October 2013 and September 2014 the trust score was 97.

Monthly meetings were in place where mortality, incidents, actions and opportunities for learning were discussed. Information was then cascaded to senior staff via email to enable sharing with other staff to support improvements in practice and outcomes for patients. However, in medical services it was unclear if any actions for improvement were agreed at the meeting and as a result opportunities for learning may have been missed.

Safeguarding

There were systems for reporting safeguarding concerns for both adults and children. Staff were able to identify and escalate appropriately issues of abuse and neglect. Practice was supported by staff training. The trust had a safeguarding team that provided guidance during weekdays. Staff had access to advice out of hours and at weekends from the hospital co-ordinator or the local authority duty social worker.

However, the safeguarding children and child protection protocols did not meet best practice guidance in a number of areas. There wasn't a paediatric nurse as part of the safeguarding team, which is recommended as best practice in the Royal College of Paediatrics and Child Health (RCPCH) guidelines 2014. In addition, the safeguarding policy was updated in December 2014, and referred to "working together 2004" yet no reference was made to the more recent guidance "working together 2010 and 2014" both of which were available at the time the policy was revised. The policy referred to definitions of abuse taken from old guidance 'working together' (2006). In addition, the safeguarding policy did not fully promote multi-agency working which is key in current child protection protocols, for example there was no mention of notifying school nurses of a safeguarding referral.

Summary of findings

The safeguarding training strategy had not been revised since 2009 and was not compliant with RCPCH guidelines 2014, which states that professionals should receive up to a minimum of three to four hours of safeguarding training every three years. Staff were required to complete training every three years but only received two hours of level 2 safeguarding training. In addition, safeguarding level 1 training was a basic overview of safeguarding vulnerable groups of people such as children. This was included in mandatory training as a 30 minute presentation and supplemented by a safeguarding information booklet instead of the recommended two hours.

Access and Flow

The emergency department was under considerable pressure from unplanned admissions and had consistently failed to meet the Department of Health target requiring 95% of patients to be seen, treated, admitted or discharged in under four hours of attendance between December 2014 and June 2015. In April 2015 only 79% of patients were seen within four hours. In June 2015 91% of patients were seen within the time frame. In July 2015 the service met the target with 97% of patients seen within the time frame but by the end of August 2015 the percentage had fallen to 88%. The number of patients waiting between 4 and 12 hours for admission to hospital was worse than the national average between April 2014 and April 2015 and had risen over time. For example in May 2014, a national average of 5 patients waited compared with 13 patients in this trust. By April 2015 this figure rose to 35 patients against a national average of 10.

For patients arriving by ambulance the department consistently took longer to complete an initial assessment (between 10 and 16 minutes) than the national average (between 3 and 6 minutes).

The department reported 952 occasions when ambulance personnel waited longer than 30 minutes to hand over patient information for the 5 months prior to our inspection.

Between March 2014 and May 2015 the trust reported 609 occasions when ambulance personnel had to wait longer than 60 minutes to hand over patient details. This was worst in March 2015 when 36 delays of more than 60 minutes occurred.

Senior staff explained that access and flow was affected by the capacity to admit patients to available beds within the hospital. The trust's patient flow workgroup focused on strategies to maintain patient flow. These included introducing daily ward reviews to identify patients ready for discharge, implementing early supported discharges through collaboration with social services and expanding the bed base through escalation procedures.

However, between November 2014 and August 2015 data showed that there had been 1,203 medical outliers at the hospital, which is an average of approximately four patients a day. However, at the time of our inspection, there were no medical outliers in the hospital.

Patients who were outliers were reviewed on a daily basis by a member of the medical team and there was an appointed junior doctor to wards that were used for medical outliers.

Cleanliness and infection control

The trust had infection prevention and control policies in place which were accessible to all staff.

Staff generally followed good practice guidance in relation to the control and prevention of infection in line with trust policies and procedures. However, in the critical care unit not all staff followed 'bare below the elbows' guidance and there was mixed levels of compliance with hand hygiene protocols.

'I am clean' stickers were used to inform staff at a glance that equipment or furniture had been cleaned and was ready for use.

The trust had strengthened its systems and processes to prevent and protect people from healthcare associated infections. As a result, there were low rates of catheter associated urinary tract infections reported between June 2014 and June 2015.

In addition the trust had a number of work streams in place for the management and treatment of multi drug resistant organisms.

There had not been any cases of methicillin resistant staphylococcus aureus (MRSA) bacteraemia infections or clostridium difficile infections identified in surgical

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services across the trust between March 2015 and August 2015. However, in the same period, medical care services reported 21 cases of clostridium difficile infections, two cases of MRSA and six cases of MSSA.

According to the submitted and verified intensive care national audit and research centre data (ICNARC), the critical care unit performed as well and sometimes better than similar units for unit acquired MRSA and clostridium difficile infection rates.

Concerns regarding sepsis were raised by HM Coroner in relation to a delay in the administration of antibiotics for a patient in September 2014. In response, the service implemented plans to improve sepsis care, which included introducing a sepsis care pathway and extra training for staff. In addition, the trust developed an electronic systemic inflammatory response syndrome (SIRS) tool. The tool worked as an adjunct to the clinical assessment to support the recognition of potential sepsis and prompt early intervention. It was developed using evidence based international standards. Following implementation of the action plan and introduction of the electronic SIRS tool, the trust reported a positive increase in the identification and treatment of patients with potential sepsis.

Overall, infection rates were within an acceptable range for a trust of this size.

Patient-led assessments of the care environment (PLACE) audits for 2013 and 2014 scored higher than the national average for cleanliness across the trust.

Nutrition and Hydration

Most patients confirmed they were happy with the standard and choice of food available.

A nutritional risk assessment was in place and consistently used by staff to determine patients individual needs. This helped identify patients at risk of malnutrition and helped staff meet existing or changing nutritional and hydration needs.

Specialist dietary support was available for patients who required specialist diets.

A coloured tray system was in place to highlight which patients needed assistance with eating and drinking. Support was given discreetly and sensitively.

We saw several areas of outstanding practice including:

- The sentinel stroke national audit programme (SSNAP) latest audit results rated the trust overall as a grade 'A' which was an improvement from the previous audit results when the trust was rated as a grade 'B'. Since October 2014 the trust had either been ranked first or second regionally in the SSNAP audit.

Arrowe Park Hospital

- Senior clinicians on the emergency surgical assessment unit had recognised that fluid balance monitoring could be improved and introduced a training programme for health care support workers to achieve this aim. Health care support workers told us they felt empowered by the training and saw fluid balance monitoring as an integral part of their role after it. Audits showed that the completion of fluid balance charts had improved since the training and senior clinicians reported that there had been a significant reduction in the number of patients developing acute kidney injuries (a condition associated with dehydration).

Clatterbridge Hospital

- We observed staff displaying a very caring, person-centred attitude which went beyond what was expected. Staff encouraged patients and their relatives to be active partners in their care. Staff went above and beyond to meet patient's preferences. There were strong relationships between staff, patients and their relatives.
- Patients' needs and preferences were central to the planning and provision of services. One example of this was the repurposing of a clinical area into a domestic dwelling. This was designed to help prepare medical and surgical patients for discharge to their own home and bridge the gap between acute patient care and community rehabilitation. Patients could 'move' into the dwelling with their relatives for short periods before discharge. This helped staff identify whether any further measures were needed before patients were discharged. It also empowered patients to maintain their independence and improve their confidence prior to discharge. Staff told us that this had been introduced partly due to issues which were raised around patients discharge home when they felt they weren't ready.

Summary of findings

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

Importantly, the trust must:

Arrowe Park Hospital

Urgent and emergency care

- Ensure call bells are available in every bay and placed with patients.

- Staffing continues to remain a focus and that shifts are adequately staffed to meet the needs of patients.

- Ensure that risks are always managed and mitigated in a timely way.

Medical care (including older people's care)

- The trust must ensure that robust information is collected and analysed to support improvements in clinical and operational practice.

- The trust must ensure that care and treatment is only provided with the consent of the relevant person and if a patient lacks capacity to consent, the Mental Capacity Act (2005) principles are adhered to. This must be supported by staff receiving training in consent and the principles of the 2005 act.

- The trust must deploy sufficient staff with the appropriate skills on wards, especially on the medical short stay ward and on ward 16 at night.

- The trust must ensure that learning is shared across all service areas and the reasons for any changes made clear to all staff.

- The trust must ensure that records are kept secure at all times so that they are only accessed and amended by authorised people.

Surgery

- The trust must ensure that there are adequate numbers of suitably qualified staff in theatre recovery areas to ensure safe patient care.

- The trust must ensure that all staff involved with the care and treatment of children receive adequate life support training.

- The trust must ensure that all staff receive are appropriately trained and able to use the incident reporting system.

Critical care

- The trust must address the governance shortfalls in critical care and make sure that the systems and processes in place for assessing, monitoring and mitigating local risk are managed effectively.

- The trust must ensure that all staff understand the thresholds for reporting incidents and are encouraged to use the electronic reporting system.

- The trust must make sure that all staff understand and comply with the best practice in infection prevention and control. This includes appropriate use of handwashing and the use of antiseptic hand gels.

Maternity and gynaecology

- Review the management of the electronic rostering system to ensure it does not allow staff to be rostered on different wards at the same time.

- The provider must deploy sufficient clinical and midwifery staff with the appropriate skills at all times of the day and night to meet the needs of women following the trust risk assessment and escalation procedures.

- The provider must ensure that there is a detailed overview of the types and seriousness of incidents and learning is shared across all service areas and the reasons for any changes made clear to all staff.

- The provider must make sure individual care records are always accurate and completed contemporaneously.

- The provider must make sure community midwives have easy access to the emergency medication and equipment detailed in best practice guidance. The equipment must be checked and items provided within the use by date.

Children and young people's services

- Resuscitation trolleys must be appropriately checked and the log book must be signed to confirm all items are in working order. The trolley must include a defibrillator at all times.

- Must ensure that there is a robust system to determine staffing numbers which takes into account the acuity of patients and skill mix of staff.

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- Information must be collected and analysed to support developments in clinical and operational practice.

- Must review the children's safeguarding training to ensure it meets Royal College of Paediatrics and Child Health (RCPCH) guidelines 2014.

End of life

- Ensure that any complaint received is investigated and necessary and proportionate action is taken in response to any failures identified by the complaint or investigation.

- Seek and act on feedback from relevant persons and staff teams, for the purpose of continually evaluating and improving services.

- Evaluate and improve their practice in respect of the processing of information relating to the quality of people's experience.

- Ensure there is a robust vision and strategy for end of life services and all staff are aware of them.

- Ensure that there is an appropriate replacement care plan in place across the trust following the withdrawal of the Liverpool Care Pathway.

- Ensure that all risks associated with end of life services are recorded and monitored with appropriate actions taken to mitigate them.

Outpatients and diagnostics

- The trust must take action to reduce the delay in referral to reporting times of urgent diagnostic investigations.

- The trust must resume radiation safety committee meetings and hold them at least annually.

- The trust must take steps to fill vacancies to ensure compliance against their current staffing establishment.

Clatterbridge Hospital

Medical care (including older people)

- Ensure that robust information is collected and analysed to support improvements in clinical and operational practice.
- Deploy sufficient staff with the appropriate skills on the Clatterbridge rehabilitation unit at night.
- Ensure there is adequate medical cover out of hours for the hospital.
- Ensure there is a clear operational protocol for the transfer of patients whose condition deteriorates

Surgery

- Ensure that all staff involved with the care and treatment of children receive adequate life support training.
- Ensure there is sufficient medical cover out of hours for the hospital.
- Ensure there is a clear operational protocol for the transfer of patients whose condition deteriorates
- The trust must ensure that the doors which lead to high balconies on the ward areas are suitably secured.

Outpatients and diagnostic imaging

- Take action to reduce the delay in referral to reporting times of urgent diagnostic investigations.
- Resume radiation safety committee meetings and hold them at least annually.
- Take steps to fill vacancies to ensure compliance against their current staffing establishment.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Background to Wirral University Teaching Hospital NHS Foundation Trust

The trust gained foundation status on 1 July 2007. The trust provides services for around 400,000 people across Wirral, Ellesmere Port, Neston, North Wales and the wider North West footprint with 855 beds trust-wide with the majority of inpatient (749) beds located at Arrowe Park Hospital.

In Wirral, there are higher than average levels of deprivation and about 15,300 children are estimated to live in poverty. Life expectancy for both men and women is lower than the England average.

Our inspection team

Our inspection team was led by:

Chair: Jenny Leggott

Head of Hospital Inspections: Ann Ford, Care Quality Commission

The team included two CQC inspection managers, 11 CQC inspectors, a senior analyst and a variety of specialists including: a director of nursing, a deputy medical director, a pharmacist, two emergency nurses, two medical care nurses, a consultant surgeon, an intensive care consultant, a consultant obstetrician, a risk and governance midwife, an independent safeguarding children consultant, a consultant paediatrician, a nurse specialist for children and young people, a director for palliative care hospice, a palliative care nurse, a critical care nurse, a consultant haematologist a renal histopathologist, a senior nurse for theatres and day care, a ward manager, a senior lecturer in radiography, a junior doctor and a student nurse. We also used two experts by experience who had experience of using healthcare services.

How we carried out this inspection

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

• Is it safe?

• Is it effective?

• Is it caring?

• Is it responsive to people's needs?

• Is it well-led?

Before our inspection we reviewed a range of information we held about the trust and asked other organisations to share what they knew. These included the Clinical Commissioning Groups, NHS England, Health Education England, the General Medical Council, the Nursing and Midwifery Council, the Royal Colleges and the local Healthwatch.

We held a listening event for people who had experienced care at either Arrowe Park Hospital or Clatterbridge Hospital on 8 September 2015 in Oxton, Wirral. This event was designed to take into account people's views about care and treatment received at the hospital. Some people also shared their experiences by email and telephone.

As part of our inspection, we held focus groups and drop-in sessions with a range of staff in the trust 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.

Summary of findings

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

We undertook an unannounced inspection on 24 September 2015 at Arrowe Park Hospital. As part of the unannounced inspection, we looked at the emergency department and medical care wards.

We would like to thank all staff, patients, carers and other stakeholders for sharing their balanced views and experiences of the quality of care and treatment the trust.

What people who use the trust's services say

- In emergency care, the NHS Friends and Family Test (FFT) results for the percentage of those who would recommend the trust was consistently higher than the England average (between 97%-100% compared to 86%- 88%) for Mar 14 – Feb 15.
- The two surgical wards at Clatterbridge hospital frequently scored 100% in the FFT for patients who would recommend them between Mar 14 and Jan 15.
- The percentage of patients recommending the trust was higher than the England average for antenatal, postnatal ward, birth and postnatal community services in the FFT Mar 14 – Feb 15. Antenatal and postnatal community scored 100% for 8 and 10 months respectively during the period.

- The trust scored better than other trusts for five of the 17 indicators in the CQC Maternity survey 2013, with the remaining 12 scoring about the same as other trusts.
- The trust was performing better than the England average in all four parts of the patient-led assessments of the care environment (PLACE). These were cleanliness, food, privacy, dignity and wellbeing and facilities.
- The trust performed about the same as similar trusts in all areas of the 2014 CQC inpatient survey.

Facts and data about this trust

The trust serves a population of approximately 400,000 people across Wirral, Ellesmere Port, Neston, North Wales and the wider North West footprint operate from two main sites:

- Arrowe Park Hospital, Upton – delivering a full range of emergency (adults and children) and acute services for adults in the main hospital building. The Wirral Women's and Children's Hospital provides Maternity, Neonatal, Gynaecology, Children's inpatient, day case and outpatient units.
- Clatterbridge Hospital, Bebington – undertaking planned surgical services, dermatology services, breast care and specialist stroke and neuro-rehabilitation services

The trust provides 855 Beds in the following areas

- 805 General and acute
- 32 Maternity

- 18 Critical care

The trust employs 4782 staff overall

- 534 Medical
- 1430 Nursing
- 2816 Other staff groups

Financial position

- Revenue: £301 million
- Full Cost: £305 million
- Surplus (deficit):£4.5 million deficit

2014/15 Activity Statistics

- Total Births 3,382
- A&E Attendances 89,277
- Emergency Admissions 54,737
- New Outpatient Attendances 111,874
- Diagnostic examinations performed 338,834
- Elective Day Case Admissions 41,693

Summary of findings

- Elective Inpatient Admissions 8,077

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Our judgements about each of our five key questions

	Rating
Are services at this trust safe?	**Requires improvement** 🟠

Are services at this trust safe?

The trust had systems and processes in place to protect patients from avoidable harm and there were low rates of avoidable harm including, falls, infections and pressure ulcers.

However, the systems for reporting incidents were not always consistently applied and staff understanding and practice in this area varied considerably. Shortfalls in the reporting of incidents meant that opportunities for learning and improvement may be lost.

In addition, although improved there were still nurse vacancies that meant the wards were sometimes inappropriately staffed. The trust was actively recruiting additional nurses at the time of our inspection. There were also medical vacancies. The vacancy rate for medical staff at the time of our inspection was 12.4%. Vacancies, extra staffing over and above normal levels and additional ward rounds were supported by the use of locum /agency doctors. The trust was aware that medical vacancies presented a (potential) risk to patient care and safety and were focused on appointing additional medical staff as a matter of priority.

There was no acuity tool used to determine staffing numbers on the paediatric ward and the system for determining midwife rota's in maternity was not robust.

Staff were able to identify and escalate appropriately issues of abuse and neglect. Practice was supported by staff training. The trust safeguarding team provided support and guidance for staff so that safeguarding issues were escalated and managed. However, the safeguarding children and child protection protocols did not meet best practice guidance in a number of areas and required further review.

Duty of Candour

- The trust had systems in place to fulfil its obligations in relation to the Duty of Candour legislation. This is a legal requirement to inform and apologise to patients if there have been mistakes in their care that have led to harm.
- The incident reporting system identified incidents that had led to serious or moderate harm to patients and prompted staff to apply duty of candour.
- There was evidence that the trust was open and honest with patients and those close to them when things went wrong for

example. Records we reviewed indicated that patients had been informed when things went wrong and a formal apology had been given along with an explanation of the actions that would be taken to prevent the issue happening again.

- However some staff were unaware of the Duty of Candour legislation. We noted this to be a particular issue in the emergency department.

Safeguarding

- The trust had safeguarding policies and procedures in place that was supported by staff training. Staff were able to identify issues of abuse and neglect and escalate appropriately.
- 82.5% of staff had completed safeguarding training which was below the trust target of 95%
- The trust had a safeguarding team that provided guidance to staff during weekdays.
- Staff had access to advice out of hours and at weekends from the hospital co-ordinator or the local authority duty social worker.
- Basic safeguarding training was included in induction training for all temporary staff before commencing work on the wards.
- However, the safeguarding children and child protection protocols did not meet best practice guidance in a number of areas. There wasn't a paediatric nurse as part of the safeguarding team, which is recommended as best practice in the Royal College of Paediatrics and Child Health (RCPCH) guidelines 2014. In addition, the safeguarding policy was updated in December 2014, and referred to "working together 2004" yet no reference was made to the more recent guidance "working together 2010 and 2014" both of which were available at the time the policy was revised. The policy referred to definitions of abuse taken from old guidance 'working together' (2006). In addition, the safeguarding policy did not promote multi-agency working which is key in current child protection protocols, for example there was no mention of notifying school nurses of a safeguarding referral.
- The safeguarding training strategy had not been revised since 2009 and was not compliant with RCPCH guidelines 2014, that states that professionals should receive up to a minimum of three to four hours of safeguarding training every three years. Staff were required to complete training every three years but only receive two hours of level 2 safeguarding training. In addition, safeguarding level 1 training was a basic overview of

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safeguarding vulnerable groups of people such as children. This was included in mandatory training as a 30 minute presentation and supplemented by a safeguarding information booklet instead of the recommended two hours.

Cleanliness, infection control and hygiene

- Both hospitals and staff areas were, in the main, visibly clean.
- The trust had infection prevention and control policies in place which were accessible to staff.
- Personal protective equipment was available for staff and we saw it being used appropriately
- There were sufficient hand washing facilities and antiseptic gels available.
- Not all staff followed 'bare below the elbows' guidance. This was a particular issue in the critical care service where there was limited compliance with hand hygiene protocols. Nursing staff were observed to wash their hands and apply antiseptic gels between patients. This was not always the case with medical staff and allied health professionals.

Incidents

- The trust had reported four never events May 14 – Jun 15 (never events are serious, wholly preventable patient safety incidents that should not occur if the available preventative measures have been implemented).
- There was evidence that these incidents had been investigated robustly using Root Cause Analysis (RCA) tools and that actions had been implemented to mitigate the risk of reoccurrence.
- A further serious incident took place in July 2015 that related to a medication error. The investigation into the root cause of this incident was still being investigated at the time of our inspection. The trust took a number of immediate remedial actions at the time of the incident and had developed an overall action plan that was still in progress.
- The trust had a policy and an electronic system for the reporting and management of incidents. The number of incidents reported by the trust was similar to the national average; however the understanding and application of the reporting systems varied across service areas.
- There was evidence of staff failing to report incidents due to a lack of understanding regarding definitions or processes. This meant that some incidents were not reported and opportunities for learning and improvement were lost as a result.

Summary of findings

- When incidents were reported, feedback was not consistently given and the systems to share learning were not always implemented robustly.

Staffing

- The trust had determined nurse staffing levels using the National Institute for Health and Care Excellence (NICE) guideline 'Safe staffing for nursing in adult inpatient ward in acute hospitals'.
- However, there was no recognised acuity tool used on the paediatric ward to determine staffing numbers. In maternity, the management of the electronic rostering system meant the skill mix on the delivery suite and antenatal/postnatal unit was unpredictable. Staff told us that the same staff could be rostered onto different units at the same time. In addition, midwives were also able to swap shifts without reference to shift leaders or the maternity matron and so skill mix and experience could not be guaranteed.
- The trust had made a positive response to the findings of our previous inspection in May 2015 and had worked hard to actively recruit additional nursing staff. As a result nurse staffing had improved considerably since our last inspection.
- The trust had employed over 50 new nurses however staff turnover, although falling, meant that there were still 70 Nurse vacancies across the trust in July 2015. The trust was still recruiting nursing staff on a rolling programme; nevertheless there were still times when the wards were not appropriately staffed.
- This was an area of concern both in Arrowe Park Hospital (in particular medical services) coupled with concerns regarding the number of nurses on duty during the night at the Clatterbridge Rehabilitation Centre (CRC) and ward 36 (both of these wards provided medical care) on the Clatterbridge site. The remainder of the services in Clatterbridge hospital were appropriately staffed to meet the needs of patients.
- To manage shortfalls in staffing and skill mix, matrons met each day to discuss nurse staffing levels across the divisions to ensure that staff and skills were appropriately deployed across all wards and departments. In addition nurse staffing concerns were escalated to managers for action. However, there were occasions when managers were unable to secure additional resources and wards were short staffed as a result. This was a particular issue in medical services and the emergency department at Arrowe Park Hospital.

Summary of findings

- The staffing and skill mix on surgical wards and in theatre areas at Arrowe Park was sufficient, with some infrequent periods of reduced staffing as a result of unplanned absence.

Medical staffing

- Medical treatment was delivered by skilled and committed medical staff.
- The vacancy rate for medical staff at the time of our inspection was 12.4%. Vacancies, extra staffing over and above normal levels and additional ward rounds were supported by the use of locum /agency doctors. The total number of shifts covered by locum medical staff in medical services trust wide between April 2015 and September 2015 was 1,428.
- In addition, the number of palliative care consultants was below the Association for Palliative Medicine of Great Britain and Ireland, and the National Council for Palliative Care guidance.
- There were also medical vacancies across in the diagnostics and imaging services.
- At Clatterbridge hospital there were sufficient numbers of suitably qualified medical staff during the daytime hours. However, there was only one junior or middle grade doctor on duty during the night and at weekends. There were no surgical doctors, anaesthetic or critical care support available on the Clatterbridge site after 8pm. If a patient's condition deteriorated the staff at the hospital would transfer the patient to the acute site, however there was no locally agreed protocol in place to support safe transfer of patients.
- The trust was aware that the current vacancy position and the use of locum and agency doctors presented a (potential) risk to patient care and safety and were focused on appointing additional medical staff as a matter of priority. Nevertheless we remained concerned that the lack of medical staff was having a negative effect on the timely care, treatment and review of patients in the care of the trust.

Staff Training

- Staff received mandatory training on a rolling 18 month programme (block B) in areas such as infection control and medicines management and a three year rolling programme (block A) in areas such as safeguarding, manual handling and fire safety. Staff were alerted that mandatory training was due via their manager. Further annual e-learning was also available.
- The trust's target was for 95% of staff to have completed mandatory training. At the time of our inspection there were

Summary of findings

high levels of compliance in many areas; however, there were areas were performance fell below the target, for example in the emergency department only 50% of medical and nursing staff had completed safeguarding training to the required standard.

- We also found that most staff in theatre recovery areas had not undertaken paediatric life support training despite regularly caring for children. A review of staffing rotas showed there were a number of shifts that had no paediatric life support trained nurses on duty.

Are services at this trust effective?

Good ●

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

Clinical pathways and care bundles had been implemented to promote appropriate and timely care for patients in accordance with nationally recognised standards.

Clinical audit was used to monitor and improve performance. Where audits highlighted areas for improvement in many cases the trust developed, implemented and monitored action plans to secure improvement. There was robust evidence of improvements in services as a result of post audit action planning.

Concerns regarding sepsis were raised by HM Coroner in relation to a delay in the administration of antibiotics for a patient in September 2014. In response, the service implemented plans to improve sepsis care, which included introducing a sepsis care pathway and extra training for staff. In addition, the trust developed an electronic systemic inflammatory response syndrome (SIRS) tool. The tool worked as an adjunct to the clinical assessment to support the recognition of potential sepsis and prompt early intervention. It was developed using evidence based international standards. Following implementation of the action plan and introduction of the electronic SIRS tool, the trust reported a positive increase in the identification and treatment of patients with potential sepsis.

However, there were improvements required in the emergency department to secure timely completion of audits and improve the management of pain relief for patients.

In surgical services there were two national audits where the Trust was performing well over the majority of indicators, however there were no action plans in place to address the shortfalls in the indicators identified as falling below the national average.

Summary of findings

In services for people at the end of life the trust performed worse than the England average in the National Care of the Dying Audit, published in May 2014, for seven of the 10 indicators.

In addition, an individual care planning toolkit was being introduced following the withdrawal of the Liverpool Care Pathway in 2013. The new 'toolkit' was in place in two of the wards we visited and incorporated the Department of Health end of life care strategy aimed at identifying patients' preferences and wishes earlier so that improved advance care planning to take place. However, ward staff we spoke with were not fully aware the new approach nor had they received any training regarding its implementation. This meant that we were not assured that the trust's approach to end of life care had been effectively or comprehensively implemented.

Multi-disciplinary team work was well established and staff worked well together for the benefit of patients in their care.

Evidence based care and treatment

- Care and treatment was evidence-based and the policies and procedures, assessment tools and pathways followed recognisable and approved guidelines such as the National Institute for Health and Care Excellence (NICE).
- Clinical pathways and care bundles had been implemented to promote appropriate and timely care for patients in accordance with nationally recognised standards.
- Clinical audit was used to monitor and improve performance. Where audits highlighted areas for improvement in many cases the trust developed, implemented and monitored action plans to secure improvement. There was evidence of improvements in services as a result of post audit action planning.
- However, there were improvements required in the emergency department to secure timely completion of audits and improve the management of pain relief for patients.

Patient outcomes

- The sentinel stroke national audit programme (SSNAP) latest audit results rated the hospital overall as a grade 'A' which was an improvement from the previous audit results when the hospital was rated as the 'B'. Since October 2014 the trust had either been ranked first or second regionally in the SSNAP audit. The trust had actions in place to improve care. These included dedicated stroke beds 'out of beds escalation policy' and weekly meetings to discuss the patient journey for people who'd had a stroke.

Summary of findings

- 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.
- In the 2013 national diabetes inpatient audit (NaDIA) the trust was better than the England average in 13 of the 21 indicators. The trust performed worse than the England average in foot assessments.
- The national hip fracture audit measures a set of outcomes for patients who have suffered a hip fracture and been admitted to hospital. The service performed better than the England average for five of the seven outcomes measured in the national hip fracture audit. The service performed worse in two of the seven outcomes measured; these outcomes were the number of patients developing pressure ulcers and the total length of stay for patient who suffered a hip fracture. There was no action plan in place to address this at the time of our inspection.

- The national bowel cancer and national lung cancer audits measure a number of outcomes that give an indication of how well patients with bowel and lung cancer are treated. The service performed better than the England average for all the indicators measured in both of these audits.
- Performance reported outcomes measures (PROMs) data between April 2014 and December 2014 showed that the percentage of patients with improved outcomes following groin hernia, hip replacement, knee replacement and varicose vein procedures was either similar to or slightly worse than the England average.
- Hospital episode statistics from January 2014 to November 2014 data showed the average length of stay for elective and non-elective patients across all specialties was similar to the England average.
- Data on hospital episode statistics December 2013 to November 2014 showed the number of patients who were readmitted to this hospital after discharge following elective and non-elective surgery was similar to the England average for all specialties except urology and gastrointestinal surgery where readmission rates were slightly worse. One of the measures put in place to attempt to improve readmission rates in urology was the introduction of a urology consultant who ran daily clinics within the emergency surgical assessment unit.

Summary of findings

- This helped reduce readmission rates by giving patients access to a specialist consultant on a daily basis rather than attending the emergency department or being readmitted to the ward unless absolutely necessary.
- In addition, the emergency surgical assessment unit had used a similar approach and had recently increased the number of surgical consultants on the unit to three from zero. These consultants worked on the unit daily ensuring that there was at least one consultant on duty every day of the week. These actions had increased clinical presence and the support had helped reduce readmission and general admissions to the surgical wards.
- In critical care, national data confirmed that patient outcomes and mortality were generally within the expected ranges when compared with similar units nationally. The exception being for delayed and out of hours discharges where the unit's performance was slightly worse than the England average.

Multidisciplinary working

- Multidisciplinary team work was well established and focused on the securing good outcomes for patients.
- There were mechanisms in place such as combined ward rounds and regular MDT meetings across services that enabled a range of relevant disciplines to positively contribute to the care and treatment of patients.
- It was evident that colleagues valued each other's contribution; relationships between the disciplines were positive and productive.
- However, multidisciplinary team meetings were not held on regular basis on all wards at Clatterbridge hospital which meant that important information was not formally discussed by all members of the care team.

Consent, Mental Capacity Act & Deprivation of Liberty safeguards

- 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.
- Staff, in the main, had appropriate skills and knowledge to seek consent from patients or their representatives.
- Records confirmed that verbal or written consent had been obtained from patients or an appropriate person. However, there were examples were patients consent had not been appropriately recorded in the emergency department.

Summary of findings

- Most staff understood the legal requirements of the Mental Capacity Act (2005) and Deprivation of Liberties Safeguards. Although the knowledge and understanding of staff in medical services varied in respect of the Mental Capacity Act with particular reference to the use of bedrails.
- 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.
- Where issues of capacity were identified they were escalated appropriately.
- Medical staff carried out mental capacity assessments for patients who lacked capacity and where deprivation of liberties safeguards applications had been made accurate records were available for review.
- There was good evidence of multidisciplinary team working and staff were aware of their responsibilities in relation to the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards on the Clatterbridge site.
- Patients' views relating to resuscitation were clearly recorded in their notes and on the appropriate documentation. However we found in end of life services, it was not routinely noted or monitored whether the patients' capacity to make and communicate decisions had been assessed.
- Also It was not clearly noted when the DNACPR should be reviewed once in place.

Are services at this trust caring?   Good ●

Care and treatment was delivered by caring and compassionate staff. Staff at all grades treated patients with dignity and respect. Patients were positive about their interactions with staff. They felt that staff were open, honest and helpful.

Staff actively involved patients and those close to them in their care and treatment. Patients understood their treatment and the choices available to them.

Patients felt their wishes and preferences were considered and valued by the staff team.

Staff provided care to patients while maintaining their privacy, dignity and confidentiality.

Meeting people's emotional needs was recognised as important and staff were sensitive and compassionate in supporting patients and those close to them during difficult and emotional periods.

Summary of findings

The NHS Family and Friends Test indicated positive and improving patient satisfaction rates across a range of core services.

Compassionate care

- Staff treated patients with dignity, respect and compassion. Staff took time to interact with patients in a considerate and sensitive manner.
- Staff respected patients' rights to make choices about their care and communicated with patients in a way they could understand.
- Staff provided care to patients while maintaining their privacy, dignity and confidentiality.
- In emergency care, the NHS Friends and Family Test (FFT) percentage recommend is consistently higher than the England average (between 97%-100% compared to 86%- 88%) for Mar 14 – Feb 15.
- Two surgical wards at Clatterbridge hospital had frequently received 100% recommend in the FFT between Mar 14 and Jan 15.
- The percentage of patients recommending the trust was higher than the England average for antenatal, postnatal ward, birth and postnatal community services in the FFT between Mar 14 – Feb 15. Antenatal and postnatal community scored 100% for 8 and 10 months respectively during the period.
- The trust scored better than other trusts for five of the 17 indicators in the CQC Maternity Survey 2013, with the remaining 12 scoring about the same as other trusts.
- The trust was performing better than the England average in all four parts of the patient-led assessments of the care environment (PLACE). These were cleanliness, food, privacy, dignity and wellbeing and facilities.
- The trust performed about the same as similar trusts in all areas of the 2014 CQC inpatient survey

Understanding and involvement of patients and those close to them

- Patients and those close to them confirmed that staff kept them informed about their treatment and care.
- Patients and those close to them were encouraged and supported to be part of the decision making processes. Patients felt that staff took in to account their wishes and preferences when delivering care and treatment.
- They spoke positively about the information staff gave to them both verbally and in the written materials, such as information leaflets specific to their condition and treatment.

Summary of findings

- Patients confirmed medical staff fully explained the risks and benefits of treatment options to them and allowed them to make informed decisions.

Emotional support

- Meeting people's emotional needs was recognised as important and staff were sensitive and compassionate in supporting patients and those close to them during difficult and emotional periods.
- Staff were supportive and empathetic to people close to patients who had died. We found that staff often went the 'extra mile' to support and comfort bereaved relatives.

Are services at this trust responsive?

Requires improvement ⬤

Services were planned to meet the needs of the local population and included national initiatives and priorities. The trust was working with health partners in the locality, leading one of the national vanguard sites to develop new healthcare models that sought to bring GPs, community services, mental health and hospital services closer together to re-shape how services are provided and support the improvement and integration of services.

Patients were appropriately assessed and provided with treatment plans based on clinical priority.

There was a strengthening approach to discharge planning that began at the point of a patient's admission.

There were positive initiative's in place to support the individual needs of patients whose circumstances or condition made them vulnerable. For example, patients living with dementia.

However, in some specialties care and treatment was not always provided in a timely way and national Referral to Treatment (RTT) targets were not consistently met. The emergency department was under considerable pressure from unplanned admissions and had consistently failed to meet the Department of Health target requiring 95% of patients to be seen, treated, admitted or discharged in under four hours of attendance between December 2014 and June 2015. In April 2015 only 79% of patients were seen within four hours.

In addition, diagnostic and imaging test results were not always provided within agreed timeframes.

Service planning and delivery to meet the needs of local people

- Services were planned to meet the needs of the local population and included national initiatives and priorities. The

trust was working with health partners in the locality, leading one of the national vanguard sites to develop new healthcare models that sought to bring GPs, community services, mental health and hospital services closer together to re-shape how services are provided and support the improvement and integration of services.

- Patients were appropriately assessed and provided with treatment plans based on clinical priority.
- There was a strengthening approach to discharge planning that began at the point of a patient's admission.
- The trust had implemented a dementia care strategy to support a sensitive person centred approach to the care of patients with dementia.

Meeting people's individual needs

- Information leaflets about services and treatments were readily available in all areas.
- Leaflets and written information could be provided in different languages or other formats, such as braille, if requested.
- Interpreter services for patients' whose first language was not English were available. Staff also had access to a telephone interpreter facility.
- A specialist lead nurse was available to provide staff with guidance and support to meet the needs of patients with a learning disability.
- A reasonable adjustment pathway was in place for patients living with a disability and in use in all theatre areas. This pathway alerted staff to any reasonable adjustments that they needed to make so that patients individual needs could be met.
- Access to psychiatric support was readily available for patients who had or developed a mental illness.
- Staff could access appropriate equipment to support safe moving and handling of bariatric patients (patients who are clinically obese).
- The theatre recovery areas had designated paediatric theatre and recovery bays. Paediatric patients frequently had to be treated in the main theatre and recovery areas for emergency surgery.
- Environmental access for patients who had a physical disability was good with the exception of the emergency surgical assessment unit. The emergency surgical assessment unit had narrow corridors and furniture blocked key access routes to toilet facilities for patients with restricted mobility. The ward sister told us that there were plans to relocate the unit to more suitable premises in the near future.

Summary of findings

- The trust scored well in the Cancer Patient Experience Survey 17 questions scored in the top 20% of trusts.

Dementia

- The trust had a well-developed approach to meeting the individual needs of patients living with dementia.
- There was a dementia strategy in place supported by mandatory staff training.
- A specialist lead nurse provided advice and support to staff.
- All wards had a dementia link nurse and dementia champions had been appointed. The champions had links with the trust's dementia lead nurse.
- Staff used 'this is me' documentation and a 'forget-me-not' sticker to alert colleagues and support individualised care planning.
- Patients or their representatives completed this document and included key information such as the patient's likes and dislikes so their wishes and preferences could be met.
- There were designated dementia friendly wards where consideration had been given to the environment to prevent patients suffering avoidable harm.
- There some excellent examples of sensitive and person centred care of patients living with dementia.

Access and flow

Emergency Department

- The emergency department was under considerable pressure from unplanned admissions and had consistently failed to meet the Department of Health target requiring 95% of patients to be seen, treated, admitted or discharged in under four hours of attendance between December 2014 and June 2015. In April 2015 only 79% of patients were seen within four hours. In June 2015, 91% of patients were seen within the time frame. In July 2015 the service met the target with 97% of patients seen within the time frame but by the end of August 2015 the percentage had fallen to again to 90%.
- The number of patients waiting between four and 12 hours for admission to hospital was worse than the national average between April 2014 and April 2015 and had risen over time. For example in May 2014, a national average of five patients waited compared with 13 patients in this trust. By April 2015 this figure rose to 35 patients against a national average of 10.

Summary of findings

- For patients arriving by ambulance the department consistently took longer to complete an initial assessment (between 10 and 16 minutes) than the national average (between 3 and 6 minutes).
- The department reported 952 occasions when ambulance personnel waited longer than 30 minutes to hand over patient information for the five months prior to our inspection.
- Between March 2014 and May 2015 the trust reported 609 occasions when ambulance personnel had to wait longer than 60 minutes to hand over patient details. This was worst in March 2015 when 36 delays of more than 60 minutes occurred.
- Senior staff explained that access and flow was affected by the capacity to admit patients to available beds within the hospital. The trust's patient flow workgroup focused on strategies to maintain patient flow. These included introducing daily ward reviews to identify patients ready for discharge, implementing early supported discharges through collaboration with social services and expanding the bed base through escalation procedures.

Medical services

- Referral to treatment times (RTT) for all medical specialities including cardiology, gastroenterology and neurology were within with the England average and general medicine was 100% compliant with 18 weeks RTT.

Surgical services

- Surgical services were performing above the England average for the national 18 week referral to treatment target. However, the service narrowly missed the target of 90% in the urology and general surgery specialities, with urology performing at 88.2% and general surgery at 89.2%.
- NHS England data showed there was a significant improvement in the number of operations cancelled from October 2013 to March 2015, where the service had consistently performed better the England average. This meant that a lower number of patients had their planned operations cancelled in this service compared to other services of a similar size in England.

Children and young people's services

- The community paediatric service consistently failed to meet national 18 week referral to treatment targets and the waiting list was lengthy with some children waiting up to 47 weeks for treatment. However, services for children at Arrowe Park consistently met the national referral to treatment targets.

Outpatients

Summary of findings

- In the period April 2014-March 2015 the trust met the target for 93% for patients to be seen by a specialist within two weeks of an urgent referral for concerns about cancer. The performance for this period ranged from 93.4% and 97.5%.

Diagnostic and Imaging services

- The national target for referral to non-urgent radiology diagnostic tests to be undertaken is six weeks. This target was achieved for 98.3% of patients across the whole trust between September 2014 and August 2015.
- In the period May 2015 to August 2015 over 90% of routine radiological tests such as plain film x-rays were reported in the required timeframe. However, in the magnetic resonance imaging (MRI) department, routine reporting times were significantly lower falling to 24% in July 2015. The radiology manager advised that a staffing review was in progress in the computerised tomography (CT), ultrasound and MRI departments.
- The trust had an internal target to report 98% of urgent radiology tests within a defined timescale from referral. The timescale was different for each and was determined by the type of radiology test required. In the period April 2015 to August 2015 the trusts internal reporting target was not achieved for x-ray, CT scans, ultrasound or MRI scans. Referral to report within fifteen operational days for urgent CT scanning ranged from 87% in April 2015 to 86.8% in August 2015. Referral to report within fifteen operational days for urgent MRI scanning ranged from 64% in April 2014 to 67% in August 2015. We saw evidence in one patient's medical record that the patient had waited a month for urgent CT scan results.

Delayed Discharges

- The high demand for medical services was having an impact on patients' length of stay, delayed transfers of care and timely discharge.
- Delays in discharge were attributed to issues relating to accessing care packages, care facilities in the community and the large geographical area covered by the trust.
- Between April 2015 and July 2015 bed occupancy across medical services at the trust was consistently above 90%. Evidence shows when bed occupancy rises above 85% it can affect the quality of care provided to patients and the running of the hospital
- The trust had recently employed a member of staff who was seeking ways looking to reduce the bed occupancy and improve patient flow.

Summary of findings

- At the time of our inspection there were 61 delayed discharges across all specialities.
- There was a multidisciplinary integrated discharge team to support the discharge of patients across the trust. This team worked seven days a week.
- The trust was working with community services to increase the number of transitional beds from 40 to 70 while patients waited for their preferred care home.
- There were plans in place to support be a fortnightly discharge planning group to look at best practice around discharges. This group will include community colleagues and social services and would be operational from October 2015.

Learning from complaints and concerns

- All formal complaints were recorded on the trust-wide system.
- Staff understood the trust wide policy and process for receiving and managing complaints.
- Complaints, emerging themes and actions for improvement were discussed and monitored at board level.
- Performance in relation to timely response was also monitored at board level.
- In June 2015, 78% of complaints had been managed within the agreed timescales. This was slightly below the trusts internal target of 80%.
- Learning from complaints was shared and disseminated to secure improvement and improve patient experience.
- Posters were displayed around both hospitals detailing how to make a complaint. Leaflets detailing how to make a complaint were readily available in all patient areas.
- Notice boards within the clinical areas included information including the number of complaints and improvements made in response.
- There was evidence of improvements in response to complaints, however we found that complaints regarding the timely issuing of death certificates had not always been managed or investigated in accordance with the trusts policy.

Are services at this trust well-led?

The trust had a vision 'to be the first choice healthcare partner to the communities we serve - from home to the provision of regional specialist services'

The vision was underpinned by the PROUD values; Patient, Respect, Ownership, Unity and Dedication

Requires improvement ●

Summary of findings

Staff were aware of and could articulate the organisational vision and values. There were examples of the trusts vision and values being put in to practice on display throughout the trust.

The trust was led and managed by a visible executive team. There had been recent changes within the senior team following the resignation of the Director of Finance, the Executive Director of Operations and the imminent retirement of the Director of Nursing (DON). The trust had plans in place to reappoint to these positions and had good interim plans in place. The trust was planning to appoint a new Chief Operating Officer and Deputy Chief Executive early in 2016.

In addition, a new Director of Nursing had already been appointed and was working closely with the current DON to facilitate and ensure a smooth handover.

The trust was aware of the challenges it faced and the areas we have as identified as requiring improvement were known to the trust. Plans were either in place or being developed to improve performance in the areas identified.

The trust had robust systems and an improving approach to governance and risk management that had developed over time. Roles and responsibilities for risk management were clear and there was a clear governance reporting structure. However there was evidence that in a number of core service areas the systems for governance, risk management and quality measurement were not consistently applied or utilised. In addition the leadership and trust oversight of the service for patients at the end of life required significant improvement.

In response to disappointing the survey results the trust had developed and implemented Workforce and Organisational Development Strategy to support the securing of a healthy organisation and a sustainable and capable workforce.

The trust had also developed an action plan and implemented a range of communication and inclusion initiatives to promote staff engagement. Staff were positive about these developments and as a result both staff and engagement and morale was improving.

Vision and strategy

- The trust had a vision 'to be the first choice healthcare partner to the communities we serve - from
- The vision was underpinned by the PROUD values; Patient, Respect, Ownership, Unity and Dedication
- The trust's Quality Improvement Strategy 2013-16 underpinned its 5 year clinical strategies

Summary of findings

- Goals and objectives were articulated in the Quality Improvement Strategy and were measured through the Quality Account.
- Quality goals reflected the trust's strategic objectives
- We were concerned in respect of the lack of leadership and strategic approach in services for patients at the end of life. There was a draft three-year vision developed by the trust's end of life care committee.
- In the critical care service there was no clear, shared vision or strategy for the service.

Governance, risk management and quality measurement

- The trust had a robust and improving approach to governance and risk management that had developed over time. Roles and responsibilities for risk management were clear and there was a clear governance reporting structure.
- The Board Assurance Framework was aligned to strategic objectives, risks, performance activity, and relevant quality indicators.
- Information relating to performance against quality, safety and performance objectives was monitored through performance dashboards.
- A trust-wide risk register was maintained and risks escalated and reported via the Quality and Safety Committee.
- Risks and performance issues were escalated to relevant committees and onwards to the board through clear reporting structures and processes.
- The board received regular assurance reports from the Quality and Safety Committee, an integrated performance report, quality dashboard and quality account reports. There was good oversight and appropriate support and challenge from the board in relation to performance and risk management.
- Staff in the wards and departments had access to performance information and were in the main able to describe the risks relevant to their service. Regular governance meetings took place at ward, department and divisional levels with opportunities for issues and achievements to be escalated appropriately. However, in medical services there was limited evidence of learning discussed at governance meetings and although a significant amount of data was captured this was not always consistently used effectively to inform clinical practice locally.
- In the emergency department, quality was measured in terms of national targets however there was limited knowledge in the department of local audits. In addition, although a risk register

was in place and was monitored, actions to manage and mitigate these risks were not always undertaken in a timely way. For example, we saw that the need for an audit was identified in January 2014 yet this hadn't been completed at the time of the inspection, over 18 months later.

- In critical care services there was a governance structure in place although at times it was unclear how risks were being managed and reviewed. There was no local risk register consequently it was unclear what controls were in place to mitigate risks within the service.

- The critical care unit was a member of the Cheshire and Merseyside Critical Care Network (CMCCN). 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. However, despite a review undertaken by the CMCCN in March 2015, some of the highlighted issues had not been addressed at the time of the inspection such as the lack of a local risk register.

- In maternity services we were concerned that the trust were not always sighted on the levels of risk at which the service was operating as the risk management systems such as the ward safety check, incident review and root cause analysis process were not always implemented correctly.

- There were local risk registers in place that highlighted risks across the services. Actions were in place to address concerns for example failure to meet National Institute for Health and Care Excellence (NICE) guidelines. However, we were not assured that risks were being managed appropriately in some services. For example, there were risks on the register in A and E, medical services and children and young people's services. Some risks had been there since 2012 and 2013 with actions still being completed.

- There had been no radiation safety committee meeting since September 2012 and it is a statutory requirement that radiation protection meetings take place at least annually.

- We saw limited evidence of an effective, overarching performance quality system for specialist palliative or end of life care and some risks relating to end of life services were not recorded on the risk register. Records we reviewed confirmed that the various aspects of the service were monitoring their own performance with monthly updates. Updates consisted of reviewing patient feedback, waiting times from referral to first appointment, patients care files, and access to death certification. However, we found no evidence of action plans or shared learning as a result of this local monitoring.

Leadership of the trust

Summary of findings

- The trust was led and managed by a visible executive team. There had been recent changes within the senior team following the resignation of the Director of Finance, the Executive Director of Operations and the imminent retirement of the Director of Nursing (DON). The trust had plans in place to reappoint to these positions and had good interim plans in place. The trust was planning to appoint a new Chief Operating Officer and Deputy Chief Executive early in 2016.
- In addition, a new Director of Nursing had already been appointed and was working closely with the current DON to facilitate and ensure a smooth handover.
- The trust was aware of the challenges it faced and the areas we have as identified as requiring improvement were known to the trust. Plans were either in place or being developed to improve performance in the areas identified. For example the trust was facing significant financial difficulties and had worked with our partner regulator Monitor to develop a recovery plan.
- At the time of our inspection the trust was making steady progress regarding the delivery of the plan and was delivering improvements within agreed targets and time frames.
- However, the leadership and trust oversight of the service for patients at the end of life required significant improvement.

Culture within the trust

- Staff were proud of the work they did and demonstrated a commitment to providing patients with high quality services.
- Morale was improving and staff were aware of the challenges faced by the trust and the plans on place to address them.
- Staff were more positive about the visibility and accessibility of the senior team as well as the improvements in staffing made since our last inspection.

Staff engagement

- The trust board were presented with the 2014 staff survey results in February 2015.
- There was a 46% response rate (2448) just above the national average of 42%.
- The trust's scores had deteriorated in 15 of the 29 key findings, with no change in 11, two not comparable and one score had improved.
- The key issues in relation to staff satisfaction related to support from mangers, job satisfaction, staff motivation at work and overall staff engagement all of which were below the national average, coupled with 16% deterioration in the percentage of staff recommending the organisation as a place to work.

Summary of findings

- The trust felt that the deterioration in the survey resulted related to a period of unprecedented challenge in relation to its use of escalation beds over a difficult winter period and its financial and staffing difficulties. In being honest and open with staff about these challenges the trust felt that instead of informing and including staff, the messages had heightened anxiety about the future of the organisation had impacted on staff morale and motivation. The trust had undertaken a reflective exercise in this regard and had taken the opportunities to learn and improve its communication with staff for the future. The trust had also improved its approach to winter pressure planning both internally and with service commissioners so that the staff and services were better sighted and prepared when pressures and demands increased.
- In response to the survey results the trust had developed and implemented Workforce and Organisational Development Strategy to support the securing of a healthy organisation and a sustainable and capable workforce.
- The trust had also developed an action plan and implemented a range of communication and inclusion initiatives to promote staff engagement such as the introduction of the "Wirral way" programme, 'Listening in to Action', a 'raising concerns' process, a culture guardian and a staff charter.
- Staff were positive about these developments and as a result both staff and engagement and morale were improving.
- The trust was aware that there was still work to in this important area and was committed to further improvements to staff engagement over time.

Fit and Proper Persons

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

Innovation, improvement and sustainability

- The trust was working with health partners in the locality, leading one of the national vanguard sites to develop new

Summary of findings

healthcare models. The new models of care sought to bring together GPs, community services, mental health and hospital services to re-shape services and support the improvement and integration of services for the benefit of patients.

Overview of ratings

Our ratings for Arrowe Park Hospital

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

Our ratings for Clatterbridge Hospital

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

Overview of ratings

Our ratings for Wirral University Teaching Hospital NHS Foundation Trust

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

Notes

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

Outstanding practice and areas for improvement

Outstanding practice

We saw several areas of outstanding practice including:

- The sentinel stroke national audit programme (SSNAP) latest audit results rated the trust overall as a grade 'A' which was an improvement from the previous audit results when the trust was rated as a grade 'B'. Since October 2014 the trust had either been ranked first or second regionally in the SSNAP audit

Arrowe Park Hospital

- Senior clinicians on the emergency surgical assessment unit had recognised that fluid balance monitoring could be improved and introduced a training programme for health care support workers to achieve this aim. Health care support workers told us they felt empowered by the training and saw fluid balance monitoring as an integral part of their role after it. Audits showed that the completion of fluid balance charts had improved since the training and senior clinicians reported that there had been a significant reduction in the number of patients developing acute kidney injuries (a condition associated with dehydration).

Clatterbridge Hospital

- We observed staff displaying a very caring person centred attitude which went beyond what was expected. Staff encouraged patients and their relatives to be active partners in their care. Staff went above and beyond to meet patient's preferences. There were strong relationships between staff, patients and their relatives.
- Patients' needs and preferences were central to the planning and provision of services. One example of this was the repurposing of a clinical area into a domestic dwelling. This was designed to help prepare medical and surgical patients for discharge to their own home and bridge the gap between acute patient care and community rehabilitation. Patients could 'move' into the dwelling with their relatives for short periods before discharge. This helped staff identify whether any further measures were needed before patients were discharged. It also empowered patients to maintain their independence and improve their confidence prior to discharge. Staff told us that this had been introduced partly due to issues which were raised around patients discharge home when they felt they weren't ready.

Areas for improvement

Action the trust MUST take to improve

The trust must:

Arrowe Park Hospital

Urgent and emergency care

- Ensure call bells are available in every bay and placed with patients.
- Staffing continues to remain a focus and that shifts are adequately staffed to meet the needs of patients.
- Ensure that risks are always managed and mitigated in a timely way.

Medical care (including older people's care)

- The trust must ensure that robust information is collected and analysed to support improvements in clinical and operational practice.
- The trust must ensure that care and treatment is only provided with the consent of the relevant person and if a patient lacks capacity to consent, the Mental Capacity Act (2005) principles are adhered to. This must be supported by staff receiving training in consent and the principles of the 2005 act.
- The trust must deploy sufficient staff with the appropriate skills on wards, especially on the medical short stay ward and on ward 16 at night.
- The trust must ensure that learning is shared across all service areas and the reasons for any changes made clear to all staff.

Outstanding practice and areas for improvement

- The trust must ensure that records are kept secure at all times so that they are only accessed and amended by authorised people.

Surgery

- The trust must ensure that there are adequate numbers of suitably qualified staff in theatre recovery areas to ensure safe patient care.

- The trust must ensure that all staff involved with the care and treatment of children receive adequate life support training.

- The trust must ensure that all staff receive are appropriately trained and able to use the incident reporting system.

Critical care

- The trust must address the governance shortfalls in critical care and make sure that the systems and processes in place for assessing, monitoring and mitigating local risk are managed effectively.

- The trust must ensure that all staff understand the thresholds for reporting incidents and are encouraged to use the electronic reporting system.

- The trust must make sure that all staff understand and comply with the best practice in infection prevention and control. This includes appropriate use of handwashing and the use of antiseptic hand gels.

Maternity and gynaecology

- Review the management of the electronic rostering system to ensure it does not allow staff to be rostered on different wards at the same time.

- The provider must deploy sufficient clinical and midwifery staff with the appropriate skills at all times of the day and night to meet the needs of women following the trust risk assessment and escalation procedures.

- The provider must ensure that there is a detailed overview of the types and seriousness of incidents and learning is shared across all service areas and the reasons for any changes made clear to all staff.

- The provider must make sure individual care records are always accurate and completed contemporaneously.

- The provider must make sure community midwives have easy access to the emergency medication and equipment detailed in best practice guidance. The equipment must be checked and items provided within the use by date.

Children and young people's services

- Resuscitation trolleys must be appropriately checked and the log book must be signed to confirm all items are in working order. The trolley must include a defibrillator at all times.

- Must ensure that there is a robust system to determine staffing numbers which takes into account the acuity of patients and skill mix of staff.

- Information must be collected and analysed to support developments in clinical and operational practice.

- Must review the children's safeguarding training to ensure it meets Royal College of Paediatrics and Child Health (RCPCH) guidelines 2014.

End of life

- Ensure that any complaint received is investigated and necessary and proportionate action is taken in response to any failures identified by the complaint or investigation.

- Seek and act on feedback from relevant persons and staff teams, for the purpose of continually evaluating and improving services.

- Evaluate and improve their practice in respect of the processing of information relating to the quality of people's experience.

- Ensure there is a robust vision and strategy for end of life services and all staff are aware of them.

- Ensure that there is an appropriate replacement care plan in place across the trust following the withdrawal of the Liverpool Care Pathway.

- Ensure that all risks associated with end of life services are recorded and monitored with appropriate actions taken to mitigate them.

Outstanding practice and areas for improvement

Outpatients and diagnostics

- The trust must take action to reduce the delay in referral to reporting times of urgent diagnostic investigations.

- The trust must resume radiation safety committee meetings and hold them at least annually.

- The trust must take steps to fill vacancies to ensure compliance against their current staffing establishment.

Clatterbridge Hospital

Medical care (including older people)

- Ensure that robust information is collected and analysed to support improvements in clinical and operational practice.
- Deploy sufficient staff with the appropriate skills on the Clatterbridge rehabilitation unit at night.
- Ensure there is adequate medical cover out of hours for the hospital.

- Ensure there is a clear operational protocol for the transfer of patients whose condition deteriorates

Surgery

- Ensure that all staff involved with the care and treatment of children receive adequate life support training.
- Ensure there is sufficient medical cover out of hours for the hospital.
- Ensure there is a clear operational protocol for the transfer of patients whose condition deteriorates
- The trust must ensure that the doors which lead to high balconies on the ward areas are suitably secured.

Outpatients and diagnostic imaging

- Take action to reduce the delay in referral to reporting times of urgent diagnostic investigations.
- Resume radiation safety committee meetings and hold them at least annually.
- Take steps to fill vacancies to ensure compliance against their current staffing establishment.

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 11: Consent **How the regulation was not being met:** Care and treatment was not always provided with the consent of the relevant person. This is because the consent for a procedure had not been documented in a patient record we reviewed on ward 14. In addition, the bed rails assessment did not include the recording of consent to the use of bedrails or best interest decisions for patients who lacked capacity to consent. HSCA 2008 (Regulated Activities) Regulations 2014, Regulation 11(1)(3)

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 12: Safe care and treatment **How the regulation was not being met:** The emergency department did not include arrangements to respond appropriately and in good time to people's changing needs. This is because we found that call bells were either out of reach of patients, or not installed at the bed side of patients in the 'trolleys' area of the emergency department.

Requirement notices

HSCA 2008 (Regulated Activities) Regulations 2014, Regulation 12 (2) (a).

How the regulation was not being met:

The service was not doing all that was reasonably practicable to mitigate the risks to service users.

This is because a resuscitation trolley on a paediatric ward was not checked regularly and it contained out of date equipment and there was no defibrillator present.

Also, there were also lengthy delays in the reporting of urgent diagnostic test results.

HSCA 2008 (Regulated Activities) Regulations 2014, Regulation 12(2)(b)

How the regulation was not being met:

Care and treatment was not always carried out assessing the risk of, and preventing, detecting and controlling the spread of infections, including those that are health care associated.

This is because not all staff in critical care were washing their hands or using antiseptic hand gel as appropriate when delivering patient care or moving from one patient or their bed space to the next.

HSCA 2008 (Regulated Activities) Regulations 2014, Regulation 12 (2) (h)

How the regulation was not being met:

Care and treatment did not include arrangements to respond appropriately and in good time to people's changing needs. The provider did not have arrangements to take appropriate action if there was a clinical or medical emergency.

This is because there wasn't a standard process or procedure in place in the event that a patient deteriorated and required transfer from Clatterbridge Hospital to an acute hospital.

HSCA 2008 (Regulated Activities) Regulations 2014, Regulation 12 (1) (2) (a) (b)

Requirement notices

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 13: Safeguarding service users from abuse and improper treatment. **How the regulation was not being met:** Safeguarding children's training was not provided in line with best practice guidance. This is because children's safeguarding training did not meet Royal Children's Paediatric Child Health (RCPCH) guidelines 2014. HSCA 2008 (Regulated Activities) Regulations 2014, Regulation 13 (2)

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 15: Premises and equipment **How the regulation was not being met:** Access to and exits from a ward were not appropriately secure. This is because the security arrangements presented a risk that patients may leave and visitors may enter unnoticed. HSCA 2008 (Regulated Activities) Regulations 2014, Regulation 15 (1) (b).

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints

Requirement notices

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 16: Receiving and acting on complaints.

How the regulation was not being met:

The registered person did not establish and operate effectively an accessible system for identifying, receiving, recording, handling and responding to complaints by service users and other persons in relation to the carrying on of the regulated activity.

This is because complaints were raised in relation to the timely completion of death certificates but the trust had not taken any action to address this at the time of the inspection.

HSCA 2008 (Regulated Activities) Regulations 2014, Regulation 16 (2)

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 17: Good Governance **How the regulation was not being met:** Systems and processes were not always operated effectively to ensure that the risks relating to the health, safety and welfare of service users and others were assessed, monitored and mitigated in a timely way. This is because the systems and processes for managing local risks did not always assess, monitor and mitigate risks such as patient transfer equipment, which did not meet the current Intensive Care Society standards for the transport of critically ill adults. In addition, all departments had a risk register but the risks were not always managed and mitigated in a timely way. This is also because radiation safety committee meetings were not being held at least annually. HSCA 2008 (Regulated Activities) Regulations 2014, Regulation 17(2)(b)

Requirement notices

How the regulation was not being met:

Records were not always secure, accurate or completed fully.

This is because record trolleys were left unlocked on some of the medical wards we visited. In addition, we reviewed a sample of 23 patient records in the emergency department and found that 19 were not fully completed. For example, pain scores were missing in six records, initial observations were missing in three records and information relating to safeguarding and social circumstances was not recorded in five records. In addition, the electronic record keeping system in maternity did not ensure records were always complete and contemporaneous in respect of each service user.

HSCA 2008 (Regulated Activities) Regulations 2014, Regulation 17(2) (c).

How the regulation was not being met:

The provider did not always assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services)

The provider did not seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity

The provider did not evaluate and improve in respect of the processing of information.

This is because the trust did not collect and analyse all available information in medical care and end of life care to support improvements in clinical and operational practice.

HSCA 2008 (Regulated Activities) Regulations 2014, Regulation 17(2)(a)(e)(f)

How the regulation was not being met:

Requirement notices

There were insufficient systems or processes established and operated in maternity to effectively ensure a robust response by staff to the guidance provided and action required to mitigate risks.

This was because of ineffective staff rostering, staffing escalation process; poor implementation of the ward safety alert protocol; insufficient implementation of changes in best practice guidance from lessons learnt from incidents or root cause analysis.

In addition, community midwives did not have easy access to emergency medication and equipment detailed in best practice guidance. The equipment must be checked and items provided within the use by date.

HSCA 2008 (Regulated Activities) Regulations 2014, Regulation 17 (1) (2) (a) (b)

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 18 HSCA (RA) Regulations 2014 Staffing
Maternity and midwifery services	Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 18: Staffing
Surgical procedures	**How the regulation was not being met:**
Treatment of disease, disorder or injury	There was not a systematic approach to determining the staff and range of skills required.
	There were not always sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed to meet the needs of the patients.
	There were shortages of nurses, midwives and medical staff in several areas throughout both hospitals, particularly in the emergency department, maternity, medical care services, children and young people services, surgical services and radiology. In addition, there was an insufficient number of staff in theatre recovery with training in paediatric life support despite regularly caring for children.
	Also, the systems to determine staffing levels in maternity and children's and young people's services were not robust.
	HSCA 2008 (Regulated Activities) Regulations 2014, Regulation 18 (1) (2) (a)