Care Quality Commission

Warrington and Halton Hospitals NHS Foundation Trust

Warrington Hospital

Quality Report

Warrington Hospital
Lovely Lane
Warrington
Cheshire
WA5 1QG
Tel: 01925 635911
Website: **www.whh.nhs.uk**

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

We carried out an announced inspection of Warrington Hospital between the 7 and 10 of March 2017. In addition, we carried out an unannounced inspection between 3pm and 9pm on the 23 March 2017. This inspection was to follow up on the findings of our previous inspections in January and February 2015, when we rated the trust as requires improvement overall. We also looked at the governance and risk management support for all of the core services we inspected.

At this inspection we inspected the following services at Warrington Hospital:

- Urgent and Emergency Care
- Critical Care Services
- Services for Children and Young People
- Maternity and Gynaecology Services
- Medical Services [Including the care of older people]
- Surgery
- End of Life Services
- Outpatient and Diagnostic Services

As part of this inspection, CQC piloted an enhanced methodology relating to the assessment of mental health care delivered in acute hospitals; the evidence gathered using the additional questions, tested as part of this pilot, has not contributed to our aggregation of judgements for any rating within this inspection process. Whilst the evidence is not contributing to the ratings, we have reported on our findings in the report.

We rated Warrington Hospital as requires improvement overall with Medicine [including older people's care] Critical Care, Outpatient and Diagnostic services and Maternity and Gynaecology Services as requires improvement. We rated Urgent and Emergency , Surgery, End of Life Services and Services for Children and Young People as good.

There had been progress since our previous inspection with, improvements noted in urgent and emergency care, maternity, surgery, outpatient and diagnostic services and Critical care. However, Warrington Hospital continues to require improvement in key areas.

Our key findings were as follows:

- Systems had been put in place to improve access and flow through the Accident and Emergency department and although targets were not been met there had been a continuous improvement in waiting times.
- The trust monitored the number of cancelled operations on the day of surgery. Performance data showed that the number of cancelled operations on the day of surgery had improved from 11.9% in February 2016 to 8.8% in January 2017.
- The National Paediatric Diabetes Audit 2014/15 showed that Warrington hospital performed better than the England average for the number of individuals who had controlled diabetes.
- There had been some improvements since our last inspection in January 2015: working relationships between medical staff and midwifery staff, overall culture was improving, WHO checklist and consent forms, laparoscopic hysterectomies were undertaken and mandatory training for nurse and midwifery compliance rates had improved.

We saw some areas of outstanding practice including:

Summary of findings

- The trust had developed the Paediatric Acute Response team to deliver care in a Health and Wellbeing Centre in central Warrington. This allowed children and young people to access procedures such as wound checks and administration of intravenous antibiotics in a more convenient location. It also allowed nurse-led review of a range of conditions such as neonatal jaundice and respiratory conditions in a community setting that would have previously necessitated attendance at hospital.
- Within the urgent and emergency care division, the use of the Edmonton frailty tool in the treatment of older people in the department and the wider health economy.
- The training of all the consultants within the accident and emergency department in the use of ultrasound for timely diagnosis of urgent conditions.
- The trust had direct access to electronic information held by community services, including GPs. This meant that hospital staff could access up-to-date information about patients, for example, details of their current medicine.
- The environment on the Forget Me Not ward had been designed using the recommendations set out by The Kings Fund to be dementia friendly. The ward was designed to appear less like a hospital ward and featured colour coded bay areas and a lounge and dining area designed to look like a home environment. There was access to an enclosed garden and a quiet room.

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

Importantly, the hospital must:

- The hospital must ensure that staff receive training on the Mental Capacity Act (2005) and that staff work in accordance with The Act.
- The hospital must ensure that paper and electronic records are stored securely and are a complete and accurate record of patient care and treatment.
- The hospital must ensure that staff receive the appropriate level of safeguarding training.
- Critical care services must improve compliance with advanced life support training updates and ensure that there is an appropriately trained member of staff available on every shift.
- The hospital must ensure that the formal escalation plan to support staff in managing occupancy levels in critical care is fully implemented.
- The hospital must ensure that there are appropriate numbers of staff available to match the dependency of patients on all occasions.
- The hospital must ensure that all risks are formally identified and mitigated in a timely way as part of the risk management process.
- The hospital must take action to ensure that all safety and quality assurance checks are completed and documented for all radiology equipment, in accordance with Ionising Radiations Regulations.
- The hospital must ensure midwifery, nursing and medical support staffing levels and skill mix are sufficient in order for staff to carry out all the tasks required for them to work within their code of practice and meet the needs of the patient.
- The hospital must ensure all necessary staff completes mandatory training, including Level 3 safeguarding training.
- The hospital must ensure that the assessment and mitigation of risk and the delivery of safe patient care is in the most appropriate place.

Summary of findings

- The hospital must review the impact of the triage system on access and flow and the appropriate assessment of patient safety.
- The hospital must review the safety of the induction bay environment to ensure patient safety is maintained at all times and that the premises are safe to use for the purpose intended.
- The hospital must ensure that all staff receives medical devices training and this is recorded appropriately.
- The hospital must ensure that that the risk register and action plans are comprehensive, robust and adequate to improve patient safety, risk management and quality of care.
- The hospital must ensure staffing levels are maintained in accordance with national professional standards.
- The hospital must ensure that there is one nurse on duty on the children's unit trained in Advanced Paediatric Life Support on each shift.

In addition the trust should:

- The hospital should ensure that the mandatory and safeguarding training rates are monitored for medical staff.
- The hospital should consider that the urgent and emergency care department make improvements to the room used to see patients with mental health problems, particularly to the doors so that they open outwards.
- The hospital should make reasonable adjustments for appropriate patients including those with a learning disability.
- The hospital should improve appraisal rates for nurses and medical staff.
- The hospital should consider that the Early Pregnancy Assessment Unit (EPAU) is opened seven days a week.
- The hospital should identify ways to improve multidisciplinary attendance at local and divisional meetings.
- The hospital should consider the safe storage of patient's notes on the wards.
- The hospital should consider the dignity and privacy of patients within the clinical areas and maternity theatre.
- The hospital should review accommodation on wards where patients are at the end of their lives. To allow them to supported in rooms that afford privacy for the patient and families.
- The hospital should review access to specialist palliative care medical support out of hours.
- The hospital should continue to review compliance with DNACPR policy and clear application and documentation of mental capacity assessments.
- The hospital should ensure all patient case note records are maintained in a complete and chronological order, with accurate details of follow up for patients who did not attend appointments.
- The hospital should ensure patients receive sufficient, clear and appropriate information regarding their hospital appointment. This should include adequate directions to clinic locations and relevant written information about treatment plans where this is indicated.

Professor Ted Baker
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Good	At the previous inspection in January 2015, we rated this service as good. Following this inspection we have maintained the overall rating because: On arrival at the hospital, patients were triaged to the most appropriate department to meet their needs. Appropriate risk assessments were in place to protect patients and analgesia for pain relief could be administered to patients. Patients were monitored using appropriate tools and any deterioration in a patient's condition would be escalated. There were processes in place to help to keep people safe, incident reporting was good and infection control measures were in place. Medicines were administered to patients in a timely way and there were regular checks of equipment. The nurses had reached the trust target for mandatory training. Treatment and pathways for patients were developed using national and local guidance and was delivered by competent staff working in multi-disciplinary teams. There were review structures in place so that treatment was up to date and these were monitored by the staff. Staff were caring and supported patients and their relatives and carers. Privacy and dignity were maintained at all times. Systems had been put in place to improve access and flow through the department and although targets were not been met there had been a continuous improvement in waiting times. Governance structures were robust and there was strong leadership in the department. Staff were empowered through development and learning opportunities and morale in the department was good. However: The department was not meeting Department of Health standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the urgent and emergency care centre. The department was not meeting the targets for time to initial assessment (emergency ambulance

cases only) which should be less than 15 minutes and the time patients should wait from time of arrival to receiving treatment is no more than one hour.
There was insufficient medical cover at night in the department though this had been addressed by the unannounced inspection.
Doctors had not completed their mandatory training. Appraisals for nurses and doctors had not been completed.
The mental health room in the department was not fit for purpose and needed to be improved.
The department needed to work better with patients with learning disabilities to understand their needs.
Reasonable adjustments needed to be made for appropriate patients.

Medical care (including older people's care) — **Requires improvement**

At the previous inspection in January 2015, we rated this service Requires improvement. Following this inspection we have maintained the overall rating because:
There were times when there were insufficient registered nurses to care for patients. There were high numbers of medical staff vacancies and agency use was high.
Patients did not always receive timely medical intervention, for example in cases of sepsis.
Medical handovers were unstructured and medical notes did not always contain sufficient information about patient care and treatment.
Mandatory training rates for medical staff, including safeguarding training, were all below trust target.
Appraisal rates were also below the trust target.
Patients were at risk of being unlawfully deprived of their liberty or receiving care and treatment without consent to because staff did not follow the trust Mental Capacity Act procedure.
Governance systems were not sufficiently embedded within the acute care division. The risk register was not effectively managed to show how risks to patients or the service were being reduced.
Complaints were not always responded to in a timely way.
However:
Care was provided in line with best practice by multi-disciplinary teams who worked well together.

Summary of findings

Patient outcomes were generally good and the trust met the national target for treatment waiting times.
Staff were kind, caring and compassionate and understood the emotional needs of their patients.
The Forget Me Not ward was designed to meet the needs of patients living with dementia and staff provided individualised care for this patient group.
Staff were positive about the leadership and culture of the service.

Surgery

Good

At the previous inspection in January 2015, we rated this service as good. Following this inspection we have maintained the overall rating because:
We found there was a good culture of incident reporting in order to learn and share good practice.
Serious incidents were investigated fully to establish the root cause, and lessons learnt were shared with staff to avoid reoccurrence.
All clinical areas and bed spaces on the surgical wards we visited appeared visibly clean and cleaning schedules were maintained.
Staff could identify and respond appropriately to changing risks to patients, including deteriorating health and wellbeing or medical emergencies.
Mandatory training compliance for nursing staff across the division had improved following the last inspection.
We saw that the service took part in a range of local and national audits and results were discussed at clinical audit meetings and actions for further improvements identified.
All patients and relatives we spoke with told us that that all members of staff treated them with dignity and respect.
We observed many positive interactions between staff and patients during our inspection. We saw that staff were professional and friendly and created a relaxed friendly environment.
Patients we spoke with were very positive about the way staff treated them.
Patients and those close to them told us that they were involved in planning and making decisions about their care and treatment.
Bed meetings took place four times a day to ensure flow was maximised across the hospital.

Summary of findings

The trust monitored the number of cancelled operations on the day of surgery. Performance data showed that the number of cancelled operations on the day of surgery had improved from 11.9% in February 2016 to 8.8% in January 2017.
Between October 2015 and November 2016, the average length of stay for surgical elective patients was better at the trust at 2.7 days, compared to 3.3 days for the England average.
There were a number of specialist nurses within the trust to help support the care and treatment of patients.
The trust's referral to treatment time (RTT) for the percentage of patients seen within 18 weeks was 76.9%, which was better than the England average of 71.5%.
There was 24-hour medical cover on site to attend to patients who had deteriorating needs.
Senior managers were clear on their strategy to provide high quality services for patients, which included working collaborative within the organisation, and in partnership with other trusts to deliver high quality services.
We saw that Local Invasive Standards for Invasive Procedures (LocSSIP's) had been developed in partnership with the North West theatre network. The standards were in place to ensure high quality, safe care and treatment for all patients.
However:
We found not all theatre equipment was clean. However, we saw on the unannounced inspection that all theatre equipment appeared clean and new cleaning schedules introduced with oversight provided by managers.
We found some omissions in the completion of daily checks such as resuscitation equipment, anesthetic machines and controlled drugs. However, we saw on the unannounced inspection that new anesthetic logbooks were in use, and daily checks recorded and, controlled drugs and resuscitation equipment had been checked.
We found in theatres that not all stock ready for use was within its expiry date. For example, on the emergency airways trolley the suction catheter and flexible tracheal tube introducer commonly known as a bougie had passed its expiry date.

Summary of findings

Vacancy rates for nurse staffing was variable across the wards. All staff we spoke with reported this as a concern and often meant they needed to move wards to provide safe staffing levels.
In recovery, we saw that national guidance was not being adhered to ensure there were enough suitably qualified recovery nurses on shift with advanced life support training.
Although ward staff had knowledge of capacity assessments and best interests meetings, we saw no evidence in three applicable records that this had been applied for those patients who were unable to consent to care and treatment.
Theatre lists did not always run on time due to there not always being available beds for patients post operatively.
Data provided by the trust showed that between September 2016 to December 2016 there were 1180 medical outliers on surgical wards. This number of medical outliers impacted on the number of available beds for surgical patients on the surgical wards.
Although there were formal audits completed that included infection control, we saw no evidence that managers had a formal system or process of oversight, that ensured the cleanliness of equipment, and system checks were maintained.
However, during the unannounced inspection we saw that the service managers had reacted quickly to our concerns, and new systems and processes implemented with management oversight to ensure compliance with standards and policy.
September 2016 to December 2016, there were 1180 medical outliers on surgical wards. This number of medical outliers impacted on the number of available beds for surgical patients on the surgical wards.

Critical care **Requires improvement**

At the previous inspection in January 2015, we rated this service as Requires Improvement.
Following this inspection we have maintained the overall rating because:
We were not assured that critical care services were able to provide a member of staff who was up to date with advanced life support training on every shift. Advanced life support training for adults and

children was not provided for any nursing staff. Additionally, only 55% of medical staff and 79% of acute response team staff had completed training updates.

At the time of inspection, there was limited evidence that sufficient controls were in place to prevent the service exceeding full capacity. This was because critical care services were not currently using a formal escalation policy.

There were several occasions when the service had been unable to provide appropriate numbers of nursing staff to match the dependency of patients.

Critical care had an informal vision and strategy to improve the services provided. However, we found that this plan was not documented in either departmental documentation or in the divisional business plan. This meant that we were unsure how the strategy was being monitored and measured.

We found that appropriate actions had not always been taken in a timely way to mitigate the level of risk for those which had scored highly. Additionally, there were a number of risks that had not been formally identified.

The critical care unit had struggled to meet the standard set by the Department of Health in managing mixed sex accommodation appropriately. We saw examples of this during the inspection.

Records indicated that between January 2016 and December 2016, there had been 75% delayed discharges (greater than four hours following the decision being made that a patient is fit for discharge to a ward).

However:

The unit used a combination of best practice and national guidance to determine the care that they delivered. These included guidance from the National Institute for Health and Care Excellence (NICE) and the Intensive Care Society (ICS).

The most recently available and validated ICNARC data (April 2016 to September 2016) showed that the patient outcomes and mortality were similar to benchmarked units nationally.

Summary of findings

Staff treated patients in a caring and compassionate way; maintaining their privacy and dignity at all times. Both relatives and patients were positive about their time in the unit and spoke highly of the way in which they had been cared for. Staff informed us they felt that there was an open and honest culture within the department. We observed all team members working well together during the inspection.

Maternity and gynaecology

Requires improvement

At the previous inspection in January 2015, we rated this service as Requires Improvement. Following this inspection we have maintained the overall rating because:
Although staffing levels had improved since the last inspection, adequate staffing and skill mix remained an issue within the service.
Shift leaders on the labour ward and other wards within the division, were often not supernumerary due to staffing levels and workload.
There was no dedicated Triage area or Triage team in the maternity unit.
The induction bay area was an inadequate and unsafe environment for patients and had an adverse effect on staffing levels on the maternity ward.
Due to medical staffing levels and access and flow issues, there were often delays in patients being admitted, reviewed and /or discharged from hospital.
Outlier patients posed access and flow issues on the gynecology ward.
There were no established transitional care facilities available for babies on the maternity wards.
There was no dedicated obstetric staff for the daily elective caesarean section list. This led to cancellations and delays in treatment and care.
The maternity services did not have a current robust data collection system, such as a maternity dashboard, to benchmark and review clinical and quality performance outcomes and implement clinical changes to improve patient care.
The risk register did not provide assurance that action plans were comprehensive, robust and adequate to improve patient safety, risk management and quality of care, as many risks were static in their ratings.

Summary of findings

			The service did not record staff competencies for medical devices training. Patient records were not securely stored in locked trolleys. We observed a patient experiencing a sensitive procedure in a six-bedded bay in a gynaecology ward. This was due to access and flow issues but also highlighted that the needs of the individual were not met. Staff informed us that senior trust leadership were "still slightly reactive" in their management style, even though this had improved recently. Senior management told us that the organisation tended to focus on displays of compliance and safety after incidents and events had taken rather than anticipating and mitigating risks to improve the quality of care. Not all staff were clear on the future strategy for maternity services. However: There had been some improvements since our last inspection in January 2015: working relationships between medical staff and midwifery staff, overall culture was improving, WHO checklist and consent forms, laparoscopic hysterectomies were undertaken and mandatory training for nurse and midwifery compliance rates had improved. The appointment of the new Head of Midwifery had a positive effect on staff and the future of the service. The Alongside Midwifery Led Unit (AMU) was in its early stages of development but there was a real focus on normal labour and birth. The service had recently relaunched the Maternity Services Liaison Committee (MSLC) with a newly appointed chair. Staff were caring, kind and patient and were committed to providing good care to patients.
Services for children and young people	**Good**		Staff could demonstrate the process to report incidents. The wards and clinical areas were visibly clean. Staff were aware of and adhered to current infection prevention and control guidelines such as the 'bare below the elbow' policy.

Summary of findings

Staff were aware of their safeguarding roles and responsibilities and knew how to raise matters of concern appropriately.
Paediatric consultants who took part in a "Consultant of the week" rota were present in the hospital during times of peak activity.
Age dependant pain assessment tools were in use in the children's unit and analgesia and topical anaesthetics were available to children who required them.
The National Paediatric Diabetes Audit 2014/15 showed that Warrington hospital performed better than the England average for the number of individuals who had controlled diabetes.
Staff were observed treating patients and their relatives with kindness and respect both in person and on the telephone. Facilities were available for parents to stay with their children.
Specialist nurses were in post in a range of specialities including Epilepsy and Diabetes and provided support to young people transitioning to adult services.
A Child and Adolescent Mental Health Services (CAMHS) worker was present in the paediatric emergency department between 5pm and 11pm seven days per week to ensure timely assessment of children and young people.
The Paediatric Acute Response Team (PART) worked with a local community trust to reduce the need for children and their families to attend hospital.
Data from the trust showed 90.5% of patients referred to paediatric services were seen within the 18-week standard.
There was no dedicated paediatric pharmacist for the children's unit which is not in line with accepted best practice. There was not always a nurse on duty on the children's unit with Advanced Paediatric Life Support (APLS).
Staffing within the children's unit did not follow Royal College of Nursing (RCN) standards (August 2013) and neonatal nurse staffing did not meet standards of staffing recommended by the British Association of Perinatal Medicine (BAPM).
Adult areas were children were seen with the exception of ophthalmic clinic, lacked any child friendly decoration or activities.

Summary of findings

End of life care

Good

At the previous inspection in January 2015, we rated this service as Good. Following this inspection we have maintained the overall rating because:
Since our last inspection the hospital specialists palliative care team (HSPCT) had reviewed the strategy for end of life care and had undertaken a self-assessment structured around the six national ambitions for palliative and end of life care.
We reviewed the trust self-assessment and action plan for ensuring the implementation of the "Ambitions for Palliative and End of Life Care" to improve the provision of better care for patients at end of life. Actions included the development of more leaflets for relatives to improve communication and active engagement in regional audits to ensure the HSPCT is complying with best local and national best practice.
There were systems for reporting actual and near-miss incidents across the hospital which meant the service was able to monitor any risks and learn from incidents to improve the quality of service delivery.
There were sufficient numbers of trained clinical, nursing and support staff with an appropriate skill mix to ensure that patients receiving end of life care were well cared for in all the settings we visited.
Medicines were prescribed, stored and administered safely. Access to medicines for people needing continuous pain relief was available to ensure patient's pain was managed.
The HSPC team had received mandatory training such as safety and safeguarding in order to maintain the safety of patients.
To meet patients' needs the HSPC team had developed a training programme for specialist palliative care across the trust with end of life link nurses for each ward to support, advise and educate other ward staff in relation to end of life care.
The HSPC team was adequately staffed, well trained and received regular appraisals.
A care management approach "amber care bundle" was in place when doctors were uncertain whether a patient may recover and were concerned that they may only have a few months left to live. This is an approach to care management used in hospitals when doctors are uncertain whether a patient may

recover and are concerned that they may only have a few months left to live. The trust had appointed a designated member of staff who worked within the palliative care team to facilitate implementation across the trust.

The trust participated in the "End of life care Audit: Dying in Hospital 2016", which replaced the NCDAH. The audit results showed an improvement in end of life care at the trust. Out of 17 clinical and organisational indicators the trust had performed either better than or in line with national average in the majority of the indicators. The trust performed better than the England average for three of the five clinically related indicators. The trust scored particularly well for having documented evidence that the needs of person(s) important to the patient were asked about, scoring 3% compared to the score of 56%.

However:

At our last inspection, we found there was no access to specialist palliative care medical support out of hours. At this inspection, we found this was still the case with no access to out of hour's specialist palliative care medical support.

Senior managers told us that they had improved access to support and advice through the hospital intranet and the lack of specialist palliative medical support had been identified on the trust risk register.

The trust had commissioned an external audit of the use of the DNACPR policy as well as its own internal audit. Results showed there were a number of occasions, where documentation in relation to DNACPR forms has not been in line with Trust Policy.

Engaging in difficult conversations with patients, family or carers was not always fully recorded within the case notes. Patient's wishes were not appropriately discussed and recorded, and as a result, they are not treated appropriately We reviewed the action plan which had been put in place to ensure the staff training and monitoring of the DNACPR policy was strengthened.to ensure that the DNACPR's are completed accurately with the medical rationale for not attempting resuscitation and discussions with patients and family being recorded appropriately.

Summary of findings

The lack of a clear mental capacity assessment meant that the service could not be clear how much the patient understood the care they were receiving and it may not have access to reasonable adjustments such as access to specialist support.
We found that patients at the end of their lives could not always be assured of a single room to ensure privacy.

Outpatients and diagnostic imaging

Requires improvement

At the previous inspection in January 2015, we rated this service as Requires Improvement. Following this inspection we have maintained the overall rating because:
The CT waiting area was not suitably designed to keep people safe. The area was too small and lacked equipment that would be required in an emergency. The area lacked also privacy and dignity.
We found three breaches of Health and Safety Executive guidance note PM77 'Equipment used in connection with medical exposure' Regulation 36 where there was no record that the equipment had been tested and signed back into use following fault repairs in the CT department.
Audit evidence showed poor compliance with the WHO (World Health Organisation) surgical safety checklist in interventional radiology.
We found six separate breaches of Ionising Radiation Regulations 99, regulation 32, which refers to routine quality assurance of equipment used in diagnostic imaging.
Appraisal rates and personal development reviews across the department did not meet the trust target of 85%.
The general outpatient area was difficult to locate with poor signage from the main entrance to the department.
There was a lack of available rooms for counselling patients in the breast screening clinic.
There had been significant changes in the leadership team which had the left the staff feeling disconnected and ensure of the strategy and future vision of the service.
However:
We saw evidence of safe practice within the Outpatient department.

Summary of findings

There was evidence of hand hygiene compliance and monitoring with regular audits undertaken across six outpatient locations.
Clinical audits were performed in line with best practice and results frequently shared at a regional and national level.
We saw evidence that staff from several disciplines work together to assess, plan and deliver care and treatment to patients including clinicians and allied health professionals.
Cross-site culture was good and staff reported good collaborative working, staff were happy to move between hospital teams.

Warrington Hospital

Detailed findings

Services we looked at

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

Detailed findings

Contents

Background to Warrington Hospital

Warrington Hospital is the main district general hospital site, located in Warrington, Cheshire, which hosts the accident and emergency department.

Medical care is provided at Warrington Hospital from 12 inpatient wards and an endoscopy unit. There were 17,803 inpatient medical admissions between October 2015 and September 2016. Over 90% of patients were admitted under general medicine or gastroenterology. Other medical specialities provided at the hospital include cardiology, haematology, stroke medicine and respiratory medicine.

Surgical services including: urology, ophthalmology, trauma and orthopaedics and general surgery (such as colorectal surgery). Hospital episode statistics showed that between October 2015 to September 2016, 29,590 patients were admitted for surgery at the trust across Warrington and Halton sites. The data showed that 18,069 (61%) of patients had day case procedures, 4240 (14.3%) had elective surgery and 7281 (24.6) were emergency surgical patients. The number of patients admitted for surgery had increased by 8726 from the 2013/14 statistics.

Critical care services are divided into two main areas. The main intensive care unit is an open area which has a total of 14 bed spaces. The high dependency area has six beds, including two isolation rooms that produce positive or negative pressure. The unit is part of the Cheshire and Mersey Critical Care Network (CMCCN). Between April 2015 and March 2016 there had been approximately 800 admissions to the service from the local area.

Warrington Hospital offers pregnant patients and their families' antenatal, delivery and postnatal care in the Warrington and Halton areas. The maternity facilities are based at Warrington Hospital. The services provide antenatal and post-natal care (inpatient and outpatient), labour ward, ultrasound scanning, two obstetric theatres and an Alongside Midwifery Led Unit (AMU), which is in its early development stage.

Warrington Hospital provides a range of paediatric and neonatal services. Neonatal services are located on the first floor and paediatric services are located on the ground floor of the main hospital building in Warrington. The neonatal unit has 18 cots and provides intensive care, high dependency care and special care for newborn babies. The children's unit consists of 37 beds, which include a 10 bedded cubicle area incorporating one high dependency bed, a seven bed paediatric day surgery area a six bedded assessment area and a 14 bedded bay area. A dedicated paediatric outpatient clinic is located next to the children's unit and a paediatric accident and emergency area is situated next to the main accident and emergency department. A paediatric acute response team (PART) deliver care in conjunction with a local community provider at a Health and Wellbeing centre in Warrington town centre.

Detailed findings

Hospital episode statistics data (HES) showed there were 5435 children and young people seen between 1 December 2015 and 30 November 2016. Of these 93.1% were emergency admissions, 5.4% were day case admissions and 1.5% were elective admissions. Gynaecology services are based at both the Warrington and Halton sites. The gynaecology/surgical ward at Warrington had 14 inpatient beds and a separate dedicated bay for clinic patients, however; this is used as an escalation bay when bed shortages in the hospital. The ward has provision for emergency attenders who require a medical review. The Early Pregnancy Assessment and Gynaecological Rapid Access clinic is situated at the end of the area in a separate space. The ward also consists of outpatient procedure rooms for Colposcopy and Hysteroscopy. Main Gynaecology Outpatients is a dedicated outpatient area with a dedicated scanning room from January 2017.

End of life care services were part of the hospital acute care division. Warrington Hospital's specialist palliative care team offered a service from Monday to Friday with core hours of 9am to 5pm seven days a week. Patients with palliative/end of life needs were accommodated on the general wards in the hospital. The trust provided a consultant led hospital specialist palliative care (HSPC) team. The HSPC team is a resource available to all clinical areas within the hospital providing specialist palliative care, advice and support for adult inpatients that are affected by cancer and other life limiting illnesses. The HSPC team provides an advisory and supportive service whilst the medical and nursing management of the patient remains the responsibility of the ward teams.

A range of outpatient and diagnostic services are provided at Warrington Hospital. A number of outpatient appointments are also offered at the Halton site.

Warrington Hospital offers a combination of consultant and nurse-led clinics for a full range of specialities including cardiology, respiratory medicine, breast surgery, gynaecology, dermatology, pain management, trauma and orthopaedics, maxillo-facial surgery, audiology and therapy services.

Warrington Hospital offers a comprehensive range of diagnostic and interventional radiography services to patients including: general x-ray, computerised tomography (CT) scans, magnetic resonance imaging (MRI), ultrasound and mammography.

Our inspection team

Our inspection team was led by:

Chair: Bill Cunliff, Consultant colorectal surgeon with 6 years' experience as a medical director

Head of Hospital Inspection (lead): Ann Ford, Care Quality Commission.

The team included two CQC Inspection Managers, 12 CQC inspectors and a variety of specialists including Junior doctor, NHS Consultant, Emergency Department Doctor and Nurse, Consultant physician, Clinical Nurse Specialist: Infection Prevention & Control, Surgeon, Lead Specialist Nurse, Midwife, Consultant Obstetrician, Midwifery Nurse, Consultant Paediatrician and Paediatric Nurse Consultant, a Head of Safeguarding, a Senior Governance and Risk Manager, Allied Health Professional, Senior Nurse Practitioner, Clinical Governance lead, Emergency Department nurse specialist and consultant, a Critical Care nurse, Specialist Occupational Therapist and an End of Life Specialist Consultant.

We had four Experts by Experience on the team and held a listening event on 21 February 2017 which was attended by a number of local people who had experienced the services at the trust.

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?

Detailed findings

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

The inspection team inspected the following core services at the Warrington Hospital:

- Emergency Department
- Critical Care
- Children and Young People
- End of Life
- Outpatients and Diagnostic Imaging Services

Prior to the announced inspection, we reviewed a range of information we held and asked other organisations to share what they knew about the hospital. We interviewed staff and talked with patients and staff from all the ward areas and outpatient 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 received feedback through focus groups. 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 at Warrington and Halton NHS Foundation Trust.

Facts and data about Warrington Hospital

Warrington Hospital is one of three locations providing care as part of Warrington and Halton Hospitals NHS Foundation Trust. In total, the trust has 591 beds. Between January 2016 and January 2017, there were 500,000 individual patient appointments, procedures, stays, and 109,000 emergency department attendances. Warrington and Halton Hospital NHS Foundation Trust provides services across the towns of Warrington, Runcorn (where Halton General Hospital is based), Widnes and the surrounding areas. It provides access to care for over 500,000 patients. The trust employs 4,200 members of staff. The total revenue for the trust was £212.7 million while the full cost was £215.6 million. This meant the trust had a deficit of £2.9 million. The health of people across Warrington and Halton varies, but outcomes for people tend to be worse than the national average, particularly in the Halton area. Life expectancy for men and women in both areas is worse than the national average. There is also a higher number of hospital stays due to self-harm and alcohol related harm in both areas, compared to the national average.

Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

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

Urgent and emergency services

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

Information about the service

The urgent and emergency care department was part of the acute care directorate. Patients were triaged on arrival in the department to the most appropriate area; the areas were resuscitation, major injuries, minor injuries, clinical decision unit, ambulatory care and paediatrics.

In the period April 2016 to February 2017 the department had seen 57,922 adult patients and 15,714 patients who were children and young people. In the period April 2015 to March 2016, the department saw 64,758 adult patients and 17,728 children and young people. Approximately 21% of attendances at the unit were children and young people.

During the inspection we spoke with fifteen patients and two carers. We also spoke with the business unit clinical leads and business lead, five consultants (including the training lead), a paediatric nurse consultant, a locum doctor, two middle grade doctors, a trainee doctor and a paediatric doctor. We also met with the matron and the deputy matron for the department and the paediatric matron, two paediatric nurses, the clinical practice facilitator, three senior nurses, three mental health nurses, two staff nurses, a band four nurse and two health care assistants. We spoke with the lead nurses for ambulatory care and the clinical decisions unit, a student radiographer, the alcohol specialist nurse, two student nurses, an agency nurse, a porter and two reception staff including the co-ordinator.

Before the inspection we looked at information supplied by the trust and nationally available data. As part of the inspection, we reviewed policies and procedures, minutes of meetings and we spoke with staff and patients and their carers. We also looked at patient records.

The trust was previously inspected in January 2015 and were rated as good.

Urgent and emergency services

Summary of findings

We rated this service as good because:

- On arrival at the hospital patients were triaged to the most appropriate department to meet their needs. Appropriate risk assessments were in place to protect patients and analgesia for pain relief could be administered to patients. Patients were monitored using appropriate tools and any deterioration in a patient's condition would be escalated.
- There were processes in place to help to keep people safe, incident reporting was good and infection control measures were in place. Medicines were administered to patients in a timely way and there were regular checks of equipment. The nurses had reached the trust target for mandatory training.
- Treatment and pathways for patients were developed using national and local guidance and was delivered by competent staff working in multi-disciplinary teams. There were review structures in place so that treatment was up to date and these were monitored by the staff.
- Staff were caring and supported patients and their relatives and carers. Privacy and dignity were maintained at all times.
- Systems had been put in place to improve access and flow through the department and although targets were not been met there had been a continuous improvement in waiting times.
- Governance structures were robust and there was strong leadership in the department. Staff were empowered through development and learning opportunities and morale in the department was good.

However:

- The department were not meeting Department of Health standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the urgent and emergency care centre. The department were not meeting the targets for time to initial assessment (emergency ambulance cases only) which should be less than 15 minutes and the time patients should wait from time of arrival to receiving treatment is no more than one hour.
- There was insufficient medical cover at night in the department though this had been addressed by the unannounced inspection.
- The department needed to work better with patients with learning disabilities to understand their needs. This includes making reasonable adjustments to meet the needs of the individual.

Urgent and emergency services

Are urgent and emergency services safe?

Good

We rated safe as good because:

- Staff reported an open culture of incident reporting in the department and there was a variety of ways that senior staff fed back to staff about incidents. Mortality meetings were used to identify trends and issues.
- There were audits and actions were put in place for infection control purposes and the numbers of health care acquired infections were low. Patients said that areas were visibly clean and tidy and there was point of care testing for appropriate patients to identify those who may need to be isolated to reduce the spread of infection.
- There were issues with the reconciliation of medicines according to the trust policy.

However:

- There were insufficient middle grade doctors to cover the night shift at the hospital. This had been addressed by the unannounced inspection and work was on going to address this.
- Doctors were not always compliant with the trust mandatory training targets.

- Equipment, including resuscitation trolleys were checked regularly and this was recorded. Medicines were stored correctly and fridge temperatures were recorded.
- There had been a reorganisation of nurse staffing, as currently the department did not have enough nurses. There was a programme of workforce development to help to address the gaps in nurse staffing and active recruitment of graduate nurses.
- Risk was managed in the department and there were processes in place to monitor adults and children who were deteriorating clinically.
- There were issues with the reconciliation of medicines according to the trust policy.

Incidents

- The trust had an electronic system for the recoding of incidents. In the reporting period 1 January 2016 and 31 December 2016, the ED recorded 1,224 incidents. Most of the incidents were no harm or minor harm, 14 were moderate harm. The three top categories for types of incidents were pressure ulcers, falls and medicine incidents. There was feedback to the staff through the daily safety briefings, staff meetings and by e-mail.
- It was evident that there had been significant under reporting of incidents before April 2016. There was a change in the senior management of the urgent and emergency care department in April 2016 and following this, the numbers of incidents reported increased. There was an open culture of reporting in the department.
- In accordance with the serious incident framework, the trust had reported three serious incidents(SI's) in the urgent and emergency care department which met the criteria set by NHS England. The trust had conducted investigations into these serious incidents. One of the three incidents was a slip trip or fall a second was abuse/alleged abuse of child patient by third party. The third of the serious incidents was detected at the mortality review group and was a failure to act on test results; the incident was reported on the 27 January 2016. The investigation report was a level two serious incident investigation and an action plan has been put in place following the incident. The duty of candour was not applied within the appropriate timescales as the incident was detected at the mortality review group.
- There were criteria for the reviews of deaths and this was done by consultants who reviewed patient records. The outcomes of reviews were fed into the mortality and morbidity group and any concerns were then taken to the mortality review group. These meetings were used to identify any themes, issues or problematic areas in the trust.
- A 72-hour report following an incident had highlighted training needs around domestic violence, and multi-agency referrals for children, training had been put in place following the review.
- We observed that duty of candour was being applied in the department; this was demonstrated through

incident investigations. We spoke with staff about duty of candour and that staff understood the duty of candour, they apologised to patients who had been waiting for treatment and explanations were given.

Safety thermometer.

- The Patient Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.
- Data from the Patient Safety Thermometer showed that the trust reported no new pressure ulcers, three falls with harm and no new catheter urinary tract infections between February 2016 and February 2017.
- All three falls happened between July and August 2016.

Cleanliness, infection control and hygiene

- There was a housekeeper who worked in the urgent and emergency care department. Other housekeeping and domestic staff came into the department early and we observed that all areas in the urgent and emergency care department were visibly clean and tidy. Areas were well maintained and in a good state of repair. There was a task team who were responsible for monitoring and changing curtains in the urgent and emergency care department. All the curtains we checked were clean and in date.
- Personal protective equipment (PPE) was plentiful and hand gel was available in all areas of the department and on going compliance to infection control audits had improved since April 2016. We saw that staff used PPE as appropriate.
- There was a trust specialist nurse for infection control and a link nurse in the department. Infection control was an agenda item on the senior management team meetings.
- The department undertook health care acquired infection monitoring for MRSA, methicillin-sensitive staphylococcus aureus (MSSA), clostridium difficile (c.diff), catheter associated urinary tract infections and wound infections. In October 2016 there had been one reported MSSA infection in the clinical decisions unit of the department for the period October 2016 to December 2016. In the previous three months there had been no health care acquired infections in the urgent and emergency care department.
- Hand washing audits took place every three months, most areas in the department had between 90% and100% compliance with hand washing though in three areas of the department there was a compliance of 87.5%, 89.6% and in one area 62.6%. Actions were put in place to improve the hand washing audit compliance. During the inspection we saw that staff washed their hands. The department had introduced a hand hygiene light box in September 2016, the box helped to detect flaws in hand washing techniques.
- The audit of sharps bins which was completed every three months and showed 95% compliance with the audit standards. Actions were put in place if compliance fell below 95%.
- There was a trust staff uniform policy and staff uniform audits were 100% compliant in October 2016. In the previous three months there had been an issue with the uniforms of two agency staff which were raised with the agency.
- There were commode audits completed which were 100% compliant in October 2016.
- There was point of care testing for patients who presented with diarrhoea; the kit was requested from the microbiology department on authority from the infection control lead. This could identify whether the cause of the diarrhoea was due to infection and evaluate the need for barrier nursing and other precautions. The test took approximately one hour.
- In a patient survey members of the public were asked “how clean was the accident and emergency department” the replies were about the same as the England average. Patients we spoke with said that the department was very clean and that they had seen housekeeping and domestic staff cleaning the department.
- Coloured tape was used to show that equipment was clean and ready for use.
- In June 2016, 88% of the staff were trained in putting on and removing personal protective equipment for preparedness for any infectious disease outbreaks.

Urgent and emergency services

Environment and equipment

- The urgent and emergency care department comprised of a triage area or hub which had five trollies and six seats, a resuscitation area which had five cubicles with a specific cubicle for children. There was a clinical decisions unit with four beds for male patients and four for female patients; an ambulatory care unit with 16 spaces for chairs and trollies and an area for minor injuries. There was a separate paediatric unit with six cubicles.
- There were resuscitation trolleys in the five bays in the resuscitation area and one in all the areas of the department. All trolleys had security tags with a tag number. Oxygen and suction were available in all the resuscitation bays and were wall mounted.
- In one of the bays in the majors area of urgent and emergency care unit we checked the resuscitation trolley, all medicines were in date and equipment had been portable appliance tested.
- There was a dedicated anaesthetics trolley for use only by the anaesthetics team in the bay, we saw that the equipment had been portable appliance tested.
- In the clinical decisions unit of the urgent and emergency care unit, the trolleys were well stocked with appropriate equipment and medicines, all the medicines and equipment were in date but the monitoring and recording of the trolley had not always been recorded and so we were unaware if the daily checklists had been completed. We raised this with the nurse in charge during the inspection.
- There was an equipment audit to check that equipment in the different areas of the department was present in the department, that servicing was in date and that it worked correctly. Actions were put in place following the audit. We saw that weighing scales had been calibrated, this was done annually.
- In the ambulatory care department we checked the equipment; all had portable appliance testing in date. Trolleys were well stocked and checklists had been completed with very few gaps.
- There were paediatric resuscitation trolleys in the paediatric in the resuscitation area of the department and one in the paediatric emergency department. The paediatric resuscitation trolley in the resuscitation area was sealed and tagged and had appropriate medicines and equipment including equipment for intraosseous (injecting directly into the marrow of a bone) access for paediatric patients. We considered that the trolley in the paediatric department was overstocked and this was raised with the department during the inspection who said that they would address this.

Medicines

- The trust reviewed incidents regarding medicines every week for the quality of reporting and incidents involving medicines were reviewed monthly by the trust for any trends and there was feedback to departments with the learning from incidents.
- There were patient group directives (PGD's) available for specific nurses to give patients appropriate pain relief. PGD's allow healthcare professionals to supply and administer specified medicines to pre-defined groups of patients, without a prescription. This helps patients to access medicines in a safe and timely manner and PGD's were audited by the department. There was a competency framework for those nurses covered by the PGD. The department was also considering a PGD for some antibiotic therapies and there was a need to consider the development of PGD's for paediatric patients.
- There were six advanced nurse practitioners and as part of this role they were nurse prescribers who could prescribe medicines from a set formulary. We spoke with a non-medical prescriber (NMP) who told us they received good support from the consultant in the department and received individual feedback in response to audit. Additionally, the trust NMP lead co-ordinated twice-yearly meetings for sharing learning and updates.
- In the CDU we saw examples where people's medicines had not been reconciled (checked and confirmed) within the trust's target of 24-hours according to trust policy. The clinical decisions unit is a 24-hour observation ward but three of the four patients had been in the unit for longer than this. None of these three patients' medicines had been reconciled within 24-hours.
- There were link nurses for intravenous medicines.

- Medicines were stored securely in the department and were checked daily and stocks were replenished. Fridge temperatures were monitored and recorded. We saw that records that showed that appropriate checks had been made and recorded. We saw that drug charts had been completed appropriately.

Records

- Patient records were electronic though there were some paper records in the department.
- A consultant had completed an audit of record keeping of doctors' records, this was done in October 2016 and they looked at 33 records. Areas that scored highly were records of acceptable quality 96%, pathways followed 91% and a clear management plan for patients 96%. Areas that needed to be addressed were recording of medicines 73%, correct coding 76% and GP discharge letters 76%. There was individual feedback to each doctor with a quality improvement plan.
- An emergency nurse practitioner had completed an audit of 99 nursing records. They used the 12 standards of record keeping from the Royal College of Physicians. The average score overall was 96%, the lowest scoring area was recording of medicines 85% with all other standards scoring over 94% and some areas scoring 100%. There was feedback to the nurses as a whole and individual feedback.
- We reviewed six patient records during the visit; five of the records had appropriate risk assessments completed except one that did not have a pressure area assessment. Allergies were recorded and we saw that early warning scores and pain assessments with appropriate analgesia provided had been completed. Confusion assessments had been completed on appropriate patients.
- One of the senior nursing staff in the department did an informal audit of a random sample of records when on shift and fed back to the staff.

Safeguarding

- There was a trust safeguarding policy and female genital mutilation was part of this trust policy.
- The nursing staff in the department were compliant with the trust safeguarding training target of 85% for vulnerable adults', level one and two and for children and young people levels one, two and three. However, the medical staff had not met the trust target for safeguarding for vulnerable adults and children and only 68% of the medical staff had completed level three safeguarding training for children and young people.
- There were specialist nurses for adult and paediatric safeguarding in the trust and link nurses in the department.
- There was a coloured file in the paediatric emergency department which contained all relevant information about safeguarding. This was accessible to staff.
- There was a separate page on the electronic records system for children. If registered as a child the system would generate a none accidental injury screening tool within the documentation. This was for children under 16 years of age and would appear in the nursing and doctor's records. If there was a safe-guarding concern about a child there was an alert in the electronic record.
- If staff has suspicions about any child they could contact social services, staff said that they were very responsive and would respond in a timely way including out of hours.
- If there were concerns about a child, staff would complete the notification forms and contact social services and the health visitor liaison.
- A hidden child pathway had been developed with the trust safeguarding lead. An example of this was a parent who might remove a child before or during treatment.
- During the inspection we spoke with a nurse who had raised a safeguarding concern for the child of a patient who was admitted to the department. They were concerned about the effect of the patients' health on the child, the nurse tried to contact the duty social worker but could not get a response and so they contacted the child's school so that the safeguarding lead at the school could let the child know about arrangements for their care while their parent was in hospital.

- A nurse we spoke with described a recent incident and how staff became suspicious about a child's injuries. They then described the procedures that were followed to safeguard the child.

Mandatory training

- At the time of the inspection, we saw the training matrix that showed that at least 85% of all nursing staff were compliant in their mandatory training. This included fire safety, infection control, moving and handling, health and safety equality and diversity, mental capacity act and medicines management. However the medical staff had not achieved compliance with mandatory training with the lowest compliance 36% for equality and diversity and mental capacity act and the highest for medicines management of 57%.
- Training lists were circulated every month to identify those staff that were close to the expiry of their mandatory training or who were non-compliant with their mandatory training. Incremental payments to salaries were withheld for those staff that were not compliant in their mandatory training.
- All staff including porters received training in mental health awareness as part of the induction process.

Assessing and responding to patient risk

- There was a nominated nurse and medical lead for each shift who managed staff in the department according to patient risk.
- The department used a recognised triage system to manage patient flow and assess patient risk; patients were then signposted to the most appropriate department in the department for treatment. This helped to facilitate the release of patients from the ambulance service into the department.
- The triage (known as the hub) was run by emergency nurse practitioners (ENP's) who would undertake a rapid review of patients which included a falls assessment, a mental health assessment and a pain assessment and provide pain relief for patients on arrival in the department as appropriate. The nurses could order pathology testing and some diagnostic imaging for patients and patients were then streamed to the most appropriate part of the department for their treatment needs, these departments were resuscitation, majors, minors, ambulatory care or the clinical decisions unit (CDU).
- Walk in patients who arrived in the department who were complaining of chest pain were asked to sit in front of the triage cubicles so that the triage nurse could see them and the reception staff made the triage nurses aware of their condition.
- On admission, patients at high risk were placed on care pathways so that they received the appropriate level of care. The department used an early warning score tool (EWS) that recorded and scored the patients vital signs and staff were then able to identify patients who were deteriorating clinically. The vital signs were recorded in the patient record and there were clear instructions for the escalation of these deteriorating patients. This was compliant with guidance from the National Institute for Health and Social Care Excellence (NICE). The escalation policy for these patients was detailed and explicit with evidence of rapid assessment and treat processes.
- All band 6 and 7 nursing staff received advanced life support (ALS) training and all nurses were trained in paediatric intermediate life support.
- All shifts in the department were covered by a doctor or nurse with ALS training. It was proposed that all band 6 and 7 nurses would be trained in both ALS and advanced paediatric life support (APLS). This would give a larger pool of nurses who could support the medical staff. This was evidenced in the training needs analysis and was a requirement of the faculty of Emergency Medicine and Nursing Skill Competence for Caring for Children in the Emergency Department. (RCN) Skills for Health.
- There was a daily safety briefing of nurses and medical staff by the nominated nursing and medical lead for the shift. This coincided with the medical handover; these were at 9am, 3pm and 10pm. We observed a safety briefing and saw that it was well managed with a register taken.
- There was a standard operating procedure for corridor nursing and only patients with a EWS score of four or less were nursed on the corridor. Patients with dementia were not nursed on the corridor. There was

a ratio of one nurse to four patients on the corridor. During the inspection, the department became very busy and there were trollies in the corridor because the department was full. There was intentional rounding by the nursing staff and we saw that patients received appropriate care and treatment while waiting on the corridor.

- There was an interdepartmental handover form for patients who were moving to different areas of the department for treatment, the form noted situation, background, assessment and recommendation (SBAR). We saw that these forms had been completed appropriately.
- Patients who required thrombolysis following a stroke and patients who required percutaneous coronary intervention (PCI) were transferred to nearby specialist hospitals for treatment; this was part of the appropriate care pathway.
- There was a mental health team based in the hospital during the day and the department were doing a pilot of a mental health triage tool to identify the level of risk to patients with a mental health condition. Patients with mental health problems were graded into low, medium and high risk and those who were at high risk of harm were nursed in the clinical decisions unit of the department with one to one observation or in one of the high visibility cubicles in the majors section of the department so that staff could observe patients at all times.
- There were posters around the department flagging the sepsis pathway and we saw that sepsis was included in the safety briefing that we attended.
- There was a potential risk to staff and patients as the alarms in the department showed an incorrect location on the panel when activated, this was addressed during the inspection.
- Children and young people were not triaged by a paediatric-trained nurse though this was part of the future plans for the paediatric service and there had been an audit of initial assessments of children in the department. Following the inspection all children and young people were triaged by a paediatric nurse. A training programme to develop on going assessment skills to utilise the triage tool had been undertaken and a core group of eight paediatric emergency nurses were trained.
- There was a dedicated paediatric resuscitation bay and this would be attended by a paediatric nurse if necessary. Less urgent paediatric patients were taken directly to the paediatric area by ambulance crews.
- The services used paediatric early warning scores (PEWS) to monitor and observe patients; these were done according to pathways. Staff told us that these pathways were very clear.
- There was a paediatric escalation tool and a fever chart for children under five years of age. The paediatric acuity escalation tool was for patients to be checked every two hours; Staff gave good feedback about the use of the tool.
- One of the cubicles in the paediatric department had a resuscitaire and new-born resuscitation equipment for treatment and management of very young babies. Oxygen and suction outlets were available in each of the bays in the paediatric department.
- There was an emergency button in the paediatric department, staff told us that when it was pressed everyone came running.

Nursing staffing

- The department was using the safer staffing model, this tool determines the number and skills of the staff needed to effectively manage and care for patients. The nursing establishment for the department was for 44 full time nurses and at the time of the inspection, there were just under 39 full time equivalent nurses in post. In December 2016 the vacancy rate for nurse staffing was 21.9%. Nurse staffing was on the risk register.
- There were currently ten nurses on the early shift, 11 nurses on the late shift and nine staff on the night shift. The matron had submitted a safer staffing proposal for 11 nurses on the early shift, 13 nurses on the late shift and 11 staff on the night shift which included a twilight shift that finished at 2pm. The increase in staffing would cover the busy periods from

November to March and allow staff to take annual leave and undertake training from April to November. We were told that the trust was looking favourably at the proposal.

- In January 2017, 26.1% of qualified nursing shifts were unfilled and in February 2017 23.5% of nursing shifts were unfilled.
- As a result of the gaps in nurse staffing the matron, who had been appointed to the department in May 2016, had made significant changes to the nursing structure in the department. Many of the nurses had been upgraded or were on secondment to higher banded roles. Training and competency assessments had been put in place to support this. Nursing staff were more autonomous and this was supported by the medical staff. The matron said that the trust had been very supportive of this workforce development and it had supported retention of staff in the department as some staff who had considered applying for other jobs had decided to stay because of new opportunities.
- There were less band five staff in the department but the matron had recruited a number of student nurses who were graduating in summer 2017, we spoke with two student nurses who said that they had been given jobs in the department and were looking forward to starting work as they had enjoyed their placements. An agency nurse told us that they were going to apply for a permanent position in the department as they said it was a good place to work. The matron said that the department would be fully staffed with nurses by September 2017.
- The department was using band 4 nurse associates and health care assistants to support the work of the department.
- The matron told us that they tried to keep agency costs to a minimum by not using bank and agency costs at weekend. Staff did extra shifts and received overtime payments and bank and agency staff were generally known to the department.The sickness rates at the end of March 2017 for nursing staff within the emergency care department was 8.5%.Following further recruitment, improved return to work interview rates the implementation of the new absence management policy this sickness rate was 2.5% at the end of June 2017.
- Nursing staff rotated around the different departments of the urgent and emergency care department including into the medical assessment unit. This helped staff to understand how the different areas of the department worked.
- Following the recent change in the management of the paediatric urgent and emergency care department from the paediatric department a paediatric nurse consultant, from a neighbouring trust, had been working to review the staffing and training needs in the department. A transformation plan had been developed and was being implemented.
- The paediatric nurse consultant was undertaking clinical work for 50% of their time.
- An additional four paediatric nurses had been recruited in February 2017 and the department was over established by three nurses, this was to increase the numbers of nurses on each shift in the department.
- There was a small core of band 6 and band 5 nurses who worked in the department and other staff rotated from the paediatric department. Staff we spoke with said this was unsatisfactory as there was no continuity in the department.
- There was always a registered children's nurse on duty in the paediatric emergency department and a paediatric nurse would attend the resus area of the department to support care of a sick child if necessary.

Medical staffing

- There werenine consultant posts, though not all were full time and two associate specialists who took part in the consultant rota and were considered equal in the department. There were no consultant vacancies at the time of the inspection. This was the same as the England average.
- There was always a consultant presence in the department between 8am and 11pm though when the department was very busy consultants would cover the period 7am to 8am and 11pm to 1am. Shift times

were staggered to meet anticipated demand. There was a consultant on call rota from 11pm to 7am at weekend consultants worked 7am to 3pm or 3pm to 11pm and there was an on call rota for the period 11pm to 7am.

- There should have been 25 junior doctors but there were vacancies in the junior staffing rota which were three senior house officers, one registrar and six middle grade doctors. This was a vacancy rate of 22.6% which meant that the service was ten doctors short. The sickness rate for medical staff was 1.1%.
- Junior doctors worked a variety of shifts, seven or eight hours in the day and up to nine hours at night, shift times were staggered to try to anticipate the greatest demand on the department.
- The shortage of junior doctors is a national issue and we were told by senior medical staff that the shortfall of staff was not a financial issue but was a recruiting issue and they would appoint if there was the availability of applicants.
- Medical daytime cover was two consultants, two middle grade doctors, two registrars and two senior house officers. At night there was one registrar and two senior house officers which meant that the service was short of one doctor at night. In the period following the CQC visit the department were able to increase their 'as and when' bank medical staff who had previously worked within the Trust. There was a shared clinical fellow post within the critical care speciality that further reinforced clinical cover. The August rotation of junior doctors had increased the establishment from 4.0 whole time equivalent (wte) to 4.6 wte staff.
- The department spoke with other local hospitals to identify their levels of cover overnight and found that one senior doctor was standard practice for a night shift and there were overlapping shift patterns which meant that another senior doctor was present until 2am.As a result the department were trialling an additional roistered shift of 19:00-03:00 within the urgent and emergency care department rota to enhance senior medical cover at night. There was a consultant roistered until 11pm who will often stay until 1am as clinical need demands.
- Recognising the competitive market nationally for speciality doctors, the clinical business unit had redefined the approach to recruitment through the following job advert and job description. This is in the hope of attracting speciality doctors to substantive posts within the trust.
- The trust used locums to cover the gaps in medical staffing; locums were usually known to the trust and required no induction. If there was any agency staffing, there was an induction pack which was given to the staff which we reviewed as part of the inspection. One of the consultants would provide an induction to the electronic patient record system at the start of the shift. Bank and locum usage rate was 16.7% in the department. At December 2016 medical staffing reported a turnover rate of 49.2%.
- We observed a medical handover, these happened three times every day at 9am, 3pm and 10pm. The handover was consultant led and attended by consultants, junior doctors and nurses including senior nurses. A register was taken of those attending and the meeting began with a safety briefing and then proceeded to the handover. All the patients in the department were discussed using the board in the department was a guide and specific doctors were allocated specific tasks and roles were clear.
- In the period April 2015 to March 2016 the paediatric service in the urgent and emergency care department saw 17,728 children aged between 0 and16 years. The guidelines from the Royal College of Paediatrics and Child Health state that a consultant with sub-speciality training in paediatric emergency medicine should be employed if the department was seeing more than 16,000 patients per year.
- There had been a paediatric consultant for emergency medicine who had left in December 2016 and a consultant from the urgent and emergency care department was covering the role until a paediatric consultant could be appointed, the consultant covering the role was also the associate medical director for quality and was able to support staff in measures of quality and best practice.
- There was a review of the repatriation of paediatric accident and emergency service to urgent and emergency care on going at the time of the inspection.

The service had only been part of the urgent and emergency care department for a month. The vision for the paediatric service was to try to attract a paediatrician with an interest in emergency medicine, the trust were considering a rotation with the nearby specialist children's trust.

- Following the inspection the trust had recruited to a lead paediatric and urgent care consultant who had accreditation in paediatric emergency medicine. This was in July 2017.
- The trust commissioned a review of paediatric urgent care services from March to May 2017. The review was tasked to look at urgent care provision for children across the urgent and emergency care department, the paediatric assessment unit and the community paediatric acute response team.
- The review had identified short, medium and long-term actions required to deliver a paediatric urgent care service. The review has coincided with the successful recruitment to a lead acute consultant in paediatric emergency medicine. The substantive post will lead the delivery and development of paediatric emergency care and will be supported by a middle grade tier of medical staff who are keen to develop skills and competencies within paediatric emergency medicine.
- The nursing skill mix within the team was reviewed to identify a team leader with management and leadership responsibilities for the paediatric emergency care service. A lead nurse was recruited and a band six experienced urgent and emergency care nurse will help lead and develop the service of the future.

Major incident awareness and training

- The major incident plan had been updated in 2017. New action cards had been produced and there had been training including practical scenarios. We saw the updated action cards around the department. There were a number of link nurses for major incidents.
- There were simulations of major incidents every six months and also table top multi-agency exercises that involved the North West ambulance service. There was a lock down plan that required staff to manually close all points of access. This had a standard operating procedure and has been tested. The department was working with estates to implement an electronic lock down which could be centrally managed.
- Major risks had been identified in the plan as there were a number of heavy chemical industries and a nuclear facility in the area. The trust had also identified the threat from terrorism.
- We saw the decontamination tent which was used in case of chemical spillage and contamination. There had been two incidents of chemical contamination one of which involved up to fifteen individuals. The matron said that they had learnt from both incidents and appropriate changes had been made to the policy.
- During the inspection there was a flood of contaminated water through the ceiling into the minor injury department of the urgent and emergency care unit. The minor injuries area had to be closed and a temporary area was set up in another part of the department Patients awaiting treatment were relocated to this area. Staff in the department dealt with the incident calmly and additional housekeeping staff were brought in to clean the area, which was reopened several hours later.
- We observed security staff in the department and there were panic alarms in all areas of the department.
- We saw on the children's ward that there was an emergency evacuation procedure.

Are urgent and emergency services effective?

(for example, treatment is effective)

Good

We rated effective as good because:

- The department used guidance from the National Institute of Health and Care Excellence and other organisations for their clinical care pathways. Compliance with guidance was audited and recorded.

- National and local audits were completed and actions from audits changed practice in the department.
- The recognition and treatment of sepsis had been redeveloped with the introduction of the sepsis pathway. Patients received timely diagnosis and treatment.
- Patient's pain was assessed on arrival in the department and appropriate pain relief was administered to patients.
- Staff were competent and there was a focus on training and development for all staff.
- There was good multi-disciplinary working with a range of agencies and organisations.

However:

- Appraisal rates were 50% for medical staff and 74% for nurses.

Evidence-based care and treatment

- The department used guidance from the National Institute of Health and Care Excellence (NICE) and other organisations including the British Thoracic Society, the regional trauma network and local specialist hospitals. NICE guidance was assigned to appropriate consultants for implementation and compliance was audited and recorded.
- There were a range of clinical care pathways that adhered to NICE guidance and guidance from the Royal College of Emergency Medicine (RCEM) and points relevant to this guidance in the pathways were highlighted in the documentation. These pathways included cardiac chest pain, fractured neck of femur, sepsis and stroke. One of the consultants was responsible for pathways and these were updated at regular intervals.
- New guidance was assigned to relevant individuals and implementation was monitored. We saw an example of where NICE guidelines had been updated with new guidance and how this had been circulated to staff through the safety briefings and the clinical governance newsletter which was circulated to all staff in the department every month. There were also emails of governance updates and teaching sessions were used to inform staff of changes to guidance.
- The trust completed the trauma unit dashboard and this showed that the trust scored 88.9% of patients had rapid access to specialist major trauma care within 12 hours of the referral request. This compared to a national mean value of 71.4%.The trust scored highly in every area except one which was the proportion of patients receiving a computerised tomography (CT) scan within an hour of arrival in the department.
- The paediatric department had identified the appropriate guidance from NICE and were developing pathways for a number of paediatric conditions including sepsis, asthma and bronchiolitis.

Pain relief

- Pain scores were assessed on arrival at the department by the triage nurse and recorded on the electronic record system; appropriate analgesia was administered as necessary. This was audited by the department.
- One of the questions for patients using the self-check in was their requirement for pain relief and patients who required analgesia were followed up by the triage nurses.
- There were specialist nurses for pain management in the trust who supported the staff in the department.
- In answer to the question "do you think the hospital staff did everything they could to help control your pain and "how many minutes after you requested pain relief medication did it take before you got it" the trust scored about the same as the England average.
- Patients we spoke with, with the exception of one patient said that their pain had been discussed and appropriate medicines had been given.
- In the paediatric department we saw an observational pain chart that was used for children and young people and pain scoring tools with appropriate analgesia.

Nutrition and hydration

- There were a number of vending machines available in the urgent and emergency care department; we saw that these were refilled on a regular basis. There were food and drink outlets in the main hospital.

- During the busy period in the department we saw that patients on trolleys were provided with food and drinks.
- A patient's relative told us that that the patient was refusing food as they were nauseous but that the staff were doing their best to find palatable foods for them.
- Patients in the clinical decisions unit had the malnutrition universal screening tool (MUST) completed, this identifies individuals who are malnourished. We also saw that hydration charts had been completed for patients on the unit.
- Various drinks including water and fruit squash were available for children in the paediatric department.

Patient outcomes

- There was an audit programme that included audits from the Royal College of Emergency medicine (RCEM), the Commissioning for Quality and Innovation (CQUINs) scheme and internal audits for the department.
- Following sub-optimal findings from the RCEM sepsis audit in 2013/14, the sepsis pathway had been redeveloped with the consultant sepsis lead, a microbiologist, a pharmacist and the infection control nurse. There was a sepsis screening tool and every patient attending the majors area of the department had venous blood collected for a venous blood gas analysis, there was a near point testing machine for blood gases and blood sugar levels in the department.
- Following learning from an incident and as part of the quality improvement work the pathology department had changed their policies to always phone results through to the urgent and emergency care department to speed up appropriate treatment for patients with sepsis.
- There was an antibiotic formulary which was accessible via the trust extranet which advised on choice of antibiotic therapy. Microbiology were contacted for more complex cases and for patients with drug allergies.
- Implementation of the revised sepsis pathway and the screening tool had led to an increase of 81% of patients being screened from 28% a year ago and 79.9% receiving antibiotics within an hour of admission as compared to 29% a year ago. Since the inspection there has been an increase in the number of patients screened for sepsis within one hour of arrival in the urgent and emergency care department, this was 98% for the period April 1 April 2017 20 June 2017, The percentage of patients being given antibiotics within one hour of arrival in the urgent and emergency care department was 98% the same time period.
- There was a sepsis nurse of the day who carried a bleep who would undertake screening and initiate the sepsis six pathway. There was a sepsis trolley that contained everything required for the diagnosis and treatment of sepsis.
- Twelve staff from the urgent and emergency care department had received three hours protected teaching time for training in sepsis management; this was to be rolled out to the paediatric nurses in the department. Nurses had been trained to take blood for blood cultures for the diagnosis and treatment of sepsis. The taking of blood for blood cultures was audited by the department.
- Since the inspection there has been a dedicated cubicle in the urgent and emergency care department for patients with possible sepsis, this has supported the early intervention and screening for sepsis. There are additional trollies for sepsis with one in majors and one in the paediatric area. This means that everything needed to treat a patient with sepsis is available and easy to find. There has also been on going education, particularly involving new members of the urgent and emergency care team, to highlight the importance of screening for sepsis.
- Audits from RCEM in 2014/15 included " assessing for cognitive impairment in older people" the audit had mixed results with one measure scoring in the top 25% and one in the bottom 25% with two other measures somewhere in between. Actions had been put in place following the audit.
- There was a RCEM audit of mental health in the emergency department in 2014-2015 which had also shown mixed results. One of the measures was that

patients did not have a documented mental health risk assessment, this had been addressed by the department and appropriate patients undertook a risk assessment at triage.

- In the 2013-2014 RCEM audit for consultant sign-off the trust was in the middle 50% for three out of four measures and in the lower 25% for one of the measures. Actions had been put in place to address this.
- There was a nurse-led pathway for patients with fractured neck of femur. At triage these patients had blood taken for pathology, they also had diagnostic imaging and were given appropriate pain relief. The department was working towards a target of diagnostic imaging for patients in less than an hour and they had achieved this. Once a diagnosis was confirmed the patients would be sent directly to the orthopaedic ward. The department was working towards a target of diagnostic imaging for patients with suspected pneumonia in less than an hour.
- The consultants were introducing the Edmonton frailty score into the department to improve outcomes for older patients and the department had a "confusion" assessment tool which was a mini-mental health assessment to help to identify patients with delirium.
- A pathway had been developed for non-invasive ventilation (NIV) and the nurse skills had been identified to support this pathway. NIV is used to support patients in acute and chronic respiratory failure. A standard operating procedure was in place for the pathway. One of the consultants had developed a thoracic injury pathway which was now being used in the department.
- The department unplanned re-attendance rate within seven days from November 2015 and October 2016 was worse than the national standard of 5% and generally similar to the England average. The percentage of attendances requiring an admission to hospital was 20.1% for 2015 to 2016 compared to the England average of 21.6%. For the period 2014 to 2015 the trust percentage was 21.7% compared to the England average of 22.2%.
- The department had a radiology alert log and one of the consultants would work through this every day. It was a list of abnormal reports produced by the diagnostic imaging department and the consultants worked through the list checking that each one had been recognised and acted on. All were listed and document with a clear outcome described. We saw evidence that the consultant had emailed a GP to clarify the diagnostic image reporting.
- The nurse consultant was working to develop pathways for children across the paediatric emergency department, the paediatric department and primary care.
- Paediatric referral to specialities was generally to a nearby children's hospital.
- In the RCEM audit of initial management of the fitting child (2014 to 2015) the department was in the lower 25% of hospitals for two of the five measures, in the top 25% for one of the measures and between for two of the measures. In the audit of asthma in children (2013 to 2014) the department was in the top 25% for four of the ten measures, and in the bottom 25% for one of the measures. The other five measures fell in the middle 50%. Actions had been put in place to address issues arising from the audit.

Competent staff

- There was a consultant trauma lead for the department who maintained their high skill level skills by carrying out sessions at a nearby major trauma centre.
- One of the consultants had taken a lead on the new ultrasound machine and was trained to level one from the British Medical Ultrasound Society; they were training other doctors in the department to use the ultrasound machine. They were also working with the Deanery to train doctors from other hospitals in how to use ultrasound in an urgent and emergency care setting.
- We spoke with one of the junior doctors in the department. They spoke positively of their training, experience and support in the department from the consultants. There was protected time for weekly teaching which was rotated with the Deanery. They had been involved in a College of Emergency medicine (CEM) audit, a hospital audit and were involved in the development of guidelines for the treatment of anaphylaxis.

- There was a nurse clinical practice facilitator (PEF) who had been in post for three years as a clinical nurse educator, the role had evolved as staff were becoming more autonomous and were developing their skills.
- Five staff from the emergency department, two consultants and three nurses, have led a working group to produce a new course for nurse trauma and critical care. They have been working with the Royal College of Surgeons and the local trauma network. The course will be approved by the Cheshire and Merseyside trauma network and will be offered nationally in 2018. Warrington emergency department nurses are the first in the United Kingdom who will attend the course, together with staff from a nearby major trauma centre. The course will cover all the major trauma competencies.
- There had been a range of training for urgent and emergency care staff including advanced nurse practitioner training, emergency nurse practitioner training, post –graduate qualifications, leadership and some continuing development modules from local universities. Five nursing staff were booked on the trauma nursing core course for 2017/18.
- There were trauma and paediatric simulations of medical emergencies that were run every week to develop readiness to manage emergencies for doctors and nurses. These were well attended and there was feedback to all staff involved. The feedback from staff about the simulations was very positive.
- There had been training for nurses in the requesting of diagnostic imaging for x-rays of the chest and hips, pelvis and lower limb and the shoulder. A pathway and standard operating procedures had been put in place and staff had received appropriate training on the ionising medical exposure regulations. Triage nurses could request x-rays for patients during the triage process so that patients had these results before they saw a doctor.
- Drop in sessions for informal mental health training had been organised by the PEF, these were supported by the mental health team. Training had been booked for a member of staff to attend suicide prevention training.
- The trust submitted data to CQC that indicated medical staff appraisal rates were at 50%. However as part of the factual accuracy process a statement was submitted to indicates the rate reported to the trust board for the year preceding the inspection was 94%. No additional evidence was submitted to support this statement. The appraisal rate for nursing staff was 74%.
- Revalidation had been discussed at the safety brief and senior staff, the practice education facilitator and a link nurse were available to support staff. There was preceptor scheme in place for newly promoted staff and those on secondment.
- If nursing staff had made any clinical errors or there were concerns about their practice, there would be an open discussion with the nurse and any additional training needs would be identified and an action plan developed. This was known as a “record of contract” and became part of the staff member’s human resource record.
- The paediatric nurse consultant and the clinical practice facilitator (CPF) were using the guidelines for training from the Faculty of Emergency Medicine and Nursing Skill Competence for Caring for Children in the Emergency Department. They had undertaken a training needs analysis of the nursing staff and had identified the essential skills and competencies needed in the paediatric department and were starting to work towards them.
- The vision for the paediatric department was to develop the nursing staff so they could become more autonomous practitioners with advanced nurse practitioners and emergency nurse practitioners in paediatric emergency care nursing.

Multidisciplinary working

- There was cohesive working between the urgent and emergency care doctors and the physicians in medicine. The department were working towards better joint working with critical care.
- Doctors and nurses worked well together in the department and we saw physiotherapists treating patients.
- The department had strong links to the police service and there was a police liaison attached to the hospital, there were also good links to social services.

- The trust worked closely with neighbouring trusts including the major trauma unit, specialist trusts and other district general hospitals in the area. They also worked with the North West Ambulance Service.
- The paediatric department had good relations with the nearby specialist children's trust and with the child and adolescent mental health services from a nearby mental health trust. Children and young people could also be referred to drug and alcohol services.
- The paediatric nurse consultant had developed links to primary care as part of their role.
- There was an alcohol liaison nurse who worked for the trust. They were mental health trained and had developed pathways in the trust for the treatment of patients following alcohol and substance misuse. Their role was to help to identify those patients who were at risk from alcohol and substance misuse, to give advice to the patients and to staff, to plan treatment for patients and to provide aftercare for patients. They had a liaison role and had links to mental health services, social care, housing, the voluntary sector and the police.

Seven-day services

- The urgent and emergency care services were available 24-hours, seven days per week though not all the departments were open for this time period. Ambulatory care opened between 10am and 9pm and minor injuries opened 8am till 10pm and till midnight at weekends.
- Diagnostic imaging and reporting was available 24 hours a day, seven days a week.

Access to information

- Staff needed a smart card to access electronic systems in the department and temporary staff were allocated with a card. Due to the number of temporary staff leaving the department with the cards, they were asked to leave something in exchange so that they could reclaim it at the end of the shift.
- NICE guidance and clinical pathways were available through the trust electronic system.
- Staff in the mental health team said that there were good electronic systems and so appropriate staff could view appropriate information about patients in different organisations. The psychiatric liaison service used the same systems.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Mental capacity act training was part of adult safeguarding training. The trust lead for mental capacity facilitated the nurse assessment training on the assessment of capacity.
- There was a standard operating procedure for mental capacity and deprivation of liberty safeguards.
- Patient records showed that appropriate consent had been taken and recorded.
- We saw that capacity assessments were discussed during the medical handover.
- If a patient without capacity left the hospital before receiving treatment this was discussed with the police and a pro-forma was completed to decide if the police needed to follow up on these patients

Are urgent and emergency services caring?

Good

We rated caring as good because:

- The department were consistently better than the England average in the friends and family test and this had improved every month since April 2016.
- Patients we spoke with were full of praise for the care that they received and for the staff in the department. Staff were polite and courteous even when the department was very busy and privacy and dignity were maintained at all times.
- Relatives and carers were supported by the staff and information about their relatives was delivered in a calm and consistent manner.
- Staff were being trained in delivering compassionate care and communication in difficult circumstances.

Urgent and emergency services

Compassionate care

- The urgent and emergency care department friends and family test (the percentage of people who would recommend the department) was better than the England average between March 2016 and November 2016. The trust were performing worse than the England average from December 2015 until February 2016 and in January 2016 scored 76%, this rose to 92% in April 2016.
- We spoke with 15 patients and their relatives. All the feedback about their care was positive and comments included "the staff are brilliant here" and "this is not our local hospital but it is the one we choose to come to."
- Care was holistic and we saw that a patient had been referred for a benefits check. Staff introduced themselves by name and told patients what their role was in their treatment. Patients said that they were treated like a person and not a number.
- We observed that staff were courteous and kind to patients even when they were very busy.
- Privacy and dignity were always maintained in the department and we saw that curtains were always used when appropriate. During the medical handover, curtains were closed around the patients and discussions about them were discreet and confidential. When the corridor in the urgent and emergency care department became busy we saw that screens were used at both ends of the corridor to protect privacy and dignity.
- We saw a patient in the emergency department who had to go to another hospital for tests and only had an hour before he needed to leave. He spoke with the receptionist and was triaged immediately even though he had offered to return later that day.
- During the inspection a patient, with limited mobility, who was leaving the department stopped to thank the consultant for their help. The patient had received an appointment for a magnetic resonance imaging scan but as they were attending the urgent and emergency department on an unrelated issue the consultant had spoken with the diagnostic imaging staff and the patients scan had been brought forward. This had saved the patient an additional journey.
- We saw some feedback from a parent whose child had attended the paediatric urgent and emergency care department who said that the care that they had received in the department was fantastic.

Understanding and involvement of patients and those close to them

- Relatives were involved in the decisions made about patient's treatment and staff communicated in calm and measured way. Staff showed empathy to patients and their relatives.
- A patient's relative told us that the doctor had explained everything about their relative's condition so that they would know what to expect. Another patient told us that the staff had telephoned their relative to update them about her condition during their time in the department.
- We observed that the department received a phone call from a patient's relative to ask on his progress as the patient's mobile phone wasn't working. The staff asked the patient if they wished to speak with the relative and brought him to the phone on the nurses' station. Staff vacated the area to give the patient privacy when speaking with their relative.
- The matron told us of an incident following the sudden death of a patient where relatives had watched the resuscitation efforts of the staff. Following the death of the patient, staff had been visibly upset by the experience and the relatives returned the following day to thank staff who had been involved in the treatment of their relative.

Emotional support

- There were clinical nurse specialists in the trust who were available to support patients in areas including alcohol and substance misuse, dementia, palliative care and transplant/organ donation.
- The alcohol specialist nurse was able to refer patients to increased access to psychological therapies (IAPT). These services were for patients who suffered from mild to moderate mental health conditions such as anxiety and depression and included a range of different therapies.
- The band 5 nursing competency framework included a number of modules including compassion,

communicating delicate information and confidence in their role. Stage five of these competencies was that staff would be able to support and guide others in compassion with individuals, undertake and deal with delicate situations to a high standard and act effectively as the patient's advocate. These competencies were reviewed regularly and should have been achieved after 12 months in post. Achievement of these competencies would enable staff to effectively communicate, support and advocate for patients.

- A nurse had provided support for a patient with additional needs following a traumatic event, a relative had written to the trust to thank the nurse and the department. The nurse had won employee of the month for the department and the trust.
- We observed relatives of a young patient who had died suddenly the day before, the nurse who had cared for him spent time with the relatives and dealt with the patient's belongings.

Are urgent and emergency services responsive to people's needs?
(for example, to feedback?)

Requires improvement

We rated responsive as requires improvement because:

- The department were not meeting a number of targets set by the Department of Health.
- Processes were not in place to support patients who needed reasonable adjustments for their care and treatment.
- There was little support for people with a learning disability including easy read material and leaflets and information in pictorial form.

However:

- Although the department were not meeting targets they had consistently performed better than the England average in the delivery of some of the targets with consistent improvement.
- There were processes in place when the department became extremely busy and there was a shortage of beds in the hospital.
- Services had been put in place to improve the flow of patients through the department; this included the ambulatory care unit.
- Patients and their relatives were invited into the department to attend staff meetings following complaints, staff and patients had found the process useful.

Service planning and delivery to meet the needs of local people

- The department was divided into triage (hub) major injuries (majors), minor injuries (minors), the clinical decisions unit (CDU), paediatrics and ambulatory care. There was a resuscitation area with five bays, one of which was a dedicated paediatric bay and there were seven cubicles in the majors department. The CDU had four beds for male patients and four for female patients.
- All patients including those who arrived by ambulance were triaged in the hub though some patients who walked into the department used a self-check-in triage system. These patients would respond to a number of questions and would be directed to the most appropriate place to receive treatment; this was usually the minor injuries unit. We observed patients using the self-triage system and staff would help them if necessary.
- The minor injuries department was staffed by emergency nurse practitioners and by foundation level two doctors as part of their training. It was open from 8am until 10pm Wednesday to Friday and until midnight from Saturday until Tuesday.
- Ambulatory care was open from 10am till 9pm; the unit would take its last patient about 7.00pm. Any patient remaining on the unit after 10pm was returned to the main department, so that staff could go home. The unit had 16 spaces for chairs or trollies. Patients with an early warning score of less than six were admitted to this unit and GP's could admit patients directly to the unit. There was close working between the medical staff from urgent and emergency care and physicians from the medicine department with

dedicated ward rounds by the physicians' morning and afternoon to manage flow through the department. Fewer than 10% of patients were admitted to the hospital from this unit which saw about 40 patients per day.

- Respiratory nurses in the community could refer patients directly to the ambulatory care unit and there were also direct referrals for patients with a deep venous thrombosis and transient ischaemic attacks. Some of the consultants ran clinics the department.
- During the inspection the unit was used to keep patients overnight due to high numbers of patients in the emergency and urgent care department. This was not ideal though all the patients had a hospital bed but no locker or bed side table. The unit could not serve hot food and drinks to patients as they had no trolleys so the matron had turned the staff room into a dining room so that patients could have a hot meal. All the patients had a stay which was less than 24 hours and all were being discharged or waiting for a bed or diagnostic testing. We spoke with patients on the unit during the inspection that had stayed overnight; they told us that they all had a bed in the hospital or a discharge time. All said that their care had been good and they didn't have any complaints.
- Staff told us that it had been used to keep patients overnight three times since Christmas 2016 and when this happened it did not function as an ambulatory care unit. Consultants told us that this severely impacted on the flow through the urgent and emergency care department.
- The CDU had admittance criteria and generally accepted patients with head injuries, drug overdoses and patients waiting for the rapid response team. During the inspection we saw that three of the beds were occupied with medical outliers and a patient who was waiting for a care package from social services.
- The urgent and emergency care department had its own x-ray facility with a separate waiting area for children with 24 hour, seven day a week access to plain imaging and computerised tomography (CT) scanning with reporting of plain films between 8am and 5pm. For out of hours reporting the trust was part of the regional radiology hub that provided cover for the reporting of CT scanning.
- Trauma scans were reported by a consultant within one hour of the CT occurring and all other films were reported by the radiology registrar on-call. All images performed overnight/out of hours were reviewed the following day by a radiology consultant for assurance purposes. Any discrepancies were highlighted and reviewed in the radiology discrepancy meeting minutes of this were maintained.
- Some of the consultants were trained in ultrasound, this meant that scans could be undertaken and patients could access appropriate and safe treatment in a timely manner.
- The department had a fast track to the orthopaedic ward for patients with a fractured neck of femur.
- There was a relative's room which contained a couch, a telephone and facilities to make a hot drink. This was connected by an internal door to a viewing room; this room was basic with dimmable lighting. The matron told us that is was going to be refurbished.
- There were plans to put a rapid response team (RRT) into the department to try to prevent admissions of older people. This would involve putting physiotherapists and occupational therapists into the hub so that patients who were triaged and could be dealt with by the RRT could be discharged home with appropriate support.
- There was an enhanced care home team with medical, nursing and pharmacy support from primary care services to try to reduce admissions and to prioritise patients with complex issues, those who had recently been discharged and patients with advanced care plans for end of life conditions. A consultant told us that they were not yet sure on the impact of attendance or a reduction of admissions to the department.
- There were six cubicles in the paediatric department one of which was designated for adolescents

- The paediatric emergency care department had restricted access and patients had to use a bell to gain entry. Staff on the desk could see everyone who entered and left the department.
- The department was quite small but was visibly clean, bright and airy with themed murals on the walls and curtains. The waiting area in the department was being painted at the time of the inspection. There was a small range of toys available for very young children and there was a television.
- There was a good range of advice leaflets available in the paediatric department.
- The vision for the department was to have a paediatric assessment unit co-located with the paediatric urgent and emergency care department and an area in the department had been identified as the most suitable area for relocation.

Meeting people's individual needs

- There was a mental health team based within the ambulatory care unit from 8am to 8pm, 365 days per year. There was 7.5 whole time equivalent nursing staff for the service and one full time consultant who was employed by the nearby mental health trust. The nurses were all mental health trained. The staff working in the team felt that the service would be improved if provided a 24 hour service.
- The mental health liaison services were able to access acute physician and ED medical teams.
- Staff from the urgent and emergency department could make referrals to the team by email during the day and at night referrals were faxed securely to the nearby mental health trust.
- There was a mental health room in the urgent and emergency care department. The room was sound proof and without windows. There was a concern that the room was not fitted with anti-barricade fixtures and the door opened inwards.
- Patients with mental health problems could be seen by the mental health team for face to face assessment or following telephone triage would return home with follow up from the home treatment team from the nearby mental health trust.
- There was a CRISIS team provided by the nearby mental health trust who were on site but they were rarely able to see patients from the urgent and emergency care department.
- The trust were working with commissioners across primary care, and mental health services, as part of a national CQUIN, to look at improving outcomes for patients with mental health needs. CQUIN is commissioning for quality improvements and is a scheme is intended to deliver clinical quality improvements
- Although there was a trust policy for those with a learning disability support for those with a learning disability was poor as there was no easy read material or pictures of procedures for patients.
- As part of the inspection we undertook a pathway tracking exercise, this was a scenario where the patient was a high-functioning female patient with a history of self-harm; she had two children who needed to be collected from school. The issues raised during the exercise were that the environment was very busy and no adjustments were made for the patient. The injuries sustained through self-harming were treated but the patient was passed on to multiple staff through the process instead of one member of staff staying with the patient through the department. The patient was passed onto the psychiatric liaison who was responsible for the patients discharge planning and after care. The psychiatric liaison did not feel able to manage the case and wanted the psychiatrist to see the patient, this involved a potential wait. During the visit the patient visited five clinical areas and was seen or cared for by ten individual members of staff.
- Translators were available as necessary but the black minority ethnic population in the area was very low.
- There was mandatory dementia training for the staff in the department this was by e-learning and included the use of tools. Toilet doors in the department were painted bright orange and so were very visible to patients with cognitive impairment. Patients with cognitive impairment were assigned to one nurse who tried to follow them through the department for continuity.
- One of the consultants told us that some of the patients from a local head injuries unit attended the

department, they had health passports that contained useful information about their health preferences and also information about their "do not resuscitate" decisions. Some patients "do not resuscitate" documentation was scanned into the electronic records system.

- The department were doing an audit of attendances in the department from care homes to decide if the attendance was unavoidable and if the patient would have been treated more appropriately by another healthcare professional or team. This audit was in progress at the time of the inspection
- The department were using the Edmonton frailty tool to identify frailty in older people attending the department; this would identify measures that could be put in place to support patients to help them to maintain their independence. Recruitment of a nurse consultant post to support this work was in progress in the trust.
- There were a number of frequent attenders to the department, action plans were in place for all frequent attenders, many of whom had refused an intervention from the mental health team.
- There was appropriate seating in the emergency department for bariatric patients.
- The department saw approximately 1500 patients per week (this was excluding minor injuries patients).
- The Department of Health's standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the urgent and emergency care centre. The department had breached the standard between December 2015 and November 2016. However they had shown a consistent improvement and from April 2016 had performed better than the England average. In December 2016 and January 2017 the department had performed the same as the England average. Following the inspection the department had improved their escalation plans for adults and for children and young people.
- The declared figures included the urgent care centre at Halton and the Widnes walk-in centre, which performed consistently well. The figure for the period April 2016 to June 2016 was 88.2% (declared figure 92%) for July 2016 to September 2016 was 90.1% (declared figure 93.4%) and for October 2016 to December 2016 was 84.2% (declared figure 89.6%).
- The department were not meeting the targets for time to initial assessment (emergency ambulance cases only) which should be less than 15 minutes. The figures were worse than the England average. Between June 2016 and February 2017 there was an upward trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes.
- Following the CQC visit, the department has seen a considerable improvement in ambulance handover compliance and the average overall turnaround time .The trust has been recognised by the North West Ambulance Service (NWAS) as a top performing trust within the north west region and has started on a 90-day improvement project with NWAS to improving handover compliance. The urgent and emergency care department has been asked to present at the next project group meeting for the region as an example of good practice.
- The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment is no more than one hour. The trust did not meet the standard for 11 months over the 12 month period between January 2016 and December 2016. Performance over the time period showed a consistent trend of being higher than the England average. In August 2016 the trusts performance was better the standard.
- The department had consistently achieved the average time to decision to treat in less than 60 minutes from April 2016 to December 2016 with no waiting time of greater than 56 minutes.
- Between December 2015 and November 2016 the department monthly percentage of patients waiting between four and 12 hours from the decision to admit until being admitted was worse than the England average until May 2016. From May 2016 the trust performance had improved and is mainly better than the England average. Over the last 12 months no patients waited more than 12 hours from the decision to admit until being admitted.

Urgent and emergency services

- The total time that admitted patients were spending in the department was worse than the England average from November 2015 to March 2016, however the performance had improved and since April 2016 the total time in the urgent and emergency care department was better than the England average.
- The number of patients who left without being seen was consistently worse than the England average though the trust have improved their performance during the time period(November 2015 and October 2016).
- Between January 2016 and December 2016 there was an increase in the monthly percentage of ambulance journeys with turnaround times of 30 minutes. In the period 3 January 2016 to 1 January 2017, the trust reported 900 black breaches. This is when a patient waits over one hour before they are handed over to the staff of the urgent and emergency care department. There was an improvement with the highest number of breaches recorded in February, March and April 2016. Numbers fell until December 2016 when there was a high number of breaches though not as high as at the beginning of the year.
- The status of patients and the length of time that they had been waiting was available to staff in the department. This was electronic and different colours were used so that staff knew at a glance how long patients had been waiting.
- There were daily bed meetings at 9.30am, 3pm, 5pm and 8pm, there were more meetings dependent on the escalation level for the hospital and the escalation level was updated after every meeting.
- We attended a bed meeting during the inspection when the trust was at red escalation level. The meeting was attended by senior nurses, consultants and staff from diagnostic imaging. The meeting was well practiced and focused on an immediate plan to establish the flow of patients through the hospital as there were a number of patients who required a bed. Due to the pressure on the hospital there was a conference call at 11am with commissioners, social care and community services to look at how community services could respond to the pressures on the hospital and support discharges.
- The ambulatory care unit opened from 10am until 9pm and provided a flexible and adaptive area for ambulatory patients, who could be more effectively managed and the majority discharged within four hours. Ambulatory care had improved both the patient experience and benefited the performance of the main emergency department.
- There had been a GP based in the department and although this service had worked well, it had been withdrawn by the clinical commissioning group. The service had seen about 30 patients every day. There were access to emergency appointments at a nearby GP surgery but staff said that patients could be quite abusive if they were asked to take up these appointments. There was an audit of numbers of patients who refused to go to primary care services.
- The lead nurse for the shift could move staff around the department to meet varying demands on different parts of the department.
- Staff told us that they could meet the demands of their own patients but ambulances were diverted to the department from other hospitals. In the two months before the inspection there had been four diverted ambulances from the same trust all for sixty minutes. One of the diverts was at night. Doctors said they struggled to manage sometimes when patients were diverted from other hospitals and that it was difficult to repatriate some of the diverted patients especially if they required intermediate care services or social care intervention.
- The department had its own porter service so that patients could be moved quickly around the department and to other departments as necessary.
- The paediatric service saw 17,728 patients aged between 0 and 6 years in the period April 2015 to March 2016, this was a decrease from April 2014 to March 2015 when the service saw 18,108 patients. This was about 21% of patients who attended the department. This was about 50 patients per day though they could see up to 70. Attendances of children were usually highest between midday and 8pm with decreasing numbers up to midnight.
- Staff told us that sometimes they had to wait for a while before the doctor came to the department to

see non-urgent cases and numbers could have accumulated during this time. They said that this was contributing to the four hour breaches in the department.

- There was an on going audit of paediatric attendance and parental awareness of services as an alternative to the urgent and emergency care centre. Numbers of 0 to 16 year old patients had fallen slightly in the period 2015 to 2016 compared to the previous two years.

Learning from complaints and concerns

- Between January and December 2016 there were 52 complaints about the urgent and emergency care department. The trust took an average of 150 days to investigate and close complaints; this is in line with their policy which states that complaints should be closed within six months.
- The matron told us that patients and relatives were invited into the department to attend staff meetings following an incident or complaint. Both the staff and those complaining had found the process very useful. People could be asked to return to future meetings to learn what changes had been made following their concerns.
- Plans were drawn up following complaints to address issues raised in complaints; we were given an example about how a patient with a disability was working with the urgent and emergency care department and other departments in the trust to help to address their communication problems on future visits.

Are urgent and emergency services well-led?

Good

We rated well-led as good because:

- Robust governance structures were in place in the department and there was reporting of governance was done at departmental, directorate and board level. The department was aware of their risks which were managed appropriately.
- Leadership was strong from senior managers and they were keen to develop leaders throughout the department.
- Staff said that they felt empowered and that the department had invested in them. Morale was good despite the heavy workload.
- The culture in the department was open and there was a positive approach to improvement and meeting targets. Senior managers were visible in the department.
- Although there had been significant change in the department staff said that this was for the better and that it was clinically led.

Leadership of service

- The urgent and emergency care department had undergone a change in leadership early in 2016 with the clinical business unit (CBU) model brought in. The trust had used assessment centres and other management tools to identify leaders in the potential applicants for the clinical and nurse leads for the CBU. The CBU had a clinical lead who was a consultant anaesthetist, a lead nurse and a manager. Both of the clinical staff had come from outside of the department. Since the implementation of the CBU, performance in the department had shown marked and on going improvements in safety and performance. This was due to the leadership in the department which was robust and the senior staff led by example.
- The CBU had implemented improved integrated working with other departments across the hospital particularly medicine, staff said that the department was more fluid and responsive and that pathways and partnerships were much improved. The department were not afraid to try new ways of working and if they didn't work they would try something else. There was a "can do" culture.
- Senior staff said that they felt that the trust was better than it had been a year ago; they said that this was partly due to the appointment of the medical director.

- Staff said that there had been big changes in the department but that this was change for the better. It was described as a massive shakeup. They said the active involvement of clinicians at every level was why the changes had been successful.
- The department had appointed a new matron in May 2016 who had implemented significant change across the department with development of the workforce to meet the needs of the department. They had looked at new ways of working and staff had been given opportunities to develop through promotion and secondment opportunities.
- The department was developing strong leaders in the nursing and medical staffing. This started with the competency framework for the band 5 nurses. Staff described a vacuum in nursing leadership before the management changes.
- Every Friday from 1pm till 3pm the senior nurses in the department had an open door policy where staff could drop in and discuss any issues. This was publicised widely across the department.
- Senior staff covered when the department was busy so that staff could take breaks particularly for those on long shifts.
- The staff who worked in the paediatric department said that they did not feel like they belonged to the paediatric service of the urgent and emergency care department. A nurse consultant had been brought in to review the service and staff thought that this would be beneficial. The matron from the urgent and emergency care department had started to visit the department every day to speak with the staff.

Vision and strategy for this service

- There was a vision for the department which was the strategic work programme, this included five current strategies of work and the progress of these strategies which were mainly about the development of the workforce, including the medical workforce and improving performance. Appropriate strategies involved partners from outside the organisation.
- Staff we spoke with were aware of the vision for the department particularly in improving the performance of the department.
- The paediatric urgent and emergency care department had only become part of the main department in the month before the inspection. A transformation plan with an accompanying training needs analysis had been developed and a nurse consultant had been brought in from a neighbouring trust to drive and support the necessary changes in the department.

Governance, risk management and quality measurement

- There were departmental governance meetings every six weeks which were attended by the consultant lead for governance. There was a standard agenda template for the meetings and agenda items included a review of guidance from the National Institute of Health and Care Excellence (NICE), a review of complaints, incident investigations, action plans for serious untoward incidents and investigation reports. Mortality was also discussed. The meetings were well attended with consultant and nurse representation.
- There were acute care directorate governance meetings that were attended by the clinical business unit (CBU) managers and these linked into the patient safety and clinical effectiveness sub-committee of the trust board. These meetings were for the acute care directorate and had a standard agenda template which included review of new NICE guidance, complaints, investigations and information from sub committees of the board including infection control. The risk register was reviewed monthly as part of the directorate meetings and appropriate risks were escalated to the corporate risk register. Each risk had a mitigation plan.
- Information from the governance meetings went to the quality committee, this included risk management, the quarterly governance report, the quality dashboard and a review of any safeguarding issues.
- There were staff meetings for senior nursing staff and band 5 staff, these were every month and there was feedback about complaints, incidents and outcomes of investigations.
- Clinical governance was seen as an integral part of the department as a tool to deliver safe and effective care. Staff we spoke with said that they realised how clinical

governance could support them in their roles. The lead consultant for governance had developed a clinical governance newsletter which was distributed to staff every month.

- There was a peoples measures action plan to try to address the issues of staffing, sickness, agency spend and training and appraisal compliance. Incremental payments could be withheld if staff did not complete their mandatory training.
- There was a paediatric urgent care action plan that supported the move of the department into the urgent and emergency care department. The plan showed that governance, the management of the nursing staff and medical leadership were issues. Actions had been put in place to start to address these issues.

Culture within the service

- There was a culture of improvement and development in the department and staff morale was high despite the busy workload. Staff now felt empowered as they had been given new roles, they felt that the department had invested in them with training and development opportunities.
- The culture in the department had changed following the management reorganisation and staff we spoke with said that the culture was more open, staff were encouraged to report incidents and that there was feedback and learning from incidents. This was through safety briefings, staff meetings and governance meetings.
- Staff we spoke with said that the culture in the hospital had changed as previously the urgent and emergency care department seemed to be blamed for everything but now there was an acknowledgment that problems were across the whole of the hospital and not just in the urgent and emergency care department. Staff said that they had been disempowered and unappreciated.
- We saw from the minutes of meetings that staff were thanked for their efforts at every meeting
- We spoke with a junior doctor in paediatric urgent and emergency care who said that there was a lot of senior support and there was always somebody to ask for help. They had completed their student training at Warrington and then taken a junior doctor post; they said that they had seen things improve in the department since they were a student.
- We spoke with three nurses who had noticed improvements in the atmosphere and culture of the service since the implementation of the clinical business unit structure. They agreed that the service was more cohesive and there was a team ethos that had not been there before. They said that quality and patient care had improved because everyone was working together. This included staff from the North West Ambulance service.
- A nursing member of staff told us how the service had recently improved and how when they requested funding for improvements to the department these had been granted.

Public engagement

- The urgent and emergency care departments at Warrington and Halton were working with players and staff from two local rugby league clubs. The department was promoting awareness of the different urgent care services and when to use these services appropriately. Filming was due to take place for YouTube videos which would be promoted via the social media platforms at one of the rugby clubs.
- The department worked with local schools to promote the work of the department.
- We saw from minutes of staff meetings that there were charity events in the department and collections for food banks.
- The department worked with a police liaison officer from the local police service.

Staff engagement

- The ambulatory care department had won an outstanding contribution award at the staff awards ceremony and one of the nurses had won employee of the month for the department and the trust.
- The department was very busy and the senior management team had introduced stress risk

assessments that were completed on line. If the scores were high there was input from the occupational health department. The risk assessments were mandatory and carried out every year.

- There was a routine debrief following significant incidents and staff gave us examples of these. occupational health and the chief nurse had been involved to provide information and to support staff. Mandatory counselling sessions had been provided to staff involved.
- There was a closed Facebook page for the urgent and emergency care department, this was used as a communication hub and was well used. Managers knew how many staff had read messages and staff we spoke with thought it was a great idea and that it worked well.
- Following the flood in the department there was a round of applause at the morning safety meeting for all the domestic and housekeeping staff who had been involved in the clear up, staff were also thanked individually for their efforts.

Innovation, improvement and sustainability

- The department had improved on a number of performance indictors since the change in the management structure at the beginning of 2016.
- The workforce development of the nursing staff was helping in the retention of staff and improving morale.
- The introduction of the ambulatory care stream had helped to improve flow through the department and the hospital.

Medical care (including older people's care)

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

Information about the service

Medical care is provided at Warrington Hospital from 12 inpatient wards and an endoscopy unit. There were 17,803 inpatient medical admissions between October 2015 and September 2016. Over 90% of patients were admitted under general medicine or gastroenterology. Other medical specialities provided at the hospital include cardiology, haematology, stroke medicine and respiratory medicine.

At our last inspection in January 2015, we told the trust it must take action to improve medical services in a number of areas. This included ensuring medical staffing cover is appropriate at all times, ensuring nursing staffing levels and skill mix are appropriate, improving mandatory training and appraisal rates and improving patient flow to ensure patients are cared for on a ward most appropriate to their needs and reduce the number of patient bed moves.

We visited the hospital as part of our announced inspection between 7 and 10 March 2017. We inspected the acute medical unit, endoscopy, the discharge lounge, cardiac catheterisation laboratory, coronary care unit, A7 (respiratory medicine), A8 (neurology), B14 (stroke unit) and the Forget Me Not ward. The Forget Me Not ward is a specialist unit caring for patients with a diagnosis or suspected diagnosis of dementia or delirium. We also carried out an unannounced inspection on 23 March 2017 when we carried out further inspection on the acute medical unit and the Forget Me Not ward and also visited ward A3 (older persons assessment and liaison ward).

As part of our inspection, we observed care and treatment and looked at 21 sets of patient records. We spoke with 41 staff, including nurses, doctors, consultants, support workers, managers and allied health professionals. We also spoke with 15 patients or their relatives who were using the services at the time of our inspection. We looked at information provided by the trust and other relevant information we requested. We received comments from people who contacted us to tell us about their experience at the trust and reviewed performance information.

Medical care (including older people's care)

Summary of findings

We rated this service as requires improvement because:

- There were times when there were insufficient registered nurses to care for patients. There were high numbers of medical staff vacancies and agency use was high. Patients did not always receive timely medical intervention, for example in cases of sepsis.
- The trust had introduced a formal medical handover at the end of 2016. However, we found that the medical handovers were unstructured and medical notes did not always contain sufficient information about patient care and treatment.
- Mandatory training rates for medical staff, including safeguarding training, were all below trust target. Appraisal rates were also below target.
- Patients were at risk of being unlawfully deprived of their liberty or receiving care and treatment without consent because staff did not follow the trust Mental Capacity Act procedure.
- Governance systems were not sufficiently embedded within the acute care division. The risk register was not effectively managed to show how risks to patients or the service were being reduced. Complaints were not always responded to in a timely way.

However:

- Care was provided in line with best practice by multi-disciplinary teams who worked well together. Patient outcomes were generally good and the trust met the national target for treatment waiting times.
- Staff were kind, caring and compassionate and understood the emotional needs of their patients.
- The Forget Me Not ward was designed to meet the needs of patients living with dementia and staff provided individualised care for this patient group.
- Staff were positive about the leadership and culture of the service.

Are medical care services safe?

Requires improvement

We have rated safe as requires improvement because:

- Medical records did not always contain sufficient information or detail about medical reviews. It was not always clear what grade of doctor had reviewed the patient and there was a lack of information about how a clinical decision had been reached. Junior doctors were not always present during consultant reviews.
- Records were not always stored securely on medical wards. On three wards, records for scanning were stored loose in document folders or within notes trolleys. In another area, large numbers of medical records were left unsecured in an office and records were left unattended on a desk.
- The medical handover was poorly structured with no formal handover document and no designated lead at the handover. This meant there was a risk that important information in relation to safe care and treatment may not be communicated between doctors effectively.
- There were times when there were insufficient registered nurses to care for patients. During our inspection we saw that staff were expected to care for up to 11 patients during the day. There is evidence that the risk of harm to patients increases if a nurse is caring for more than eight patients during the day.
- There were high vacancy rates for medical staff in some specialities resulting in a high usage of locum medical cover. The overall locum usage rate was 40.1%.
- Improvements were required in the implementation of the sepsis six care bundle. Only 75% of patients had been screened for sepsis in line with trust guidance and nearly half of patients did not receive intravenous antibiotics in a timely way.
- Mandatory training rates for medical staff did not meet the trust target in any of the seven mandatory modules. Safeguarding training rates for medical staff

were all below target. Only 56% of doctors had completed safeguarding adults level two and only 54% had completed safeguarding children level two. Basic life support training was below the trust target.

- Staff told us that they did not always report near miss incidents or receive feedback about incidents they had reported. This is despite the trust having a system in place to summarise the incidents for each area, with relevant 72-hour reviews, and cascade these to all wards for further learning and sharing with the staff in each area.
- We reviewed information provided by the trust and saw that Duty of Candour was not always followed correctly following patient safety incidents that had caused moderate harm or above.

However:

- There was good medicine management and we found all medicines were stored correctly. On the acute medical unit, pharmacy technicians were administering medications following appropriate training as an innovative way of reducing medication errors.
- Wards were clean and tidy and staff followed infection prevention and control best practice. There had been no cases of methicillin resistant staphylococcus aureus (MRSA) bacteraemia in medical services in 2016.
- Electronic patient boards provided staff with a high level overview at a glance of any particular patient risks or needs. The boards used symbols to highlight risks such as mobility needs, requirement for a venous thromboembolism assessment, infection control issues or acute kidney injury.

Incidents

- Staff reported incidents using an electronic reporting system. Staff were able to demonstrate how they reported incidents and said they felt confident using the system.
- Staff were able to explain what types of incidents they would report, however some staff told us they did not always report near misses or incidents that caused no harm to patients. This meant there may be missed opportunities to learn from these types of incidents.
- Between September 2016 and March 2017, there were 5,053 incidents reported within the acute care services division at the trust. Over 98% of these incidents were classified as no or low harm.
- Staff told us they did not always receive feedback about incidents they had reported unless there was specific learning or outcome. Most staff were able to provide examples of learning from other specific incidents. For example, a fall in the x-ray department had led to the development of a purple wristband to identify patients with a cognitive impairment.
- The trust reported 36 serious incidents (SIs) in medical care between March 2016 and February 2017 which met the reporting criteria set by NHS England. The most common type of serious incident reported was "slips, trips and falls" meeting the SI criteria which totalled 20 incidents.
- A root cause analysis tool was used to investigate serious incidents. We reviewed three root cause analysis reports and saw that action plans were developed where required to reduce the risk of the incident happening again. However, we asked the trust to provide us with updates to show if actions on the plans had been completed and the trust did not provide us with this information.
- As part of the process the service completed 72 hour reviews to ensure any immediate actions could be taken and learning from the initial investigation could be shared.
- Learning from incidents across the service and the wider hospital was shared at ward safety briefings, team meetings and via team briefs. All staff told us they received information in this way.
- Between January 2016 and December 2016, the trust reported no incidents which were classified as never events for medical care. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- Mortality and morbidity was discussed at monthly mortality and morbidity meetings. Serious cases were

shared at the divisional clinical governance meeting. At the time of our inspection there was a back log of 42 deaths to be reviewed which meant there was a risk that learning from deaths did not happen in a timely way. This was a reduction in the total number outstanding and the service was aiming to have none outstanding by April 2017.

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. There was a trust wide policy and duty of candour process in place. Some staff understood that the duty of candour required services to be open and honest, but others had not heard of the duty of candour. Senior staff understood the principles of the duty of candour.
- We saw that the duty of candour was not always fully implemented following relevant incidents. We reviewed information provided by the trust and saw that processes were not always followed. For example, there was not always evidence of an apology, discussions with the patient or their family or that relevant support had been given.

Safety thermometer

- The NHS safety thermometer is a national improvement tool for measuring, monitoring and analysing avoidable harm to patients and 'harm free' care. Performance against the four possible harms; falls, pressure ulcers, catheter acquired urinary tract infections (CAUTI) and blood clots (venous thromboembolism or VTE), should be monitored on a monthly basis.
- Medical services at the hospital used the NHS safety thermometer to monitor harm and harm free care and results for the current month were displayed on information boards at the entrances to ward areas.
- Data from the safety thermometer showed that medical services reported 24 new pressure ulcers, 17 falls with harm and 26 new catheter acquired urinary tract infections between February 2016 and February 2017.
- There was a trust wide action plan to reduce the numbers of hospital acquired avoidable pressure ulcers led by the tissue viability team. The plan was on track to achieve an agreed reduction in grade two pressure ulcers however the plan for reducing grade three and grade four pressure ulcers was not on track to meet the target. A further action plan focusing on five key themes had been developed in January 2017 when it had become clear that these targets would not be met.

Cleanliness, infection control and hygiene

- All areas we visited were visibly clean. Cleaning schedules were in place and used by ward domestic staff. We saw that these were completed on a daily and weekly basis. On one ward we saw that a used urinal bottle had been left on a record trolley in the corridor. This was immediately disposed of by the ward manager.
- Equipment was cleaned following patient use and labelled with an 'I am clean' label. In the equipment store room on the acute medical unit (AMU), we saw that less frequently used equipment was covered with a plastic covering to prevent the build-up of dust.
- Decontamination procedures were followed in line with best practice in endoscopy.
- We saw that staff had 'bare arms below the elbows' and washed or cleansed their hands before and after patient contact.
- There was access to personal protective equipment such as aprons and gloves and we saw staff using this equipment appropriately to reduce the risk of the spread of infection.
- Patients told us that the environment was clean and tidy and that they saw staff washing their hands before and after their care.
- All wards had antibacterial gel dispensers at the entrances and by people's bedside areas. Appropriate signage regarding hand washing for staff and visitors was on display.
- Sharps containers were dated and signed when assembled and temporary closures were in place when sharps containers were not in use.

- Patients with a known infection were nursed in side rooms and signs were placed on the entrance to these rooms to notify staff and visitors of the need to follow extra precautions. Information about infection was shared with staff during ward safety huddles to ensure staff were aware of any additional infection prevention and control precautions. Domestic staff told us they were also told about key infection control information.
- There had been no cases of methicillin resistant staphylococcus aureus (MRSA) bacteraemia and 19 cases of hospital acquired clostridium difficile infection in medical services during 2016.
- Infection prevention and control training had been completed by 90% of nursing staff which was above the trust target of 85%. Medical staffing training rates were below the trust target with only 71% of staff who had completed this training.
- Matrons completed monthly infection prevention and control (IPC) reports that included hand hygiene audits, uniform audits and environmental audits. The most recent hand hygiene audits reported in December 2016 showed that wards AMU, A2, A4, A7, B14, C21 and the CCU and cardiac catheterisation lab achieved 100% compliance. Compliance on ward A8 was 87.5%.
- Matron IPC reports were discussed at a monthly infection prevention and control subcommittee. We reviewed the minutes of this subcommittee and saw that any issues identified in these reports were discussed in this meeting along with the actions being taken to improve compliance where necessary.
- Patient-led assessment of the care environment (PLACE) is a measure of the care environment in hospitals which provide NHS care. The assessments see local people visit the hospital and look at different aspects of the care environment. The PLACE score for 2016 showed the hospital scored 98% for cleanliness, which was the same as the England average.

Environment and equipment

- All areas we visited were tidy and well-organised. On a number of wards, there was no door to access the clinic area where medicines and supplies such as sharps, dressings and other sterile items were stored. This meant that patients or the public could access these areas if left unattended. We were told there had been no incidents of patients or the public accessing these areas and this was confirmed when we reviewed incident reports.
- Medical wards used an electronic patient board that was linked to the EPR system. On all wards we inspected this board was located in a public area and we noted that on two wards, patient names were visible. This meant that patient identifiable information was available to other patients or visitors. In other areas, patient names were only visible when a member of staff used their EPR login card.
- All equipment we checked had up to date electrical safety testing and had been serviced and calibrated as required.
- Resuscitation trolleys were available in all areas we visited and were tagged with tamper proof seals. Trust policy set out that a full check of the trolley should be completed monthly, or following use of the trolley and a daily more limited check should be completed whenever the ward or area was open to patients. This was to ensure that there was emergency equipment available and in date when required.
- We saw that one resuscitation trolley on AMU had not been checked on 6 days since 1 January 2017. We also saw that the trolley in endoscopy had not been checked on 5 days between 1 February and 7 March 2017. We checked a further six trolleys and saw that these had all been checked, including daily checks of automated external defibrillators, in line with trust policy.
- Staff told us they had access to sufficient and appropriate equipment to enable them to care for patients safely.
- There were adequate arrangements in place for the handling, storage and disposal of clinical waste, including sharps.
- Each ward had designated toilets and showers for male and female patients.

Medicines

Medical care (including older people's care)

- Medicines were stored securely and appropriately in most areas we visited, although one medication cupboard containing intravenous medications was unlocked on ward A3. We checked a sample of medicines and found that these were all within date.
- Controlled drugs were stored in line with Home Office regulations. Controlled drugs records books were completed correctly including all relevant information and signatures.
- Medicines requiring cool storage at temperatures below eight degrees centigrade were appropriately stored in fridges. Daily temperature checklists were completed on the wards we visited. This included the temperate range. Guidance was available for staff to use if temperatures fell outside the recommended range.
- At the time of our inspection, 90% of nursing staff and 85% of medical staff had up to date medicines management training. The trust target for completion was 85%.
- Between September 2016 and March 2017, 398 incidents related to medicines were reported within acute care services. Seventy-one per cent of these incidents were graded as no harm. There had been only one incident where harm to the patient had been graded as moderate or above.
- On the acute medical unit, pharmacy technicians had been trained to administer the majority of oral medications to patients. They were also trained to act as an authorised second check and witness in the administration of controlled drugs. This system had been developed as a result of a high number of medication errors on this ward and was an innovative way of improving safety in relation to medicines. Nursing staff described this as a positive change to working practices.
- There were no dedicated pharmacists for medical services although pharmacists visited wards to reconcile medicines and check prescription charts including antimicrobial prescriptions, to identify and minimise the chance of prescribing errors. Pharmacy support was available using a bleep system.
- Medications were prescribed using a paper drug kardex which was stored with the nursing documentation.
- We reviewed eight prescription charts and found that charts contained details of patient allergy status, regular medications, one off and as required medicines. Medications had been reconciled by a pharmacist on each chart. Medication was signed as having been given or a number was documented to explain the reason for omission of a medicine if applicable.
- Staff wore disposal red tabards to identify that they were undertaking a medication round which provided a visual prompt to staff to remind them not to disturb them during the round. This was to minimise any risk of medication error due to other distractions.

Records

- Records were a combination of electronic and paper notes. All medical entries were entered on the electronic patient record (EPR), although prescription charts were hand written.
- We saw that most medical entries did not always contain sufficient information or detail about medical reviews. It was not always clear what grade of doctor had reviewed the patient or who was present on the ward round. Notes did not always provide sufficient clinical detail to evidence that test results had been reviewed, considered or information about how a clinical decision had been reached.
- When paper records were completed and no longer in use, ward clerks scanned these paper records into the EPR system to form one medical record. However, we saw that records waiting to be scanned were not always stored securely on medical wards. On wards A3 and A8 and records for scanning were stored loose in document folders or within notes trolleys. This meant there was a risk that these paper records could be lost or incorrectly filed. On other wards, completed paper records were stored securely in a medical record folder prior to being scanned into the EPR system.
- We noted that there was a large volume of paper medical records being stored in an unlocked and unattended office on AMU. We also saw that medical records for discharged patients had been left on the

unattended ward clerk desk. This meant that medical records containing confidential patient information could be accessed by unauthorised staff or the public. We highlighted this to the nurse in charge who removed the records on the ward clerk desk and told us she would immediately log a job for a key to be sourced for the office to ensure that the records were stored securely when unattended.

- The monthly records audit showed that 99% of records reviewed contained all relevant information such as patient name, date of birth and hospital number.
- In endoscopy, a paper based care pathway was in use. We saw that records were stored securely and were complete, legible and signed. The pre-operative assessment included a comprehensive assessment of patient needs.
- The trust was in the process of training all nursing staff to use the electronic patient note system to complete nursing risk assessments and care plans electronically.

Safeguarding

- There was a designated lead for safeguarding adults and children within the trust. Staff in medical services were aware of their responsibilities in relation to adult and children's safeguarding. They were able to tell us where to gain advice and how to make a safeguarding referral. The safeguarding team were available for advice during normal working hours. A safeguarding hub was available on the trust intranet with additional information to support staff.
- Staff in medical services were expected to complete training on safeguarding adults and children which included training on female genital mutilation (FGM). Clinical staff were expected to complete level two training in both of these subjects. The trust set a target of 85% for completion of safeguarding training.
- Safeguarding adults level one training had been completed by 92% of nursing staff in medical services. Safeguarding adults level two had been completed by 83% of nursing staff which was just below the trust target of 85%.
- Safeguarding children level one had been completed by 97% of nursing staff. Level two training was below target at 82%. Level three training had been completed by all relevant staff.
- Safeguarding training rates for medical staff were all below target. Only 56% of doctors had completed safeguarding adults level two and only 54% had completed safeguarding children level two.
- The nursing risk assessment booklet prompted nursing staff to ask if patients were known to social services and make consideration of whether there were any issues relating to domestic violence.

Mandatory training

- Mandatory training was a mix of face to face and e-learning sessions. The trust set a target of 85% for completion of mandatory training. Mandatory training courses included moving and handling, health and safety and fire safety.
- Training rates for medical staff did not meet the 85% target in any mandatory training module. Rates for training in these mandatory modules were 77% or below, with health and safety training completion at 54%.
- Nursing staff training figures met the 85% target in all but one of the seven mandatory modules with training rates in these modules at 90% or above. The module that did not meet target was health and safety level three where two out of six relevant staff had completed this.

Assessing and responding to patient risk

- An early warning score (EWS) system was in use in all areas. The EWS system was used to monitor patients' vital signs, identify patients at risk of deterioration and prompt staff to take appropriate action in response to any deterioration. In all the records we reviewed, we saw that scores had been calculated correctly and actions taken in line with trust guidance when a patient deteriorated.
- A medical emergency team was available and contacted via an emergency number when a patient's

EWS was over seven. There was also access to an acute care team 24 hours a day which was made up of critical care outreach nurses, assistant or nurse practitioners.

- The hospital audited the use of the early warning score system on a quarterly basis. We saw that wards C21 and A3 did not meet the 75% target set on the deterioration recognition audit completed in July 2016. Actions were taken and on the most recent audit in February 2017, both wards achieved the required compliance rate.
- An ibleep system was in use to page staff when required to review patients. Doctors and nurses told us this worked well.
- In the acute care division, only 59.1% of all staff had completed basic life support training between February 2016 and January 2017. This was below the trust target of 85%. Forty-one percent of nursing staff within the division had completed immediate life support training and less than 1% of staff (eight nurses) had completed advanced life support training.
- The trust provided details that indicated 21 (12.5%) nursing staff had completed the acute illness management course. Additional information was provided as part of the factual accuracy check that gives more details as follows, at end January 2017 there were 114 (24.36%) staff with AIM certification within Acute Care Division. these numbers are calculated from Jan 2014 as the AIM course certification lasts for 3 years.
- In quarter three, only 75% of patients were screened for sepsis where the trust sepsis screening protocol should have been completed. Only 51.4% of patients with severe sepsis, red flag sepsis or septic shock received IV antibiotics within 90 minutes of identification. This had improved from the quarter two audit which showed 48% had been screened and 50% had received antibiotics within 90 minutes. We reviewed one set of records where sepsis had been diagnosed and saw that there had been no screening for sepsis despite the patients presenting condition and that sepsis six had not been implemented for 48 hours.
- In addition to clinical observations rounds, a comfort round was carried out regularly by care workers. This included ensuring patients were comfortable, that the nurse call bell and drinks were available, positional changes if necessary and asking patients if there was anything else they needed. We saw that these rounds were recorded in the patient notes when completed.
- A paper based nursing risk assessment booklet was in use on each of the wards we visited. Assessments in the booklet included risk of falls, use of bed rails, mobility and pressure ulcers. We reviewed eight risk assessment booklets and found that risk assessments had been completed and appropriate care plans had been put in place where indicated. Clinical observations charts, fluid balance charts and food diaries were also paper based and these had also all been completed correctly.
- A monthly audit was completed to monitor compliance with key risk assessments. We reviewed the audit completed in January 2017 and saw that 100% of patients had a completed bed rail assessment, mobility assessment and Waterlow (pressure ulcer) assessment.
- Wards used bay tagging if there were a number of patients at high risk of falls or with cognitive impairment. Bay tagging is a method of ensuring one member of staff is always present in a specified clinical area to reduce the risk of patient harm. One to one support was provided when patients required an enhanced level of support and observation.
- Electronic patient boards provided staff with a high level overview at a glance of any particular patient risks or needs. The boards used symbols to highlight risks such as mobility needs, requirement for a VTE assessment, infection control issues or acute kidney injury.
- On AMU, staff told us they placed low risk patients in the GP assessment area. However, when we visited the ward on 8 March we saw that all patients in this area had been assessed as high risk of falls.
- The cardiac catheterisation lab used an adapted version of the World Health Organisation (WHO) surgical safety checklist. The surgical safety checklist was introduced by WHO as a tool to improve the safety of surgery by reducing deaths and complications. We saw that this had been completed correctly in the records we reviewed.

- On CCU, we saw that nursing staff monitored telemetry systems at all times. Patients on AMU or A2 who needed continuous monitoring via telemetry were fitted with the monitoring device and monitored remotely by the trained staff on CCU. Staff on CCU communicated with AMU via an intercom system to alert them to any action they needed to take.
- The service used an "SBAR" (situation, background, assessment, recommendation) document when patients were moving between wards to effectively communicate key information regarding the patients' clinical presentation and plan of care and areas of risk.
- In the endoscopy unit, baseline observations of patients were taken before the procedure and at regular intervals during the procedure to monitor for any deterioration. A safety huddle was held before each patient list to discuss the upcoming list and any potential safety issues or particular needs of the patients. This was formally documented for an audit trail.
- Access to an emergency gastrointestinal (GI) bleed consultant was available 24 hours a day. This meant that in the event of a GI bleed, patients could be treated quickly at the hospital.

Nursing staffing

- The Safer Care Nursing Tool had been used to calculate nursing staffing on medical wards. This had been reviewed most recently in April 2016. The introduction of this tool had resulted in an increase in the nursing establishment on some wards. The Chief Nurse had also met with some ward managers to review nurse staffing levels in November 2016. Staffing levels were reviewed by matrons on a daily basis and staff were reassigned to support other wards or brought in via the nurse bank or agency when necessary.
- There was a nursing staffing escalation procedure in place which included details of actions to be taken by staff at all levels to ensure safe staffing levels. The trust collected data to compare the planned nursing coverage to the actual nursing coverage for each ward on a daily basis. Wards we visited displayed planned and actual staffing levels for each shift that day.
- Senior staff told us that although unfilled shifts were advertised through the nurse bank or agency, shifts were not always filled. The overall fill rate for registered nurses during the day was 87.8% between September 2016 and February 2017. The fill rate for care staff during this time period was 92%. Nurses told us that they regularly worked late to catch up on paperwork when shifts had been unfilled.
- When we visited ward A8 we saw that the planned nurse cover was five registered nurses but the actual was three registered nurses. This meant that the nurse to patient ratio was one to 11 and the nurse co-ordinating the shift was also expected to care for a group of patients.
- Although there is no national maximum nurse to patient ratio, there is evidence that the risk of harm to patient increases if a nurse is caring for more than eight patients during the day. One additional bank healthcare support worker had been allocated to the ward to support the shift.
- We also noted that the nurse co-ordinating was also expected to complete IT training on the ward whilst still being expected to care for patients and co-ordinate the shift. The average fill rate for registered nurses on A8 in January and February 2017 during the day was 88.1%.
- During our unannounced inspection, we visited ward A3. We saw that the planned registered nurse on the shift was four and the actual was three nurses. This meant that the nurse to patient ratio on this shift was one to 11. The average fill rate for registered nurses on A3 in January and February 2017 during the day was 87.8%.
- The average fill rate for registered nurses on A2 in January and February 2017 during the day was 80.4%. The fill rate on the coronary care unit (CCU) was 76.8%. This meant that nearly a quarter of shifts on CCU did not have the required number of nursing staff on duty. The CCU is a ward that frequently cares for patients with a higher level of nursing monitoring and intervention (level two care). Nursing staff on this ward were also expected to monitor telemetry remotely for patients undergoing continuous monitoring on AMU.
- We asked the trust how they monitored nurse staffing on AMU when the assessment area was being used as

an escalation area to care for up to nine additional patients. The trust did not provide us with this information and we were therefore unable to establish whether the shift fill rates provided included the additional staff required to safely care for these patients. Senior staff told us that the ward was usually staffed with six registered nurses to 39 beds, with one of these nurses coordinating the shift. the trust clarified that to co-ordinator is responsible for looking after and monitoring these patients.

- Wards were generally staffed adequately on night shifts. The overall fill rate for registered nurses at night on the medical wards was over 98% between September 2016 and February 2017.
- The trust reported an average vacancy rate for qualified nurses of 15.4% in medical services in December 2016. There had been high levels of bank and agency nursing staff to improve staffing levels on medical wards. Between April 2015 and March 2016, the trust reported an average bank and agency usage rate of 16.4% in medical services. Bank and agency usage was highest on ward A8 at 32.5%.
- Bank or agency nurses completed a local induction on their first shift on a ward. This was an electronic form that was completed and automatically submitted to the human resources department and included essential information such as location of emergency equipment, systems for documentation and processes to follow in the event of an emergency. Staff told us that they had regular bank and agency staff working on the wards.
- A recruitment and retention group had been set up by the Chief Nurse and there was an associated strategy in place with two matrons leading on nurse recruitment.
- The trust was piloting the new associate nurse training programme and some of these students were placed on medical wards. There were seven nurse associates in training in medical services. These students were undertaking a two year programme of study. The nursing associate role is a regulated role bridging the gap between a support worker and registered nurse and will support registered nurses in the delivery of care.
- Nursing handovers took place at each change of shift. We observed two handovers and saw that the verbal handover was thorough and covered patients' needs and plans for care and treatment. Healthcare support workers held a separate handover to share information specifically related to patients' care needs.
- In addition to the nursing handover, a ward safety brief was held highlighting any specific patient safety concerns such as risk of falls, safeguarding concerns or that Deprivation of Liberty Safeguards were in place along with specific feedback from incidents of complaints. These were formally recorded and key messages were distributed to staff working on the wards.

Medical staffing

- In October 2016, the percentage of consultant staff working at the trust was lower than the England average. In medical services, 27% of medical staff were consultants in comparison to the average of 37%. The proportion of junior doctors was 36% at Warrington compared to the average of 20%. This meant that the trust employed a higher number of junior doctors than other trusts.
- There was consultant presence on AMU and for acute admissions between 8am and 9.30pm Monday to Friday and 9am until 9.30pm on Saturday and Sunday. Access to a consultant was available on call outside of these hours.
- Consultant ward rounds on AMU were not consistent in how they were run. Some junior doctors told us they were not always at the patient bedside during consultant review and therefore did not necessarily have a full oversight of the patients care and treatment.
- Medical staffing overnight was provided by one registrar and three other junior doctors. The team were supported by the acute care team which was made up of critical care outreach nurses, assistant or nurse practitioners should a patient deteriorate.
- Medical cover for ward A4 (a discharge and assessment ward) was provided by a GP and supported by a junior doctor (F2). On the Forget Me Not ward, patients were reviewed by a consultant

three times per week. This ward is a specialist unit caring for patients with a diagnosis or suspected diagnosis of dementia or delirium who did not have a significant physical illness but who still required acute hospital care and therefore only required this level of consultant input.

- There were high vacancy rates for medical staff in some specialities. In December 2016, the trust reported an average vacancy rate of 21.1% in care of the elderly and 16.8% in specialist medicine.
- Between April 2015 and March 2016, bank and locum usage rate was 40.7% in medical care. The specialities with the highest usage were acute medicine and endocrinology (35.7%), specialist medicine (27.4%) and care of the elderly (11.8%). Senior staff told us that where possible, regular locum consultants who were familiar with trust systems and processes were used.
- During the winter pressure months, an additional locum consultant and junior doctor was provided to care for patients on the winter pressure ward.
- There was medical handover between doctors each morning and evening at the change of shifts. We observed a medical handover and saw that there was no formal handover document and that the handover was unstructured with no clear way of sharing information. It was unclear who was leading the handover. This meant there was a risk that important information in relation to safe care and treatment may not be communicated between doctors effectively.
- There was a trust wide recruitment action plan in place that had been developed jointly with Health Education North West and the General Medical Council. The acute care division was looking at ways to make medical positions at the trust more attractive to applicants. For example, a chief of service was in post and there were plans to recruit a chief registrar to provide better clinical leadership, roles were being redefined and rosters were being reorganised. The medical director had raised these concerns to the trust board at the February meeting and work was on going to address this shortfall.

Major incident awareness and training

- There was a trust wide business continuity and major incident policy in place. All new starters were expected to complete an emergency preparedness training session. Senior staff and on-call managers undertook additional training to prepare them as 'silver commanders' in the event of a major incident.
- There had been no major incident table top exercise in medical services since the establishment of the clinical business unit and senior staff said that it had been about four years since the last table top exercise.
- The trust developed a winter pressures plan each year to manage the anticipated increase in demand for hospital beds during this period.

Are medical care services effective?

Requires improvement

At our last inspection we rated effective as good. We have rated effective as requires improvement because:

- Staff did not follow the trust Mental Capacity and Deprivation of Liberty Safeguards Operational Procedure. Large numbers of patients were subject to Deprivation of Liberty Safeguards without an appropriate assessment of their capacity to consent. In other cases, best interests decisions were being made without an appropriate capacity assessment.
- Following assessments, patients identified as requiring a further assessment by a dietician were not always referred.
- Appraisal rates were below the trust target. Doctors in training could not always access the training opportunities they required.

However;

- Patient outcomes were good. The hospital demonstrated good performance on the heart failure audit, myocardial ischaemia national audit project (MINAP) and improving performance on the sentinel stroke national audit programme (SSNAP).
- Care and treatment was generally delivered in line with evidence based guidance and local pathways reflected national guidelines. The service audited compliance with NICE guidance and participated in all relevant national audits.

- The endoscopy unit had achieved Joint Advisory Group on Gstro Intestinal Endoscopy (JAG) accreditation. JAG accrediation indicates that the services provides endoscopy in line with the Global Rating Scale Standards and is a mark of best practice.
- There was access to a range of healthcare professionals to support the delivery of care. Staff told us that multidisciplinary working was good and there were good working relationships between disciplines and with the local authority.

Evidence-based care and treatment

- Care and treatment was delivered in line with national guidance from National Institute for Health and Care Excellence (NICE), the Royal College of Physicians (RCP) and Royal College of Nurses (RCN). There were local pathways in place to support decision making in line with best practice guidance although some doctors found it difficult to locate local pathways, for example for acute kidney injury, on the trust intranet.
- In endoscopy, procedures were carried out in line with professional guidance produced by NICE and the British Society of Gastroenterologists.
- Patients received an assessment of their risk of a venous thromboembolism (blood clot) on admission and were given treatment in line with NICE quality statement (QS) 66. Staff provided care in line with 'Recognition of and response to acute illness in adults in hospital' (NICE clinical guideline 50).
- Medical services participated in all relevant national audits they were eligible to complete. There were also trust wide, divisional and clinical business unit audit programmes that reviewed compliance with local guidelines and evidence-based care. Following audits, action plans were developed to address any areas of shortfall or where further improvements could be made.
- A recent audit of the care of patients with acute kidney injury stage three showed poor compliance with NICE guidance in relation to prescription of fluids. An action plan had been developed to improve medical staff education in the prescription of fluids. We asked the trust if the actions in this plan had been implemented and if there was a follow up audit planned to review compliance but the trust did not provide us with this information.

Pain relief

- Pain scores were recorded as part of the clinical observations rounds and patients were also asked about pain levels during comfort rounds. We saw that patients' pain levels were recorded on early warning score documentation in line with the core standards for pain management services in the UK (Faculty of Pain Medicine 2015).
- Patients told us they were offered pain relief and it was provided in a timely way.
- There was access to a range of medications for pain relief, including patient controlled analgesia and strong pain relieving drugs. When pain was poorly controlled or difficult to manage, patients were referred to the specialist pain team for advice and support.
- Patients were offered sedation and pain relief when undergoing endoscopy. A "comfort score" was used to assess pain following any procedure in endoscopy.

Nutrition and hydration

- A coloured tray system was in use to highlight patients who needed assistance with eating and drinking. Patients were offered assistance when needed.
- Water jugs and cups were available at patients' bedsides.
- An audit completed by the trust in January 2017 showed that 92% of patients had received a nutritional assessment using the Malnutrition Universal Screening Tool (MUST). Of these patients 97% had a personalised care plan in place however, only 40% of relevant patients had been referred to a dietician for assessment. We reviewed one record where the MUST score was high and in this case a referral had been made appropriately.
- Patients were provided with drinks and snacks following procedures in the endoscopy unit. There was access to food and drink in the discharge lounge.

- Patients told us that the quality of food was good and that meals were hot when they arrived. On the Forget Me Not ward, a range of finger foods were available as an alternative to a main meal. The availability of finger food for patients living with dementia who may wander on a ward is good practice.
- On the stroke unit, nursing staff had been trained to undertake swallowing assessments to ensure patients could safely eat and drink without needing to wait for an assessment by a speech and language therapist.

Patient outcomes

- The myocardial ischaemia national audit project (MINAP) is a national clinical audit of the management of heart attacks. The hospital took part in the 2013/14 MINAP audit and scored better than the England average for all of the three key indicators. MINAP audit results for 2013/14 showed the number of patients diagnosed with a non-ST segment elevation myocardial infarction (NSTEMI-a type of heart attack that does not benefit from immediate percutaneous coronary intervention) seen by a cardiologist prior to discharge was better than the national average at 97.8%. Sixty-four per cent of patients with an NSTEMI were admitted to a cardiology ward. This was better than the England average of 55.6%. The hospital scored better than the England average for the number of NSTEMI patients who had or were referred for angiography (91.3%).
- The hospital took part in the quarterly Sentinel Stroke National Audit programme. On a scale of A to E, where A is best, the trust achieved grade C overall in the most recent audit between April 2016 and June 2016. This was an improvement on the grade D achieved between January and March 2016. The hospital scored a grade E for speech and language therapy. We requested the trust action plan to review any planned or proposed action to further improve performance on this audit, however the action plan supplied related to the 2014 organisational audit and did not contain details of current actions.
- Warrington Hospital's results in the 2015 Heart Failure Audit were better than the England and Wales average for all of the four of the standards relating to in-hospital care. The results for the seven standards relating to discharge were also better than the England and Wales average.
- In the 2015 National Diabetes Inpatient Audit the hospital scored better than the England average in 14 metrics and worse than the England average in three metrics.
- The proportion of patients with NSCLC receiving surgery was 36.3%. This was significantly better than the national level and an improvement from the results of the audit carried out in 2014. The proportion of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy was 64%. This was similar to the national level.
- There was a lower (better) than expected risk of readmission for non-elective admissions at the hospital. However, there was a higher (worse) than expected risk for elective admissions. Of the top three specialties for elective admissions, respiratory medicine had a relative risk of readmission of more than double the expected level. This meant that patients electively admitted for respiratory care were more than twice as likely to be readmitted to hospital.
- At the time of our inspection, the trust had two active mortality outliers. There had been a higher than expected death rate for patients with regional enteritis and ulcerative colitis. The trust had investigated each death, including an external review of one case, and found these to have been unavoidable deaths but had identified and shared learning from these cases.
- The trust was also an outlier for in hospital mortality rates for urinary tract infections. At the time of our inspection, the trust was reviewing these mortality rates to gain a better understanding of the potential reason for this outlier. Following the insp3ection that trust have reported the finding along with an action plan to the CQC.
- The endoscopy unit had achieved Joint Advisory Group on Gastro Intestinal Endoscopy (JAG) accreditation. JAG accreditation indicates that the service provides endoscopy in line with the Global

Rating Scale Standards and is a mark of best practice. We saw that there were plans in place to meet the requirements of JAG (an additional interview room) within two months of our inspection.

- The service was able to demonstrate reduced levels of agitation and behavioural symptoms in patients admitted to the Forget Me Not unit. This demonstrated that the environment and management methods were beneficial to patients living with dementia.

Competent staff

- Between April 2016 and December 2016, on average 74% of staff within Medical Care at the trust had received an appraisal. This included 78% of nursing staff, 71% of medical staff and 100% of allied health professionals. Only 25% of additional professional and scientific staff had received an appraisal during this time period.
- Staff were able to access training internally and externally. Nursing staff had allocated mentors and allied health professionals had a named clinical supervisor.
- New staff were given a period of time where they worked supernumerary that was appropriate to their role. For example, in endoscopy staff worked for two weeks and on AMU staff worked for six weeks to give them time to familiarise themselves with the running of the department and systems in the hospital and address any immediate training needs.
- The trust had begun the implementation of the care certificate for non-qualified care assistants in January 2016. The care certificate is knowledge and competency based and sets out the learning outcomes and standards of behaviours that are expected of staff giving support to clinical roles such as healthcare assistants.
- There was a designated training lead in the endoscopy department with an established system of induction and training. This included access to allocated lists as a trainee, twice yearly appraisals and agreed competency sign off.
- There were systems in place to check the competencies of staff working in the cardiac catheterisation lab. Nursing staff in the urgent and emergency care CBU rotated through AMU, ambulatory care and A2 to develop competencies and gain experience in other areas.
- A practice educational facilitator had recently been appointed to work with AMU. As part of the development of this position, a clinical skills lab was planned to train staff on AMU in specific clinical skills to enable them to accept patients with more complex needs.
- The service was working with Health Education England to improve the education and supervision of doctors in training. There was a risk that the lack of post graduate education available within the service would lead to the removal of training posts at the trust. At the time of our inspection an action plan was in progress however we found that some junior doctors still felt they were unable to access sufficient educational opportunities. Some junior doctors told us they were not always able to attend teaching or outpatient clinic observation due to the demands of their workload. This was more common in some specialities than others. Others told us they were able to access teaching.
- The acute care division had recognised an unmet need in providing education supervision to doctors working within care of the elderly and had therefore outsourced this supervision to ensure this requirement was met.
- Therapy teams held regular in service training sessions and staff on the Forget Me Not ward had attended additional training in the principles of dementia care.
- Staff had been supported to develop extended skills in some areas. Advanced nurse practitioners had undertaken training to become nurse prescribers and there were nurse endoscopists working in endoscopy.

Multidisciplinary working

- There was access to a range of healthcare professionals to support the delivery of care. Referrals were made to physiotherapy, occupational therapy, speech and language therapy and dietetics if required.
- Staff told us that multidisciplinary working was good and there were good working relationships between disciplines and with the local authority. Daily board

rounds were held on most medical wards at the start of the working day to allow multi-disciplinary team (MDT) members to exchange information about patient care and treatment and discharge plans.

- We saw allied health professionals working with patients in the ward areas we visited and saw evidence of multi-disciplinary input in patient records. Occupational therapists and physiotherapists often worked closely with patients to deliver effective outcomes for patients.
- We observed a bed management meeting and saw that these were attended by a range of professionals to ensure all disciplines were represented and involved in discussions about patient flow at the hospital.
- There was access to a psychiatry liaison service for patients with mental health, drug or alcohol issues. The trust had recently employed a psychiatrist to support the delivery of psychiatric care to patients during their admission.

Seven-day services

- There was access to X-ray and CT scanning 24 hours a day, seven days a week. The magnetic resonance imaging scanner (MRI) operated Monday to Sunday 8am to 8pm.
- Consultant cover was provided seven days a week to review all new admissions and patients who required a consultant review.
- There was access to input from specialist medical teams at weekends and out of hours such as cardiology.
- Inpatient and day case endoscopy appointments were available Monday to Friday 8am until 6pm. Emergency endoscopy was available 24 hours a day to manage gastrointestinal bleeding.
- Occupational therapy (OT) and physiotherapy (PT) was provided Monday to Friday on the stroke unit. There was also a service on Saturdays and Sundays from 8.30am till 12.30pm to assess any new admissions to the unit. Speech and language therapy was provided six days a week.
- There was access to a rapid response team of OTs and PTs seven days a week between 8.30am and 8pm for patients on AMU and A2. This team could make arrangements for a rapid discharge from these areas including reinstating care packages.

Access to information

- The endoscopy department had a full set of policies based on NICE guidance that was easily accessible on the trust intranet.
- Reports were produced in real time in the cardiac catheterisation lab and sent to the patients GP on the day of the procedure.
- Letters were sent to GPs on discharge to inform them of the reasons for admission and care and treatment provided during the patients' hospital stay. Referrals were also made to other community health staff such as district nurses and AHPs to ensure continuation of the patient's care.
- Staff had access to the information they needed to deliver effective care and treatment to patients in a timely manner including test results, risk assessments, and medical and nursing records.
- There were computers available on the wards we visited, which staff accessed for patient and trust information. Policies, protocols and procedures were kept on the trust's intranet, which meant staff had access to them when required.
- On the majority of wards there were files containing minutes of meetings, ward protocols and audits, which were available to staff.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust reported that between January 2014 and December 2016 Mental Capacity Act (MCA) training had been completed by 77% of staff within Medical Care. This was below the trust target of 85%.
- There was a trust wide Mental Capacity and Deprivation of Liberty Safeguard Operational Procedure in place which set out the legal requirements of the Mental Capacity Act (2005) and contained information and procedures for staff to follow when there was reason to doubt a patient's capacity to consent.

Medical care (including older people's care)

- We found that there was a widespread failure to act in accordance with this procedure and the Mental Capacity Act (2005) in each of the areas we visited during our announced inspection. We found that staff had not completed capacity assessments based on the two stage test as set out in the Mental Capacity Act Code of Practice. On the Forget Me Not ward, we found that 15 patients had Deprivation of Liberty Safeguards (DoLS) in place but only two of these patients had a formal documented capacity assessment completed. On the stroke unit, there were six patients with DoLS in place and none of these had a capacity assessment. This meant that patients were at risk of being unlawfully deprived of their liberty. The trust MCA and DoLS policy had not been followed in a further three records we reviewed. We also saw that best interests meetings had been held to agree the place of discharge for two patients and that there was no record of an assessment to determine the patients' capacity to make this decision for themselves before these meetings had taken place. We raised these issues with the trust safeguarding lead during the announced inspection. When we returned on our unannounced inspection, we saw that capacity assessments had been completed correctly for each of the patients who had DoLS in place on the Forget Me Not ward. The ward manager also told us that staff were attending additional training from the local clinical commissioning group and there were plans to arrange further training specifically aimed at band 5 nurses.
- Staff on the Forget Me Not ward had a good level of understanding about what constitutes a deprivation of liberty and when to apply for a DoLS; however we saw that on other wards staff did not always have this level of understanding.
- Staff on the Forget Me Not ward had a good understanding of the role of Lasting Power of Attorney. The ward manager told us they always requested copies of the LPA to ensure the LPA was for health and welfare decisions.
- The service had identified a need to review the prescription of sedation to cognitively impaired or confused patients who had fallen following a safeguarding review. The dementia lead nurse had undertaken a review of incidents in February 2017 to identify if sedation had been used as a form of restraint. The audit had found that sedation had been prescribed appropriately where it had been used and had not been used as a form of restraint. The audit did however contain recommendations about the use of DoLS and documentation surrounding the MCA (2005). This review is an example of good practice.
- Consent was taken from patients attending endoscopy on the day of the procedure. Patients told us they were given sufficient information about the procedure and time to ask questions. When we reviewed consent records during our inspection we saw that one patient had not signed the consent form although the procedure had been undertaken. We discussed this with the patient and staff at the time of the inspection and found that the consent process had been completed but the patient had not been asked to sign the consent form. This was immediately addressed by staff in endoscopy. We reviewed consent forms for two patients on the cardiac catheterisation lab and saw that these had been completed correctly.

Are medical care services caring?

Good

At our last inspection in January 2015 we rated caring as Good. We have maintained this rating because:

- Staff were kind, caring and compassionate. Staff respected and maintained patients' privacy and dignity. Friends and family test response rates were high and results were generally positive. The coronary care unit and day case catheterisation laboratory both had average recommendation scores of 99% and above.
- Staff gave explained care and treatment in a way that patients could understand and provided opportunities for them to ask questions. Relatives were involved in decisions about care and treatment.
- On the Forget Me Not unit, relatives were encouraged to visit for extended periods of time and were made to feel welcome by staff and volunteers.
- A range of specialist nurses were available in medical services. These nurses provided additional

information and emotional support. Staff made referrals for additional emotional support and sign posted patients or their relatives to other sources of support such as charitable organisations.

Compassionate care

- Patients told us staff were kind and caring and they introduced themselves when they first met. Staff called patients by their names. We saw that staff took all possible steps to maintain patients' privacy and dignity and patients confirmed this.
- We saw staff communicating with patients and their family members in a respectful, compassionate and considerate way.
- Staff respected patients' preferences and choices. On the Forget Me Not ward, staff treated each patient as an individual. They spent time with patients and their relatives to find out about their individual needs, likes and preferences and tailored activities around the patient.
- In endoscopy, staff had identified that patient's privacy and dignity may not always be maintained if other clinical staff entered the procedure room during a procedure. They took action to ensure this did not happen.
- The Friends and Family Test response rate for medical care at the hospital was 32% which was better than the England average of 25% between December 2015 and November 2016. Recommendation scores were generally over 80% during this time period although for Ward A3 the recommendation rate was 69% in August 2016 and B18 scored only 50% in October 2016. The Coronary Care Unit and Day case Catheter Lab both had average recommendation scores of 99% and above.
- All patients we spoke with told us they would recommend the hospital to their family and friends.
- The endoscopy unit used a departmental patient survey to gain feedback about patient experience. On the most recent review of the survey, all patients had reported they had been given enough privacy and dignity before, during and after their procedure.

Understanding and involvement of patients and those close to them

- Patients told us they were given enough information about their care and treatment. They were given opportunities to ask additional questions of nursing staff and consultants.
- Patients felt their relatives had been involved in planning their care, treatment and discharge. Relatives had been kept up to date with plans for discharge.
- On the Forget Me Not unit, relatives told us they had been given information about their loved one and had been given opportunities to input into their care when relevant. Relatives were encouraged to visit for extended periods of time and were made to feel welcome by staff and volunteers.
- One family whose relative was living with dementia told us they had received conflicting information from different members of staff about the plans for their relatives care, and that they did not always receive enough information from medical staff.

Emotional support

- There were a number of nurse specialists working within medical services who could provide patients with additional information and emotional support in relation to their health conditions. This included specialist stroke nurses, respiratory, diabetes and cardiology nurses.
- On the 2015 Cancer Experience survey, the trust scored 84% which was below the national average of 90% for the percentage of patients who were given the name of the specialist nurse who would support them during their treatment. However, the trust scored above the national average for the percentage of patients who found it easy to contact their specialist nurse. The trust also scored 74% for the percentage of patients who were given information about local support groups which was below the national average of 83%.
- Staff we spoke with understood the emotional impact that care and treatment had on patients and their family members. We observed staff providing reassurance and comfort to patients.
- On the stroke ward, staff completed assessments for anxiety and depression. The stroke team worked closely with the Stroke Association and referred

patients or their relatives to them for emotional support and advice. They had also worked together to support a patient through applying to a television programme for help with home alterations.

Are medical care services responsive?

Requires improvement

At our last inspection we rated responsive as requires improvement. We have maintained the rating at this inspection because:

- The service continued to experience challenges in relation to patient flow. The number of patients experiencing a delayed transfer of care had increased when comparing data from 2015 to 2016. This was despite a reduction in the overall number of patient admissions to medical services.
- At our last inspection we told the trust it must reduce the number of patient bed moves. When we compared data from 2015 to 2016 we saw that more patients experienced bed moves. This meant that the trust had not reduced the number of patient bed moves and that this issue had increased rather than decreased. Many of the ward moves happened overnight.
- Bed occupancy rates were high across all medical wards. Between November 2016 and February 2017, six wards had over 99% occupancy. When bed occupancy rates are high, the quality of care provided and orderly running of the hospital can be affected.
- There was limited personalisation of care plans in the records we reviewed. Plans were largely pre-determined. An audit of patient records in January 2017 showed that only 26% of patients had a personalised dementia care plan in place.
- Complaints were not always responded to in a timely way. In January 2017, there were 96 complaints open and the average length of time these complaints had been open was 175 days.
- The average length of stay for elective and non-elective admissions was two days longer than the national average. The risk of readmission for elective patients was worse than the expected level and for one speciality the risk of readmission was double that expected.

However:

- The trusts' referral to treatment time (RTT) for admitted pathways for medical services was better than the England overall performance. The latest figures for January 2017 showed 90.9% of this group of patients were treated within 18 weeks.
- Medical patients outlying on other wards were cared for by a named medical consultant. We reviewed the notes of three medical outliers on surgical wards and saw that they had been reviewed each day by a medical consultant.
- The environment on the Forget Me Not ward had been designed to be dementia friendly. An activity co-ordinator worked alongside volunteers to provide activities and we saw patients being encouraged to engage in social interaction and meaningful occupation. Senior staff were proactive in their approach to managing difficult or challenging behaviour in this patient group, continuously looking for ways to improve how patients living with dementia were cared for.

Service planning and delivery to meet the needs of local people

- Medical services had been planned and developed with a number of local partners and networks to meet the needs of local people and also with consideration to the sustainability of services. For example, stroke services in the area had recently been reorganised via the stroke quality improvement group involving clinical commissioning groups (CCGs), other local trusts and the local stroke network. This meant that the hospital no longer offered a thrombolysis service to this patient group but continued to provide care to patients not eligible for thrombolysis or those needing rehabilitation.
- The service was also working with CCGs, local mental health and community trusts to develop to develop pathways and improve patient access to care in the most appropriate place at the right time.

- Outpatients could directly access A7 to undergo a pleural tap to reduce breathlessness. This meant that patients did not have to attend A and E.

Access and flow

- Patients were admitted to medical services via A and E, through GP referral to AMU or by pre-arranged appointments for elective admissions and day case endoscopy.
- There was a patient flow team which included bed managers and discharge facilitators. This team worked to improve patient flow in and out of the hospital. Bed management meetings were held five times a day to discuss the current bed state and predicted bed requirements. Meetings were attended by matrons and senior nurses, allied health professionals, pharmacy, accident and emergency staff and infection prevention and control staff. We observed a bed management meeting and saw that information about bed status, patients awaiting admission from A and E, delayed transfers of care and forthcoming discharges was shared effectively.
- There was a trust wide escalation policy to which set out steps to be taken to manage bed capacity and patient flow within the hospital. This also included a full capacity protocol which set out actions to take when bed capacity did not meet demand.
- The average bed occupancy rate across all medical wards was 98.2% between November 2016 and February 2017. Six wards had over 99% occupancy during this time period. It is generally accepted that when occupancy rates rise above 85%, it can start to affect the quality of care provided to patients and the orderly running of the hospital. The CCU had the lowest occupancy rate at 91.9%.
- At our last inspection we told the trust it must reduce the number of patient bed moves. Between January 2016 and December 2016, 64% of patients were moved once or more. This was an increase of 14% when we compared figures from 2015 to 2016. The number of patient moved two or more times had increased by 10% when compared with data from 2015. This meant that the trust had not reduced the number of patient bed moves and that this issue had increased rather than decreased.
- In the six month period between July 2016 and December 2017, 1,866 patients were moved wards after 10pm. The majority of these moves were from ward A2. Senior staff told us that there had been difficulties discharging patients earlier in the day due to changes in the provision of patient transport services and this had led to more overnight bed moves for patients. The service was looking at alternatives to this provision and used a private patient transport service to supplement the provision of transport home.
- At our last inspection we told the trust it must improve patient flow in medical services at the hospital to ensure patients are cared for on wards appropriate for their needs. The trust had reduced the numbers of patients being cared for in non-speciality beds which may not be best suited to meet their needs (also known as outliers). The Cognitive Assessment Team (CAT) now identify suitable patients from assessment areas for the Forget me Unit. This enables patients to be transferred directly from assessment areas to the unit reducing a further patient move into the core bed base.
- The hospital aimed to have no more than 10 patients per day outlying on other wards. However, between September 2016 and December 2016, there were 40 days when the hospital exceeded this number of outliers. The number of outliers had been particularly high during December 2016 with up to 38 being cared for on wards that did not best suit their medical needs. The trust told us this was due to an increase in demand for non-elective medical beds during the winter period. Where possible, patients were cohorted with other medical patients on a surgical ward.
- Medical patients outlying on other wards were cared for by a named medical consultant. We reviewed the notes of three medical outliers on surgical wards and saw that they had been reviewed each day by a medical consultant.
- On AMU, there was an assessment area that was frequently used as an escalation area with up to nine beds when there were issues with access and flow. Senior staff told us this area had been in use almost daily since December 2015 beds.

Medical care (including older people's care)

- The trust had opened a discharge lounge the week before our inspection which was staffed by nurses from the patient flow team. This area cared for patients who were ready for discharge that day but were awaiting transport or medication to take home. The trust was collecting data about the use of the discharge lounge to assess the effectiveness of this facility and impact on patient flow.
- An estimated date of discharge was set for each patient on admission. The number of patients experiencing a delayed transfer of care (i.e. a delay to their discharge) impacted on the flow of patients through medical services at the hospital.
- On average there were 28 patients experiencing a delayed transfer of care between December 2016 and February 2017. A delayed transfer of care is when a patient no longer requires an acute hospital bed but is still occupying the bed. The overall number of delayed transfers of care at the hospital in 2016 was 6,656, an increase of 965 from the previous year. The main reasons for delayed transfer during this period was patient or family choice or that patients were awaiting an assessment of their needs. The trust have provided additional information following the inspection. there is a length of stay meeting held each week with all ward manager, discharge facilitators, therapy staff and partners in social care to review and plan for stranded patients. This has enabled the safe discharge of some patients with the greatest length of stay. The trust has also started to roll out the red to green days model across the trust.
- The hospital collected data to monitor how many patients were unable to access the Forget Me Not ward that had been assessed and placed on the waiting list. Between April 2016 and February 2017, 67 patients had been discharged home without receiving their care on this ward.
- The coronary care unit provided level two care and was a mixed sex ward. Patients were grouped on the ward by gender where possible to maintain privacy and dignity as far as possible. A mixed sex breach would occur on this ward when a patient no longer required level two care but was still being cared for on the ward with patients of the opposite sex. Any mixed sex breech was reported as an incident. There had been a total of 15 mixed sex breaches on CCU that were not clinically justified between August 2016 and November 2017. The most common reason for this breach was a lack of availability of a bed on an alternative ward. Trusts can be fined when a mixed sex breach occurs.
- Between December 2015 and November 2016 the trusts' referral to treatment time (RTT) for admitted pathways for medical services had been better than the England overall performance. The latest figures for January 2017 showed 90.9% of this group of patients were treated within 18 weeks versus the England average of 89.1%. With the exception of August 2016, the trust has been performing better than or the same as the England average.
- Between December 2015 and November 2016, the average length of stay for medical elective patients at the hospital was 4.6 days, which was higher than the England average of 4.1 days. Of the top three specialties for elective patients, respiratory medicine had the highest average length of stay with 6.8 days compared to the England average of 3.6 days.
- For medical non-elective patients, the average length of stay was 8.9 days, which was higher than the England average of 6.7 days. For non-elective patients geriatric medicine had the longest average stay with 13.9 days compared to the England average of 9.7 days.
- There were low waiting times for diagnostic endoscopy. The average wait for an endoscopy was around two weeks between November 2016 and January 2017 with no patients waiting over five weeks during this time period.
- Patients attending for a day case endoscopy were given information about what to expect following their procedure, when to seek medical advice and who to contact during and out of hours.
- On discharge from a ward, patients were provided with a discharge card that contained details of who to contact in an emergency and contact details for the discharging ward.

Meeting people's individual needs

- Patients with suspected dementia or cognitive impairment were referred to the cognitive assessment team. This was a team of nurses specifically trained to

assess patients with cognitive impairment and provide advice and support to wards. This team also assessed patients against clear admission criteria to determine if admission to the Forget Me Not ward, a specialist dementia ward, was appropriate. Wards had vulnerable adult link nurses who acted as a source of information for staff on the ward and attended regular update meetings.

- The electronic patient record system could be used to flag patients living with dementia or those with a cognitive impairment. There was no way of flagging patients with a learning disability.
- The environment on the Forget Me Not ward had been designed using the recommendations set out by The Kings Fund to be dementia friendly. The ward was designed to appear less like a hospital ward and featured colour coded bay areas and a lounge and dining area designed to look like a home environment. There was access to an enclosed garden and a quiet room.
- Most ward areas we visited had dementia friendly signs in place. There was a challenging behaviour care plan available to use where patients may display behaviour that was difficult to manage along with guidance to staff to identify non-pharmacological ways of managing these behaviours. The service encouraged staff to use an ABC chart (antecedent, behaviour, consequence) to identify triggers and ways to minimise these.
- On the Forget Me Not ward, an activity co-ordinator worked alongside volunteers to provide activities and engage patients in in social interaction and meaningful occupation. We saw patients being encouraged to join in with games such as cards and dominoes, and a singing group in the lounge area that was attended by five or six patients.
- The ward had also begun a three month trial where staff would wear 'pyjamas' to provide visual cues of night time as a method of reducing behavioural or psychological disturbance overnight.
- The hospital supported John's Campaign which champions the rights of carers to stay with people living with dementia whilst they are being cared for outside of their usual environment.
- There was no named lead for learning disabilities within medical services. Senior staff recognised this was a gap in within the service. This meant that staff may have difficulty accessing advice, support and training to enable them to meet the needs of patients with a learning disability and may mean that the needs of this patient group were not considered when planning and developing services.
- We saw communication aids for use with patients who experienced difficulties communicating.
- Where patients were living with dementia, the service used a "This is me" document. "This is me" is an information document developed to support people receiving care who have any form of cognitive impairment or difficulty communicating their needs and is a way of supporting person centre care. The service also used "passports" outlining preferences and how best to care for patients with a learning disability.
- There was limited personalisation of care plans in the records we reviewed. Plans were largely pre-determined. An audit of patient records in January 2017 showed that only 26% of patients had a personalised dementia care plan in place.
- There was access to face to face, telephone or written translation services 24 hours a day. Staff also had access to a local deaf persons' organisation that provided sign language interpretation when required.
- The endoscopy department had introduced the use of Entonox as an alternative to traditional anaesthetic drugs. This had increased patient satisfaction with the service as they no longer needed a relative or friend to stay with them overnight following the procedure.
- Equality and diversity training had been completed by 93% of nursing staff and 65% of medical staff. The trust target was set at 85%.
- There was a multi-faith prayer room and chapel at the hospital and access to chaplaincy services 24 hours a day.

Learning from complaints and concerns

Medical care (including older people's care)

- Most patients we spoke with knew how to raise a concern or make a complaint. Information about how to make a complaint was displayed at ward entrances or on corridors.
- In endoscopy, we saw the department also displayed information about changes they had made as a result of complaints or concerns, for example displaying information about any delays to appointment times and which staff were on duty.
- The trust had recently reviewed the way complaints were handled and agreed a new complaints and concerns policy, including a reduced time scale of 30 days for responding to complaints and allocating complainants an agreed point of contact in the patient experience team.
- Between January 2016 and December 2016 there were 176 complaints about medical services. The trust took an average of 145 days to investigate and close complaints. This was in line with their last complaints policy, which states complaints should be closed within six months.
- In January 2017, there were 96 complaints which were still open. The average length of time these complaints had been open was 175 days which was longer than the previous target.

Are medical care services well-led?

Requires improvement

We rated well-led as requires improvement because:

- The clinical governance structure within the acute care division was not sufficiently embedded into practice. We saw no evidence that governance meetings were held in most of the clinical business units and no evidence that information from the trust wide governance meeting was shared with clinical business units via the divisional meeting.
- We saw no evidence that risk, risk management and quality measurement was discussed within most clinical business units. Risks on the risk register did not have complete details of actions taken to mitigate risks or documented evidence of the outcome of progress reviews.
- There had been insufficient oversight of compliance with the Mental Capacity Act (2005). Monitoring of compliance with trust policy had been insufficient to identify widespread failure to act in accordance with the law.
- Divisional objectives did not clearly set out targets to be achieved to allow the service to identify if they had succeeded in meeting these objectives.

However:

- There was a positive and open culture. Staff described communication as good and leaders were approachable and visible. The appointment of a new chief nurse was seen as a positive development.
- The service was working in innovative ways to improve the sustainability and quality of the services it provided, including developing new roles and networks of care.

Leadership of service

- The majority of medical care was managed within the acute care division via four separate clinical business units. Some medical care such as rheumatology, endoscopy and gastroenterology was managed by business units within the Surgery and Women's and Children's Health division. This change in management structure had come into effect in April 2016. Services had been allocated to CBU based on a patient pathway rather than the traditional hospital model of medicine and surgery. Each CBU was led by a nurse, doctor and operations manager.
- The acute care division was led by a chief of service supported by an associate director of nursing and an associate director of operations.
- A consultants meeting was held in each CBU. Some medical staff who were managed within the Surgery and Women's and Children's Health division had requested that they still had the opportunity to attend a meeting of the medical specialty. An additional meeting was set up and supported by the Chief of Service to address this need.

- Leaders in each CBU were being supported to develop their leadership skills through internal and external courses. Staff told us that leaders at this level and at divisional level were strong, supportive and approachable.
- Nursing staff told us the appointment of the new chief nurse had been a positive influence on the nursing representation at board level and there had been noticeable changes in this aspect of the service.
- Staff felt there was good communication within the service. Senior staff "walked the wards" and were visible.
- Senior staff told us that the executive team was approachable and they felt confident in raising issues with the team if required.
- Senior staff told us that some consultants had been resistant to holding daily board rounds on wards to discuss patient care and discharge plans. This had been introduced as part of the safer patients' initiative. When we asked divisional leads what action had been taken to ensure consultants carried out a board round, they told us that consultants on ward A8 had committed to a board round that day.
- Matrons and ward managers held a weekly meeting. A monthly staff meeting was held in endoscopy, on B12 and the Forget Me Not ward. Minutes were used as a record of meetings and these were circulated to relevant staff. We reviewed the minutes of the endoscopy unit and saw that these meetings followed a set agenda and were well attended.
- Senior staff in the urgent and emergency care CBU had plans to change the GP assessment area on AMU into a clinical skills lab and patient dining area. There had previously been plans to develop this area into an ambulatory care unit but this had been unsuccessful due to the reliance on the unit as an escalation area. At the time of our inspection, there were no credible alternatives to free up this space on a permanent basis.

Vision and strategy for this service

- The trust mission was to provide high quality, safe and integrated healthcare. There were an established set of values at the trust that were to work as one, excellence, accountable, role models and embrace change. Pin badge awards were issued to staff who displayed these values consistently.
- Although not all staff were fully aware of the trust mission and values, most were aware that providing good quality care was central to this.
- There were divisional objectives focussed around the trust's key focuses of quality, people and sustainability. We noted that although there were objectives and associated actions in place, there were not always specific measureable outcomes attached to these objectives. For example, one of the measures of success was listed as a reduction in delayed transfers of care and there were no targets defined for the reduction in nursing or medical vacancies.

Governance, risk management and quality measurement

- There was a defined clinical governance structure within the service and a system of feeding key information up and down within the trust. Each clinical business unit (CBU) had an allocated governance lead with a dedicated governance manager within the divisions. However, this was a new structure with a recently introduced "quality bilateral" where key governance information from each CBU could be discussed.
- There was a monthly clinical governance meeting held within the division with a standard agenda although we noted that this meeting was described as "informal" in the information provided by the trust. We reviewed the minutes of the most recent meetings and saw that incidents, NICE guidance and clinical audit were discussed at these meetings. Senior staff told us that information was shared at this meeting from the trust wide governance meeting and cascaded back to staff through CBU meetings and team meetings however when we reviewed the minutes the trust provided we did not see evidence that this had happened.
- Senior staff told us there were monthly CBU governance meetings. We requested the minutes of these meetings but the trust only supplied the minutes of meetings from the airways, breathing and circulation CBU. We noted that at the most recent

divisional meeting in February 2017, the chief of service and associate director of operations had discussed the need to ensure these meetings were held within the CBUs with adequate attendance and were quorate, suggesting that meetings had not been held.

- There was a medical cabinet of senior doctors who met every three months that was chaired by the medical director and attended by around 25 senior doctors. We asked the trust to provide us with the terms of reference for this group to determine what the function of the cabinet was but they did not provide this information during the inspection. However following on from inspection, the trust provided the terms of reference for the medical cabinet, and confirmed that these were available at the time of the inspection. The trust confirmed that the medical cabinet meet every 2 weeks. The cabinet is a trust wide group, not just a medical care group.
- A divisional dashboard was in use to monitor quality, patient experience and performance along with information about staff vacancies and sickness and finance. Key metrics were displayed on this dashboard and rated as green, amber or red depending on compliance against each metric.
- There was a divisional and departmental risk register in place. Risks were managed using a process set out in a trust wide risk management policy. Risks were given a risk rating based on the likelihood of an event happening and the severity or impact this event would have. Risks scoring 12 or above on this rating were escalated to the divisional register.
- We reviewed the register and saw that key risks within the service had been identified. However, we noted that risk mitigation actions were limited and there were no progress reviews on any of the five action plans we reviewed. For example, a patient safety risk due to the number of nursing vacancies had been included as a high risk on the register. The associated action plan did not contain sufficient information about what actions were being taken to reduce this risk and did not reflect the full range of actions senior staff and managers told us were taken. Although the risk had been reviewed in January 2017, there was no documented outcome of this review.
- We saw that risks and the risk register were discussed at the airways, breathing and circulation CBU meetings including any new risks added or changes in risk ratings during the previous month. These meetings also included discussion of key safety issues, learning from incidents and complaints and compliance or actions plans from clinical audit. We did not see any evidence from other CBUs.
- Senior staff recognised that one of the biggest risks in the urgent and emergency care division was the use of the GP assessment unit for inpatient beds as part of the escalation plan.
- There had been insufficient oversight of compliance with the trust Mental Capacity Act and DoLS policy. The policy set out the responsibility of the adult safeguarding team and trust MCA lead to monitor this policy. We found that these responsibilities had not been completed in full. For example, the policy stated that the adult safeguarding lead or patient safety manager should monitor mental capacity assessments and applications for deprivation of liberty safeguards and this should be undertaken twice yearly as part of safeguarding assurances. This had not been completed effectively to allow identification of a widespread failure to follow trust policy.

Culture within the service

- There was a positive and patient focussed culture within the service. Staff told us they would feel confident to raise concerns and that there would be a no blame approach if something went wrong.
- Leaders in the urgent and emergency care CBU were keen to foster a culture of positive learning. They described "amazing and awesome" as one of the ways they were developing this culture, where success was celebrated rather than only focusing on learning from negative events.
- The trust reported an average turnover rate of 9.6% for nursing staff. The turnover rate for medical staff was 42.5% during the last financial year.
- The trust reported an average sickness rate for nursing staff of 4.1%. This was lower for medical staff at 1.3%. Both these figures were below the trust target of 4.2%.

Public engagement

- Wards displayed "how are we doing?" boards that contained information about staffing levels, patient experience and general information about the ward.
- The endoscopy unit displayed information about how patient feedback had been used to improve the service. For example, patients had feedback that they had waited longer than expected to undergo their procedure and in response to this, the team had reviewed how appointment times were offered.
- Patients were encouraged to complete the NHS friends and family test survey. The endoscopy unit also carried out a departmental satisfaction survey to gain additional patient feedback.
- The Forget Me Not ward gained additional feedback from relatives or carers during a patients' admission. In addition to this there was a steering group that was attended by a patient representative in order to gain feedback about performance or future developments to the service.

Staff engagement

- The acute care division had a social media account that could only be accessed by authorised staff. The division shared information such as learning from incidents or complaints, key feedback from meetings or messages of thanks and congratulations with staff through this account. Senior staff were able to monitor how frequently the page was accessed and by how many staff and told us this had been a successful way of engaging with staff.
- The trust used pin badge awards to recognise individuals who consistently displayed the trust's' values. Long service was recognised through the trust's "Thank you" awards.

Innovation, improvement and sustainability

- The acute care division was actively managing the number of registered nurse vacancies using a recruitment and retention strategy, alongside reviewing the roles of nurses on medical wards. Some of the changes they had implemented included increasing phlebotomy cover, ward clerk hours and band two healthcare workers to release time for the nurses to carry out registered nursing duties.
- The division was working with other local NHS trusts and partners to develop a frailty network which was due to be established in May 2016. A frailty project manager was in place and the division was in the process of recruiting a nurse consultant for frailty.
- The Forget Me Not unit had been nominated for a compassionate patient care award by the Health Service Journal in 2016 for the work the service had undertaken in improving acute hospital care for patients living with dementia.
- The physician associate role was in use within the urgent and emergency care CBU. The physician associate is an innovative new role that is used to support the medical team in patient diagnosis and management.
- The stroke team had developed the Warrington stroke scale. This is a scale used to categorise patients and care for them on an appropriate pathway following a stroke. The team were working with a local university to validate the scale.

Surgery

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

Information about the service

We visited Warrington general hospital as part of our announced inspection between 7-10 March 2017. We also carried out an unannounced visit on the 23 March 2017.

Warrington hospital carries out a range of surgical services including: urology, ophthalmology, trauma and orthopaedics and general surgery (such as colorectal surgery). Hospital episode statistics showed that between October 2015 to September 2016, 29,590 patients were admitted for surgery at the trust across Warrington and Halton sites. The data showed that 18,069 (61%) of patients had day case procedures, 4240 (14.3%) had elective surgery and 7281 (24.6%) were emergency surgical patients. The number of patients admitted for surgery had increased by 8726 from the 2013/14 statistics.

As part of the inspection, we inspected the main theatres, ophthalmic day case unit, the surgical assessment unit (SAU), ward A5 (the urology and general surgical ward), ward A6 (the general surgical ward), and ward A9 (the trauma and orthopaedics ward).

We spoke with 10 patients. We observed care and treatment and looked at care records. We also spoke with a range of staff at different grades including nurses, doctors, consultants, ward managers, theatre co-ordinators the theatre managers, matrons, the associate director of operations and the chief of service. We received comments from our listening event and from people who contacted us to tell us about their experiences, and we reviewed performance information about the trust.

Summary of findings

At the previous inspection in January 2015, we rated this service as good. Following this inspection we have maintained the overall rating because:

- We found there was a good culture of incident reporting in order to learn and share good practice.
- Serious incidents were investigated fully to establish the root cause, and lessons learnt were shared with staff to avoid reoccurrence.
- All clinical areas and bed spaces on the surgical wards we visited appeared visibly clean and cleaning schedules were maintained.
- Staff could identify and respond appropriately to changing risks to patients, including deteriorating health and wellbeing or medical emergencies.
- Mandatory training compliance for nursing staff across the division had improved following the last inspection.
- We saw that the service took part in a range of local and national audits and results were discussed at clinical audit meetings and actions for further improvements identified.
- All patients and relatives we spoke with told us that that all members of staff treated them with dignity and respect.

Surgery

- We observed many positive interactions between staff and patients during our inspection. We saw that staff were professional and friendly and created a relaxed friendly environment.
- Patients we spoke with were very positive about the way staff treated them.
- Patients and those close to them told us that they were involved in planning and making decisions about their care and treatment.
- Bed meetings took place four times a day to ensure flow was maximised across the hospital.
- The trust monitored the number of cancelled operations on the day of surgery. Performance data showed that the number of cancelled operations on the day of surgery had improved from 11.9% in February 2016 to 8.8% in January 2017.
- Between October 2015 and November 2016, the average length of stay for surgical elective patients was better at the trust at 2.7 days, compared to 3.3 days for the England average.
- There were a number of specialist nurses within the trust to help support the care and treatment of patients.
- The trust's referral to treatment time (RTT) for the percentage of patients seen within 18 weeks was 76.9%, which was better than the England average of 71.5%.
- There was 24-hour medical cover on site to attend to patients who had deteriorating needs.
- Senior managers were clear on their strategy to provide high quality services for patients, which included working collaborative within the organisation, and in partnership with other trusts to deliver high quality services.
- We saw that Local Invasive Standards for Invasive Procedures (LocSSIP's) had been developed in partnership with the North West theatre network. The standards were in place to ensure high quality, safe care and treatment for all patients.

However:

- We found not all theatre equipment was clean. However, we saw on the unannounced inspection that all theatre equipment appeared clean and new cleaning schedules introduced with oversight provided by managers.
- We found some omissions in the completion of daily checks such as resuscitation equipment and anaesthetic machines. However, we saw on the unannounced inspection that new anaesthetic logbooks were in use, and daily checks recorded and, resuscitation equipment had been checked.
- We found in theatres that not all stock ready for use was within its expiry date. For example, on the emergency airways trolley the suction catheter and flexible tracheal tube introducer commonly known as a bougie had past its expiry date.
- Vacancy rates for nurse staffing was variable across the wards. All staff we spoke with reported this as a concern and often meant they needed to move wards to provide safe staffing levels.
- In recovery, we saw that national guidance was not being adhered to ensure there were enough suitably qualified recovery nurses on shift with advanced life support training.
- Although ward staff had knowledge of capacity assessments and best interests meetings, we saw no evidence in three applicable records that this had been applied for those patients who were unable to consent to care and treatment.
- Theatre lists did not always run on time due to there not always being available beds for patients post operatively.
- Data provided by the trust showed that between September 2016 to December 2016 there were 1180 bed days lost to medical outliers on surgical wards. This number of medical outliers impacted on the number of available beds for surgical patients on the surgical wards.
- Although there were formal audits completed that included infection control, we saw no evidence that managers had a formal system or process of oversight, that ensured the cleanliness of equipment,

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and system checks were maintained. However, during the unannounced inspection we saw that the service managers had reacted quickly to our concerns, and new systems and processes implemented with management oversight to ensure compliance with standards and policy.

Are surgery services safe?

Good

At the previous inspection in January 2015, we rated caring as good. Following this inspection we have maintained the overall rating because:

- We found there was a good culture of incident reporting in order to learn and share good practice.
- Serious incidents were investigated fully to establish the root cause and lessons learnt were shared with staff to avoid reoccurrence.
- All clinical areas and bed spaces on the surgical wards we visited appeared visibly clean and cleaning schedules were maintained.
- We observed that all medicines were appropriately stored in suitable locked cabinets, and a member of qualified nursing staff held the keys.
- Staff could identify and respond appropriately to changing risks to patients, including deteriorating health and wellbeing or medical emergencies.
- Mandatory training compliance for nursing staff across the division had improved following the last inspection.

However:

- We found not all theatre equipment was clean. However, we saw on the unannounced inspection that all theatre equipment appeared clean and new cleaning schedules introduced with oversight provided by managers.
- In recovery, we saw that national guidance was not being adhered to ensure there were enough suitably qualified recovery nurses on shift with advanced life support training.
- We found some omissions in the completion of daily checks such as resuscitation equipment, anaesthetic machines and controlled drugs. However, we saw on the unannounced inspection that new anaesthetic logbooks were in use and daily checks recorded.
- We found in theatres that not all stock ready for use was within its expiry date.

- Vacancy rates for nurse staffing was variable across the wards. All staff we spoke with reported this as a concern and often meant they needed to move wards to provide safe staffing levels.
- Mandatory training and safeguarding training compliance for medical staff did not meet the trust target.

Incidents

- The hospital had an up to date trust incident reporting policy for staff to follow, which was available to them through the hospital intranet.
- All staff we spoke with at Warrington hospital had a good understanding of the reporting system and could access the system from the ward or theatre. All incidents, accidents and near misses were entered onto an electronic system. Staff gave examples of the type of incidents they reported. For example, delays in theatre. and insufficient staff on the wards.
- Data we received from the trust showed between January 2016 and December 2016 there had been 7564 incidents reported across the trust. Of these 1177 (16%) occurred within theatres or inpatient surgical wards across the Warrington and Halton sites.
- Data provided by the trust showed that approximately 82% of incidents were reported within 0-14 days and only 1.8% of incidents were reported within 61-90 days. This shows that the majority of incidents were reported soon after the incident occurred.
- Incidents were reviewed and investigated by the appropriate manager to look for improvements to the service. Moderate and severe incidents were also investigated through a process of root cause analysis (RCA), with outcomes and lessons learned shared with staff. We saw two RCA reports, which had been completed, with recommendations, action plans, and lessons learnt which confirmed the process.
- We saw evidence that hospital action reports were shared across the division. These reports highlighted errors in practice and key action points. We also saw evidence that key learning with regards to incidents and adverse events were discussed in daily safety briefings.
- We reviewed the incident recording logs and found that there was a broad spread of incidents recorded. These included cancellation of surgery and wrong patient details identified. This showed that staff were reporting appropriate incidents that occurred at the hospital.
- The trust had reported one never event at the Halton site in 2016 relating to wrong site surgery. Prior to, and following the inspection, two further never events occurred at the Halton site in March 2017, relating to wrong site surgery and retention of a swab following surgery. These were being investigated at the time of the report. 'Never events' are serious, largely preventable patient safety incidents, which should not occur if the available preventable measures have been implemented by healthcare providers. Although the never events had occurred at Halton hospital, all staff we spoke with at Warrington hospital were aware of the incidents which had occurred which demonstrated that key information and learning was shared across both trust sites.
- We saw that the debrief following surgery included all team members and included what could be improved to aid departmental learning.
- The trust reported two serious incidents in 2016 relating to surgical services. We saw that a full RCA had been completed.
- The trust reported low numbers of surgical site infections (SSI) following surgery. Between April 2015 to April 2016, there had been four incidents of SSI in knee replacement surgery and three incidents of SSI in hip replacement surgery. SSI's were monitored by the orthopaedic department in-line with National Institute for Health and Care Excellence (NICE) guidelines for quality standards for orthopaedic surgical site surveillance. The surveillance information collected during April 2015 to March 2016 showed there had been 672 hip and knee operations and indicated that the orthopaedic joint replacement infections were minimal and mainly superficial infections.
- All incidents and adverse events were discussed at the quality and safety meeting and staff reported that incidents were discussed at daily safety huddles.
- In ophthalmology, we saw that a governance review had taken place in January 2017, to review feedback and share lessons to be learnt from incidents. We saw that

the review included incidents by category that included administrative errors, communication and medicine errors. Staff we spoke with confirmed that they were aware of incidents relating to their service.

- From April 2015, all providers were required to comply with the Duty of Candour Regulation. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.
- Staff were aware of the duty of candour regulation; ensuring patients received a timely apology when there had been a defined notifiable safety incident. We saw examples of where duty of candour had been applied with regards to incidents and complaints.

Safety thermometer

- The safety thermometer is a tool for measuring, monitoring, and analysing patient harms and 'harm free' care. Data was collected on each month to indicate performance in key safety areas, for example, new pressure ulcers and falls.
- The trust monitored the incidence of pressure ulcers, falls, and venous thromboembolisms (VTEs). VTEs are blood clots that can form in a vein and have the potential to cause severe harm to patients.
- From January 2015 to January 2016 the trust reported there had been no falls resulting in harm, and three hospital acquired pressure ulcers across the surgical division. We saw that incidents regarding falls and hospital acquired pressure ulcers were reported by staff using the electronic incident reporting system.
- The surgical wards displayed information with regards to the number of falls, and pressure ulcers that had occurred on the ward to highlight their safety performance to patients and visitors. We saw that in all records we reviewed that an appropriate falls assessment had been completed to ensure the safety of patients.
- Guidelines from the National Institute for Health and Care Excellence (NICE) recommend that all patients should be VTE risk assessed on admission and reassessed 24 hours after surgery. Data provided by the trust indicated that the year to date performance up to December 2016 for patients being assessed for VTE, was 93%.This was not line with the trust target of 95%. However, performance in December 2016 was in line with the target, and all records we reviewed indicated that patients were assessed for VTE.
- From July 2016 to December 2016, there had been 11 incidents of VTE across the surgical division. Of these seven had been with trauma and orthopaedics. The trust provided information to support that RCA's had been completed in 10 of the 11 incidents.
- In January 2017, an audit to identify the percentage of patients as requiring prophylaxis following VTE risk assessment, who are given the defined treatment within required timescale was completed. The audit found that the trust was 86% compliant, against a target of 95%. An action plan had been developed to ensure future compliance. The action plan included investigation into the electronic system providing an alert that VTE had not been completed. The action plan was to be implemented by the 31 March 2017 and would highlight to staff if the VTE assessment had not been completed. All staff we spoke with were aware of the need of checking and completing VTE assessments.
- We saw that anti-embolism stockings were used on patients following surgery to reduce the risk of them acquiring VTE.

Cleanliness, infection control and hygiene

- The hospital followed their infection control policy, which included hand hygiene, use of personal protective equipment (PPE) such as gloves and aprons, to prevent the potential spread of infection.
- At the pre-operative assessment stage, staff screened patients for Meticillin-resistant Staphylococcus aureus (MRSA) and Meticillin-sensitive Staphylococcus aureus (MSSA). This is in line with Department of Health: Implementation of modified admission MRSA Screening guidance for the NHS (2014). MRSA and MSSA are infections that have the capability of causing harm to patients. MRSA is a type of bacterial infection and is resistant to many antibiotics. MSSA is a type of bacteria in the same family as MRSA but is more easily treated.
- If a patient was identified at the preoperative assessment with carrying an infection such as MRSA or MSSA, they received treatment for the infection in the

five days leading up to the surgery. The scheduling of theatre lists allowed for patients who had infections to be last on the theatre list. Patients identified with MRSA could be isolated in their rooms to prevent cross infection risks.

- Data provided by the trust showed that between December 2015 and December 2016 there had been no reported cases of MRSA and three cases of MSSA attributed to surgical wards A6 and A9. Data provided by the trust showed that the MSSA was likely to be present on admission to hospital; however, the MSSA was apportioned to the wards due to sampling delays.
- Staff were able to explain that any patient who attended or acquired an infection would be barrier nursed to minimise the spread of infection.
- All floor areas and bed spaces on the surgical wards and day case unit we visited appeared visibly clean. We saw there were signed and dated cleaning to show that areas were clean.
- Sluice rooms and storage areas across the surgical wards and day case unit appeared clean and free from clutter.
- We observed staff following the local policy and procedure when scrubbing, gowning and gloving prior to surgical interventions. When a procedure had commenced, movement in and out of theatres was restricted. This minimised the infection risk. We saw that all staff in theatres wore the correct attire; piercings were removed, and saw that hair including facial hair was covered. We saw that at the end of surgery gowns were removed ready to be laundered.
- We saw that waste was separated and in different coloured bags to signify the different categories of waste. This was in accordance with the HTM 07-01, control of substance hazardous to health (COSHH), health, and safety at work regulations.
- We saw that locked separate bins were in use for confidential waste. This ensured that sensitive data and patient identifiers were destroyed securely.
- We found equipment was visibly clean throughout the surgical wards, and staff had a good understanding of their responsibilities in relation to cleaning and infection prevention.
- In theatres, we found that not all equipment was clean. For example, we found many of the theatre trolleys had dust on them. These included anaesthetic equipment storage units, resus trolleys, and anaesthetic machines. All areas we found not clean were discussed with theatre managers and immediately rectified.
- As part of the unannounced inspection, we revisited the theatres and found that the department appeared to have been thoroughly cleaned. All trolleys had new cleaning checklists, which had been signed and dated with oversight from managers to ensure compliance with all cleaning across the department. The trust also re-established a theatre infection control group aimed at strengthening infection prevention and control throughout the organisation.
- In the recovery area, we found that cleaning schedules were completed weekly and all areas (seven bays) we inspected appeared clean.
- We reviewed the theatre cleaning audits for February 2016. The audit showed an overall compliance rate of 93%. The audit highlighted to domestic, nursing staff and to estates the actions that were required for full compliance. For example, the audit found dust on top of a fridge, and trolleys and who was responsible for cleaning.
- Policies and procedures for the prevention and control of infection were in place and staff adhered to “bare arms below the elbow” guidelines. Hand gel was readily available in all clinical areas and entrances to wards and we observed staff using it appropriately.
- We saw Personal Protective Equipment (PPE), was used on surgical wards on a regular basis in line with hospital policy. PPE was also provided for visiting relatives when needed.
- The infection control matrons produced a monthly infection control report, which included results from hand hygiene, commode, work wear compliance, environment cleanliness and high impact intervention (catheter care) audits. We looked at a report from January 2017, which showed there was a high level of staff compliance across the surgical wards. We saw from the audits that any areas of non-compliance were addressed immediately with the ward or theatre.

- The hospitals Patient Led Assessment of the Care Environment (PLACE) audit for 2016 showed the hospital scored 98% for cleanliness, which was in-line the England national average of 98%.

Environment and equipment

- The wards and theatre areas we visited were generally well maintained, free from clutter and provided a suitable environment for treating patients.
- We saw all fire escapes were kept clear and signposted for use in an emergency.
- There was sufficient storage space on the wards in the theatres. We saw that on all surgical wards, medical consumables such as syringes and dressings were appropriately stored in tidy and well-organised storage containers.
- In theatres, we found a sharps bin was over full and needed replacing and another had not been labelled. This potentially could result in a needle stick injury.
- Porters collected waste using entrances that were not used by patients or visitors. This ensured that waste was not taken through the ward to minimise the risk of infection or contamination.
- Records indicated that equipment was maintained and used according to manufacturer's instructions. There was sufficient equipment to maintain safe and effective care. We saw service schedules were kept for all electrical equipment with service dates for scheduled servicing.
- We saw that medical gases in theatres were appropriately stored and secure.
- Managers informed us that upon failure of any equipment an external contractor provided replacements quickly to avoid delays in surgical procedures taking place.
- The service had arrangements with an external contractor for the sterilisation of reusable surgical instruments. Managers informed us that the contractor provided a good service and any errors were rectified usually the same day. Records were kept of any errors in providing suitable reusable equipment in order for senior managers to monitor the ongoing contract.
- A theatre maintenance schedule was in operation to ensure that quarterly, half-yearly and annual revalidation of theatre maintenance was co-ordinated. The schedule included building maintenance and the maintenance of the air-handling units to ensure optimum performance of air extraction.
- Daily morning surgical meetings were held to ensure that all staff had the required equipment for the surgeries planned for that day.
- Records indicated that resuscitation equipment for use in an emergency in operating theatres and ward areas, were generally regularly checked and documented as complete and ready for use. The trolleys were secured with tags, which were removed and replaced following checking the contents of the trolley. However, we found that on both the ward and theatres there were some omissions in the recording that the daily checks were completed. This was highlighted at the time of inspection for immediate action.
- At the time of inspection we found that the anaesthetic machines were not been checked in accordance with the Association of Anaesthetists for Great Britain and Ireland (AAGBI). Daily checks of anaesthetic machines should be recorded daily. This was highlighted to the theatre manager immediately. At the unannounced inspection we found that new anaesthetic recording log books had been introduced and completed appropriately with oversight of ensuring compliance from managers.
- In theatres, we found 12 out of date stocks out on various trolleys. For example, we found out of date stock on the emergency varices trolley, the intubation trolley, the emergency airways trolley and percutaneous tracheostomy trolley. This was highlighted immediately to theatre managers and all out of date stocks removed and replaced. Out of date equipment included suction catheters which expired December 2016 and tracheal section set which expired December 2016.
- There were systems to maintain, and service equipment as required. Medical devices we looked at across the surgical wards, theatres and day case unit indicated that equipment had been tested appropriately to ensure that it was safe to use. Portable Appliance Testing (PAT) is a process by which electrical appliances are routinely checked for safety once a year.

- Recording systems were in place to ensure that details of specific implants and equipment could be provided rapidly to the health care products regulator. An implant register was kept within theatres of all cosmetic implants and prosthesis, and serial numbers noted. We reviewed the register and found that it was legible, up to date, and contained the necessary serial numbers of implants or prosthesis used.
- The surgical wards used electronic whiteboards to provide information about patients. The electronic board provided the nursing and medical team with the name of the consultant and enabled the staff team to know where a patient was situated within the ward.

Medicines

- There were arrangements in place for managing medicines and medical gases. Nursing staff were able to explain the process for safe administration of medicines and were aware of policies on preparation and administration of controlled drugs as per the Nursing and Midwifery Council Standards for Medicine Management. We saw that there was an up to date policy for the safe storage, recording of, administration and disposal of medicines. This was available for staff on the intranet.
- Surgical wards did not have a dedicated pharmacist to assist the supply of medication or support on the ward. We were informed that a bleep system was used to enable the ward to access pharmacy support. Staff we spoke with reported this was due to a shortage of pharmacists across the trust. However, the wards reported that they received a good service from the pharmacy department and there was a ward based pharmacy technician on the surgical wards to improve medicine safety.
- We saw that medicines were ordered, stored and discarded safely and appropriately and medical staff were aware of the policy for prescribing antimicrobial medicines.
- We observed that all medicines were appropriately stored in suitable locked cabinets, and a member of qualified nursing staff held the keys.
- Records on the ward and theatres indicated that controlled drugs were checked once daily as a minimum, and were signed as correct by two staff. This was in line with the trust's policy to ensure controlled drugs were accounted for, and were in date.
- We observed that controlled medicines stocks were in date.
- Medicines that required storage at temperatures below 8ºC were appropriately stored in medicine fridges. Records indicated that staff completed daily fridge temperature checks in line with the hospital policy.
- We reviewed 11 prescription charts and found them to be generally legible, dated and signed, allergies documented and saw antibiotics were administered appropriately. However, we found three examples where medicines reconciliation (checked and confirmed) was not completed within 24 hours of admission (NICE Medicines Optimisation Quality standard QS120). The patients' allergy status had not been recorded on one of the charts we examined, and the indication and duration of antibiotic treatment had not been recorded for two antibiotic prescriptions, although they had been reviewed and stopped appropriately within 72 Hours.
- We saw evidence in patient records that the trust completed weekly antimicrobial stewardship ward rounds (NICE Quality Standard QS121 Antimicrobial Stewardship) to ensure that patients were not on antibiotics unnecessarily to address the increasing concern of multi-drug resistant bacterial infections.
- A quarterly medicine management report highlighted areas where medication incidents had occurred across the division. The report was disseminated across the trust to enable shared learning. The report highlighted medication errors by location and by type in order to address compliance and training needs. For example, following an insulin incident further training for staff had been arranged by the diabetic team. Staff we spoke with confirmed that extra training was available following a medicine incident.
- Staff informed us that following a medication incident, lessons learnt were shared at the daily ward safety brief and individual staff completed a medicine competency if a dispensing error was made. Additionally, the wards received support from the medicines safety nurse to improve medicines safety.

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Records

- The hospital staff followed their trust patient records policy, which included confidentiality of patient records.
- The trust used a mix of electronic and paper patient records to detail the care and treatment of patients. We found that all records were securely stored in each area we inspected. The trust was moving towards a paper free records procedure to ensure records were secure and contemporaneous.
- Staff and managers we spoke with highlighted that that the electronic new system had functionality problems as not all assessments and pathways were electronic. This meant that staff were required to use both the paper and electronic system to record care and treatment of patients and information was not all contained in one place. Managers were aware of the functionality issues and work was being completed to provide a single electronic record to ensure all information was contained in a single source.
- Staff highlighted to us there had been issues in patients not receiving follow up appointments, and new appointment letters had not always been issued, meaning some patients would not be seen in clinic. We saw that the trust had carried out a review in January 2017. The review highlighted the numbers of patients that required either a follow up or new appointment so that contact could be made and necessary appointments booked. This was added to the risk register and a risk mitigation plan and a steering group developed to ensure all patients received the necessary appointments. We reviewed the steering group meeting minutes from February 2017 and saw that the meetings were well-attended and provided updates with progress.
- At the time of inspection, we saw patient personal information and medical records were managed safely and securely, in line with the data protection guidelines. We observed no records left out on the ward or theatre and were stored in cabinets once used.
- Patient records we viewed were integrated to ensure that they contained all information from pre-assessment, through to surgery, to the ward. This provided staff with the necessary information as to the care and treatment required for each patient.
- Records indicated the individual needs of the patients that included previous diagnosis of dementia, learning disability or mental health related diagnosis.
- We saw in theatres that a perioperative care pathway was used to detail consent had been obtained and health related needs documented.
- We looked at the records for five patients. These were structured, legible, complete and up to date.
- Patient records included risk assessments, such as for falls, venous thromboembolism, pressure care and nutrition and were reviewed and updated on a regular basis.
- Patient records showed that nursing and clinical assessments were carried out before, during, and after surgery and we saw that these were documented correctly.
- Standardised nursing documentation was kept at the end of patients' beds. Observations were well recorded and the observation times were dependent on the level of care needed by the patient.
- Patient records were audited on a monthly basis. The audit looked at a random sample of records across the surgical division to ensure compliance with the trust management of medical records. In January 2017, the surgical division records audit showed a compliance rate above the trust target of 75%. The report provided an action plan for improvement in future audits that included further training for ward staff. Staff we spoke with confirmed that they were confident in the use of the paper and electronic records.

Safeguarding

- The trust had a senior named nurse lead for safeguarding for both adults and children. All staff we spoke with were aware of their safeguarding adults and children responsibilities and who to contact if guidance was required.
- Staff received mandatory training in the safeguarding of vulnerable adults and children. This included an awareness of female genital mutilation (FGM). We saw that FGM information was posted on the walls in theatres as a reminder for the staff on the department.

- Data provided by the trust showed that between January 2014 to December 2016, 91% of nursing staff across the division had completed safeguarding adult's level 1 training and 83% of staff had completed safeguarding adult's level 2 training.
- Between January 2014 to December 2016, 92% of nursing staff across the division had completed safeguarding children level 1 training and 75% of nursing staff had completed safeguarding children level 2 training. The trust target was 85%.
- Safeguarding training compliance for medical staff to December 2016 was poor, and did not meet the trust target in safeguarding adults or children. 78% of medical staff completed level 1 adults and children and 62% completed level 2 adults and children.
- All staff we spoke with were aware of how to identify abuse and report safeguarding concerns.
- We saw from staff handovers that the needs of vulnerable patients were discussed at the daily team briefings. Staff reported that the handover would include handover of information for those patients with psychological and emotional needs.

Mandatory training

- Mandatory training was made available to all staff to enable them to provide safe care and treatment to patients. Some of the training was completed through e-learning, which staff could access at a time to best suit their needs. Staff we spoke with told us that they were given time to complete training.
- Staff received annual mandatory training, which included key topics such as infection control, equality and diversity, fire safety, health and safety, dementia and medicine management.
- In theatres, staff training was co-ordinated and monitored by the ward manager and by a practice educator within to ensure staff training was completed.
- Data provided by the trust showed that up to December 2016, the division met their target (85%) for compliance in five of the seven applicable mandatory training modules for nursing staff.
- Mandatory training for medical staff for the same period to December 2016 was below the trust target in all modules, ranging from 75% in moving and handling to 54% compliance with health and safety training level 1.
- Data provided by the trust showed varying performance across the surgical wards and departments. The day case unit and surgical assessment unit staff training rates were consistently above the trust target, ranging from 89% to 100% across all mandatory training modules.
- The surgical wards performance ranged from 57% to 100% across the mandatory training modules.

Assessing and responding to patient risk

- The service had introduced a nurse led pre-operative service, with pre-operative guidelines for staff to follow to ensure pre-assessment practice for elective surgery was underpinned by evidence-based guidance. The guidelines provided staff with a clear framework for safe practices relating to pre-assessment, and set out the standards and competencies expected to ensure staff were able to competently assess patients.
- Pre-operative assessments were completed for each patient to ensure that they are fit to undergo an anaesthetic and therefore the planned surgical operation. The assessment was a clinical risk assessment that included for example, any communicable diseases, blood results, allergies, and in female patient of childbearing age they were asked if they could be pregnant.
- We saw that patients with allergies wore coloured name bracelets to highlight to staff that the patient had an allergy.
- Staff we spoke with could identify and respond appropriately to changing risks to patients, including deteriorating health and wellbeing, or medical emergencies.
- The trust used the National Early Warning Score system (NEWS). This is a national standardised approach to the detection of a deteriorating patient and has a clearly documented escalation response, in line with National Patient Safety Agency (NPSA) 2007 guidelines. On the NEWS chart, staff recorded observations including

oxygen saturations, blood pressure and temperature and collated a total score. We saw that guidance was available on the NEWS charts to show what escalation was required for each trigger score.

- We reviewed five patients' NEWS charts and found that all observations had been completed appropriately and at the appropriate time required.
- A NEWS score audit had been carried out in December 2016 to January 2017 and the results showed an 86% compliance rate in NEWS recording across a sample of 80 patient records. This was above the 75% compliance rate target for the trust.
- A sepsis-screening tool was used to identify patients who were identified of potential sepsis. There were flow charts to support staff, with the procedures to follow, and patients were required to be immediately escalated to the medical team for review. Staff we spoke with on the wards reported they understood the escalation and guidelines to follow. Data provided by the trust showed that compliance with training in summoning emergency medical assistance on the surgical wards was consistently above the 85% trust target, ranging from 85% to 100%.
- In theatres we saw that the sepsis pathway was posted on the notice board. The information board also included the name of the sepsis link nurse to provide additional support to the staff.
- The hospital used a care and comfort round form, to ensure their patients were safe and comfortable. The care and comfort round included assessing patient pain scores, nutrition, and NEWS score. The care and comfort rounds were undertaken at least every two hours for all patients to ensure patient safety.
- If a patient's health deteriorated, staff confirmed they were supported with medical input and were able to contact the critical care outreach team if needed.
- In theatres there was an extended recovery bay for use when a patient may need an extended recovery phase post-surgery, or a critically ill patient may be admitted to the recovery area for pre optimisation and stabilisation prior to transfer to theatre, a ward environment or intensive care. The critical care outreach team oversaw the care of these patients.
- The service had a standard operating procedure in place to ensure that patients were not kept in the extended recovery area for more than four hours. The records we reviewed showed the bay was only used for 55 patients from 2016 to 2017. However, 21 of these patients breached the four-hour target. We were informed this was due to the availability of a suitable bed for the patient to transfer to and included the travel time for the patient if they transferred to a neighbouring trust.
- Staff we spoke with reported that they received timely access to psychiatry services and safeguarding team for those patients whose metal health deteriorated following surgery.
- All patients were given a call bell so they were able to summon help in an emergency. We observed that patients on all wards we visited had call bells, and we saw these being used by patients to summon help from nursing staff.
- A theatre team brief was held before each theatre list started. This meeting highlighted all procedures that were being undertaken and allowed staff to confirm that the appropriate equipment was available. We observed that the briefing was well attended by theatre staff.
- We observed the theatre teams undertaking the 'five steps to safer surgery' procedures, including the use of the World Health Organization (WHO) checklist. The theatre staff completed safety checks before, during and after surgery and demonstrated a good understanding of the 'five steps to safer surgery' procedures.
- We saw that an adapted WHO checklist was used in eye surgery to ensure that safer surgery took place.
- A WHO audit was completed in July 2016. The data reviewed showed 100% compliance in 1251 patients across the Warrington and Halton sites.
- We observed the WHO checklist was performed appropriately at the Warrington site.

Nursing staffing

- Staffing levels and skill mix were planned and reviewed so that patients could receive safe care and treatment at all times, in line with relevant tools and guidance. The ward used an acuity tool to determine the numbers of staff that were required on a daily basis to provide safe care and treatment to patients. The service provided

three shifts; a long day, an early shift and a night shift to ensure adequate numbers of staff, and continuity for patients. We saw that nurse staff numbers were displayed at the entrance to the ward so patients and visitors could see how many staff were on shift. Ward staff reported that acuity of patients was monitored throughout the day in order to escalate to senior managers if extra staffing resources were needed.

- In theatres, staffing was arranged to meet the Association for Perioperative Practice (AfPP) safe staffing guidelines. This ensured that there was adequately trained staff to provide safe surgical care to patients. We saw from the surgical procedures we attended there was appropriate staffing levels for each theatre.
- In theatres, 16, band six registered nurses had completed advanced life support training to be able to provide emergency life support if a patient deteriorated. We were informed that further training for band five nurses was going to be made available. The ALS course teaches the knowledge and skills required to recognise and treat the deteriorating patient using a structured approach; deliver standardised CPR in adults; and manage a cardiac arrest by working with a multidisciplinary team in an emergency.
- In recovery, we saw that there were no recovery staff on shift who were ALS trained. The Association of Anaesthetists of Great Britain and Ireland (AAGBI) guidelines states that there should be at all times, at least one member of staff in recovery that is a certified ALS provider. We were informed that eight of the 14 recovery staff had this qualification, and they had all completed immediate life support training. Managers informed us that there were always staff on the department in close proximity who had completed ALS training, and anaesthetists and other medical staff were available to support with advanced life support. Following the inspection, we were informed that all recovery staff had been booked on the ALS course and had completed the training.
- The ward managers monitored staffing levels throughout the day and escalated staffing shortfalls due to unplanned sickness or leave. Managers we spoke with told us staffing levels were based on the dependency of patients and this was reviewed daily. Staffing levels on the wards were increased when necessary so patients needing 1:1 care could be appropriately supported. At the time of inspection, we did not see any patients that required 1:1 support.
- All wards we visited had a number of staff vacancies. Data provided by the trust for December 2016 showed that the vacancy rate on the surgical wards ranged from -5% (ward A9) to 44% (ward A6). Managers informed us that recruitment and retention of nurses was a priority. We saw from data provided by the trust that the vacancy rate on ward A6 in January 2017 had improved from 44% to 21%.
- We saw that recruitment was taking place and senior nursing staff co-ordinated regular daily staffing meetings to cover staffing shortages.
- Matrons across the division met regularly to discuss shortfalls in staffing across the wards. An electronic daily staffing review tool was used to ensure that the daily staffing level was visible trust wide. This also enabled the senior on call team out of hours to see the staffing plan for each ward. Due to staffing shortfalls, staff were moved to other wards to be able to provide adequate cover on wards where staffing was insufficient. Staff we spoke with confirmed this.
- We reviewed data provided by the trust for December 2016 with regards to the fill rates (percentage of the number of staff working on the department) across the surgical wards and found that fill rates for registered nurses ranged from 77% to 100% through the day and ranged from 97% to 100% through the night. The data showed that although there were staff vacancies, the managers generally ensured the surgical wards were staffed to ensure the safety of patients.
- We reviewed the staffing hours reports for January 2017, and saw that on wards A5, A6, and A9 the total monthly planned and actual hours for registered nurses and care staff at night were generally filled. However, the planned and actual daytime hours filled showed there were shortages in qualified nurses on the wards. For example, planned staffing hours on ward A9 was 1782.5 hours and the actual was 1386.5 hours (fill rate 78%). We saw that although there were shortages of qualified staff, extra

care staff were provided to support the nursing team. However, this does not negate the need to have sufficient qualified nursing staff on the wards to provide care and treatment to patients.

- Staffing levels were maintained by staff working overtime and with the use of agency staff. Trust data showed that the average rate of use of bank and agency staff for March 2016 ranged from 7% to 31%. High rates of agency and bank staff were being used due to high staff turnover (range from 0% to 25%) and sickness rates (range 1% to 6%).
- The ward managers told us they tried to use regular bank or agency staff and ensured temporary staff were accompanied by permanent trained staff where possible, so that patients received an appropriate level of care. Agency staff underwent induction and checks were carried out to ensure they had completed mandatory training prior to commencing employment. Nursing staff confirmed that they were often moved to wards to ensure agency staff worked alongside permanently employed staff.
- We saw that nursing staff reported incidents where they felt there was insufficient nursing staff on the ward. This showed a good culture of reporting of low staffing levels to ensure quality and safety of the wards in which they worked.
- Nursing staff handovers occurred at every shift handover and included discussions about patient needs, and any staffing, or capacity issues.

Surgical staffing

- All treatment was consultant led at the hospital. Following surgery the continued care of the patient remained the responsibility of the surgical consultant.
- The trust reported that the medical staffing vacancy rate up to December 2016 ranged from 0% to 30%. Managers informed us that the vacancy rate was improving, as a number of medical staff had been appointed that included two colorectal surgeons, two ophthalmology surgeons, two spinal surgeons, and one upper limb surgeon.
- Data provided by the trust up to December 2016, showed that the medical sickness rate was low, ranging from 0% to 3%. However, medical staff turnover was high ranging from 1% to 22%.
- There was on-call consultant cover over a 24-hour period and there was medical cover outside of normal working hours and at weekends. The on-call consultants were free from other clinical duties to ensure they were available when needed. Nursing and junior medical staff confirmed that they were able to access consultant support if required.
- As of October 2016, the proportion of consultant staff reported to be working at the trust was lower than the England average by 2% and the proportion of junior medical staff was higher than the England average by 6%. Junior doctors informed us that they felt very well supported by the senior medical staff and they had sufficient opportunities for training.
- We saw that daily medical handovers took place during shift changes and these included discussions about specific patient needs.

Major incident awareness and training

- We saw there was a documented major incident plan and business continuity plan that listed key risks that could affect the provision of care and treatment.
- Managers informed us that the fire alarm was regularly tested and in theatres had completed a fire drill.
- In theatres, we were informed that they were looking into providing tabletop scenario training to support staff in major incident awareness.
- The trust had back-up generators for if the power supply failed. We were informed that these were regularly tested. We saw from the 10-year capital plan that new back-up generators were needed and was added to the risk register.

Are surgery services effective?

Good

At the previous inspection in January 2015, we rated effective as good. Following this inspection we have maintained the overall rating because:

- Care and treatment was delivered to patients in line with the National Institute for Health and Care Excellence (NICE) guidelines.

- Pain scores were regularly recorded and patients informed us that they were offered appropriate pain relief.
- Patients who required support and assistance with eating and drinking were identified using a coloured jug system and supported by staff in accordance with their personal needs.
- We observed good multidisciplinary working with effective verbal and written communication between staff.
- We saw that the service took part in a range of local and national audits and results were discussed at clinical audit meetings and actions for further improvements identified.

However:

- Although ward staff had knowledge of capacity assessments and best interests meetings, we saw no evidence that this had been applied for those patients who were unable to consent to care and treatment.

Evidence-based care and treatment

- Care and treatment was delivered to patients in line with the National Institute for Health and Care Excellence (NICE) guidelines. For example the national early warning system (NEWS) was used to assess and respond to any change in a patients' condition. This was in-line with NICE guidance CG50. Staff also assessed patients for the risk of venous thromboembolism (VTE) and took steps to minimise the risk where appropriate, in line with venous thromboembolism: 'reducing the risk for patients in hospital' NICE guidelines CG92.
- The hospital used care pathways that had been developed to meet best practice guidelines, which staff followed to ensure patients received safe care and treatment. We saw that on the trauma and orthopaedic ward, a care pathway was in place for patients undergoing hip surgery. The pathway incorporated pre-assessment through surgery to post-operative care.
- In theatres a perioperative care pathway was completed for all patients undergoing a surgical procedure. The pathway included the surgical safety checklist, preoperative site marking, baseline observations and a preoperative checklist.
- The surgical teams participated in clinical audits. Findings from clinical audits were reviewed at the monthly clinical audit meetings, divisional integrated governance group meetings, and any changes to guidance and the impact that it would have on their practice discussed. We saw from the meeting minutes that these meetings were attended by consultants and junior doctors to share learning.
- Staff told us policies and procedures reflected current guidelines and were easily accessible via the trust's intranet. We saw that policy and procedures were up to date and reviewed regularly.
- Discrimination, including on grounds of age, disability, gender, gender reassignment, pregnancy and maternity status, race, religion or belief and sexual orientation was avoided when making care and treatment decisions. A trust policy was in place regarding equality and discrimination. We observed staff to treated patients individually and without prejudice.
- The service contributed to national audits including Patient Reported Outcome Measures (PROMS). These audits were published nationally to provide evidence of outcomes of the service provided.
- We saw evidence of an audit programme that scheduled the audits to be completed for the year 2016. For example, we reviewed the audit programme for ophthalmology surgery and anaesthetics and found there was a broad range of audits had taken place throughout the year.
- In theatres, a medical device implants register was kept to ensure there was a system to record all implants used and to report defects.
- Following day surgery patients were provided with appropriate information and contact numbers in line with the Royal College of surgeons (RCS) good surgical practice 2014.
- We saw that staff followed NICE guidelines QS86 following a patient fall that included checking for injury and medical examination following a fall.
- We saw that staff used anti embolism stockings on patients following surgery to reduce the risk of them acquiring VTE. This was in line with NICE guidelines QS3 statement 5.

- We saw that the Association of Anaesthetists of Great Britain and Ireland (AAGBI) guidance for day case/short stay surgery was followed, as patient social, medical and surgical factors were taken into consideration prior to surgery. For example, assessments were completed to ensure the patient was fit for surgery and we saw the early mobilisation of patients following surgery to enable patients to return home with a reduced length of stay in hospital.

Pain relief

- Pain scores were recorded as part of the NEWS. We saw that pain scores were documented and that pain relief was given to patients at the specified times. We reviewed five patient records and found pain had been recorded appropriately in all records.
- We saw that pain scores were recorded by nursing staff as part of the two hourly care and comfort rounds. The care and comfort round was used to ensure that patients were checked on a regular basis and that their needs had been met.
- Staff on the surgical wards and theatres were supported by a team of acute pain specialist nurses that worked across both hospitals. Ward staff reported that if a patient experienced pain they would escalate their concern to the medical team and refer to the specialist pain team for symptom control.
- All patients we spoke with told us that they thought their pain was well managed.
- Patient records showed that patients received the required pain relief and they were treated in a way that met their needs to reduce discomfort.

Nutrition and hydration

- We reviewed eight patient records and found that Malnutrition Universal Screening Tool (MUST) scores had been recorded appropriately. The MUST score is a five-step screening tool to identify adults who are at risk of malnutrition.
- Staff followed guidance on fasting prior to surgery, based on the recommendations of the Royal College of Anaesthetists (RCA), which states that food can be eaten up to six hours and clear fluids can be consumed up to two hours before surgery. We saw that as part of the perioperative pathway, ward staff attended the theatre to provide a handover of patients, which included hand over of starve times.
- Most patients we spoke with reported that they enjoyed the food at the hospital.
- Patient records included assessments of patients' nutritional requirements and any allergies or food intolerances.
- Patients who required support and assistance with eating and drinking were identified using a coloured jug system and supported by staff accordingly.
- A dietetic service was available for those patients who required specialist dietary support.
- There was a Trustwide multi-disciplinary nutrition steering group to advise the clinical governance audit and quality subcommittee on issues relating to clinical nutrition. The group also reviewed reports of incidents, patient experience or complaints relating to nutrition.
- Patient led assessments of the care environment (PLACE) showed that 84% of patients thought that the food was good at the hospital. This was below the national average of 88%. However, our feedback from patients reported that the food was good.

Patient outcomes

- Information about the outcomes of patients' care and treatment was collected and monitored by the trust. Managers we spoke with were aware of their responsibilities to collect and disseminate the findings. We saw from clinical audit meeting minutes that audit data was shared and outcomes for patients discussed.
- The Service participated in clinical audits through the advancing quality programme. The advancing quality programme aims to improve the quality of care patients receive in hospitals across the North West of England by measuring and reporting how well the hospitals are performing. Performance data in the April 2015 to March 2016 hip and knee audit showed excellent results across all six measures, ranging from 99% to 100%. The measures included appropriate antibiotics given one hour before surgery and VTE medication given for the right amount of time after surgery.

- The service participated in a full range of national audits to measure outcomes for the local population against the England average. The outcomes for patients were used to ensure that the services offered provided patients high quality safe services at the trust.
- From the April 2015 to March 2016, Patient Reporting Outcomes Measures (PROMS), hip replacement (EQ VAS), knee replacement (EQ VAS and EQ-5D index) and varicose vein (EQ-5D index) indicators showed more patients' health improving and fewer patients' health worsening than the England average.
- In the 2016 National Emergency laparotomy Audit (NELA), the trust achieved a green rating (good) for the numbers of cases with pre-operative documentation of risk of death, the number of cases with access to theatres within clinically appropriate time frames, and number of highest risk cases admitted to critical care post operatively.
- In the 2016 hip fracture audit, the risk adjusted 30-day mortality rate was 6.4%, which was within the expected range and was an improvement over the 2015 audit at 7.1%. The percentage of patients having surgery on the day or day after admission, the perioperative surgical assessment rate, and the proportion of patients developing pressure sores did not meet the national standards, however, the trust had seen some improvement over their 2015 results.
- In the national bowel cancer audit, the trust was in expected range for the risk adjusted 90 day post-operative mortality rate, the risk adjusted two year post-operative mortality rate, the risk adjusted 90 day unplanned readmission rate and the risk adjusted 18 month stoma rate. However, 72% of patients undergoing a major resection had a longer length of stay than the national aggregate. This performance was an improvement over the 2014 data.
- Between September and October 2015, patients' relative risk of readmission for non-elective surgery was similar to the England average.
- Hospital episode statistics 2015/16 data showed the number of patients that underwent non-elective surgery and readmitted to hospital within 30 days following discharge was similar to the England average for all specialties. For patients undergoing elective surgery, the readmission rates to hospital were similar with the exception of urology readmissions, which was slightly higher (113 patients readmitted against an expected 109). This was highlighted in our previous inspection in 2015 where we were informed there were two factors that impacted on urology readmissions. All surgical elective patients undertaken at Halton General Hospital were given information on discharge to attend the surgical assessment unit at Warrington Hospital if they had any concerns. There was also a poor community-based care infrastructure to support patients with urinary tract infections and catheter related problems, which meant these patients attended the emergency department or surgical assessment unit at this hospital.
- The trust provided the inspection team with an action plan for reducing the readmission rates for urology. The action plan included monitoring readmission data, and discussion in governance and business meetings. However, although the trust was monitoring and discussing readmission rates the action plan did not provide clear actions taken to reduce urology readmissions.

Competent staff

- Staff were able to access training internally and externally. There was an online learning system across the trust where staff could access training. All staff we spoke with reported that they were encouraged and able to access training to improve their skills and knowledge.
- In theatres, a practice educator monitored training compliance across the department and supported the development of staff through teaching and organising training.
- All qualified nurses who worked within theatres or the ward for six months or more had recorded validation of professional registration. This meant the hospital conducted annual checks to make sure all nurses were registered with the Nursing and Midwifery Council (NMC) and is considered good practice. We saw that a nursing staff validation report highlighted those staff that needed to revalidate within the next six months.

- Appraisal rates were variable across the surgical specialties and theatres. Data provided by the trust for January 2017, showed that that the numbers of nursing and medical staff receiving an appraisal ranged from 71% to 95%. The trust target was 85%.
- Newly appointed staff had an induction and their competency was assessed before working unsupervised. Agency and locum staff also had inductions before starting work.
- The nursing and junior medical staff we spoke positively about their learning and development opportunities and told us they were well supported by their line manager.
- We reviewed three competency handbooks within theatres. The handbooks were relevant to their roles and responsibilities and included review and mid-way review meetings with mentors. However, we saw that competencies were not always signed and dated to show the staff member had completed the competency.
- In theatres, we saw that records were kept of staff professional qualifications, which was used to aid further education development.
- Additional role specific training was provided to staff based upon their clinical practice. This included summoning emergency medical assistance. Compliance with this training across the division was consistently above the 85% trust target, ranging from 85% to 89%.

Multidisciplinary working

- We observed good multidisciplinary working with effective verbal and written communication between staff. Staff confirmed that there were good working relationships between staff that included physiotherapists, nurses, and consultants.
- We saw that the therapy team worked closely with the ward staff to ensure that patients were seen quickly following surgery to further enhance their discharge.
- We observed nurses working alongside consultants. Interactions were positive and professional.
- We observed a theatre briefing and saw that it was well attended by all levels of staff.
- We observed positive working relationships between managers and the staff groups. We observed managers across the department to have close professional relationships with the staffing groups and provided them with advice and guidance as required. In theatres, we saw senior staff provided mentorship to junior members and students.
- Ward staff liaised with a number of different services when co-ordinating a patients discharge. This included hospitals, community services, and social services depending on where the patient lived.
- Staff handover meetings took place during shift changes and safety briefings were carried out on a daily basis to ensure all staff had up-to-date information about risks and concerns.
- Patient records showed there was routine input from nursing and medical staff and allied health professionals.
- The service had established links with a neighbouring mental health unit to ensure they were able to best support the needs of the patients.

Seven-day services

- Theatres were scheduled to operate between Monday and Friday on a weekly basis.
- The trauma theatre provided surgical procedures over the weekend from 8.30am to 2pm on Saturday.
- There was a 24-hour service with dedicated emergency and trauma theatres so any patients admitted over the weekend or at night that required emergency surgery could be operated on.
- At weekends, a consultant saw newly admitted patients, and the ward-based doctors saw existing patients on the surgical wards to ensure optimum levels of care.
- Microbiology, imaging (e.g. x-rays), physiotherapy and pharmacy support was available on-call outside of normal working hours and at weekends.

Access to information

- The theatres department used an electronic system to capture information about patient scheduling and theatre performance.

- Computers were available in the wards and theatre areas. All staff had secure, personal log in details and had access to e-mail and all hospital systems. We observed that no computer terminals were left unattended displaying confidential information.
- All staff had access to the trust's policy and procedures via the intranet to support and guide professional practice.
- All relevant staff had access to patient records electronically or paper based, to enable a complete and contemporaneous record of patients care and treatment.
- Discharge summaries were sent to GPs on discharge to ensure continuity of care within the community. We saw evidence that when a patient was discharged from hospital they were given a copy of their discharge form and a copy was forwarded to the GP. We saw that discharge summaries included the type of surgical procedure and medication prescribed to highlight to GP's their ongoing care needs.
- The division monitored that GP discharge summaries were sent within 24 hours to the GP practice. Compliance up to December 2016 was 84%, which was below the trust's 95% target. Managers informed us that there were some issues relating to the new electronic system but improvements month on month were being seen. We saw that compliance was improving and in December 2016 the compliance rate was 86%.
- The consultant and nurses names were on boards above the patients beds so that patients and their relatives knew who was responsible for their care.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The hospital had a current policy for consent, mental capacity (MCA) and deprivation of liberty safeguards (DoLS). This was available for staff on the intranet.
- Staff were able to demonstrate their knowledge of consent and mental capacity and Staff told us if there were concerns over a patient's capacity to consent, they would seek further advice and assistance.
- There was a trustwide safeguarding team that provided support and guidance for staff for mental capacity assessments, best interest meetings and deprivation of liberties safeguards applications.
- From the records we reviewed, and our observations of surgical procedures, we saw that consent was obtained prior to treatment.
- A consent audit was completed by the senior management team in January 2017. The audit focussed on the two-stage consent process. Stage 1 is the provision of information, discussion of options and initial (oral) decision with the patient. At this stage patient information leaflets should be given to the patient and documented. The patient signs the top white copy indicating they have received the information; and the yellow copy is given to the patient. Stage 2 is confirmation that the patient wishes to go ahead with the procedure and signs the documents and the yellow copy is given to the patient.
- The audit found the trust to be 86% compliant with the use of the two-stage consent form. Areas of improvement were recorded on an action plan, which included ensuring patients are given a copy of the consent form and document the information and leaflets given to patients. Staff we spoke with were aware of these actions and we saw that information provided was documented.
- We reviewed three patient records that should have required a capacity assessment and best interests meeting. We found that capacity had been ascertained, but for those patients who lacked capacity to consent to care and treatment, we saw no evidence of a best interest meeting contained in the patient record.

Are surgery services caring?

Good

At the previous inspection in January 2015, we rated caring as good. Following this inspection we have maintained the overall rating because:

- All patients and relatives we spoke with told us that that all members of staff treated them with dignity and respect.

Surgery

- We observed many positive interactions between staff and patients during out inspection. We saw that staff were professional and friendly and created a relaxed friendly environment
- Patients we spoke with were very positive about the way staff treated them.
- Patients and those close to them told us that they were involved in planning and making decisions about their care and treatment.

Compassionate care

- We spoke with 10 patients and relatives who all told us that that they were treated with dignity and respect by all members of staff. Patients told us they found the staff polite, friendly and approachable. Comments included; "Staff here are fabulous and the service is excellent".
- We observed staff greeting patients and relatives. Staff were polite friendly and helpful in their approach.
- Staff demonstrated flexibility and kindness when meeting people's wishes. We were informed by managers and staff that the wishes of a terminally ill, dying patient to have Christmas with his young daughter were accommodated. The ward set out an end bay as a grotto with a Santa Claus in order to make his wishes come true. The ward staff recently won a 'thank you' award to thank the staff for their exemplary efforts.
- Care and understanding was given to patients living with a mental health disorder. The surgical division had worked collaboratively with a local mental health unit to help reduce anxiety and fear. An action plan, and process had been established to be seen in a designated area and receive treatment quickly. Following surgery the patient could be moved to an individual side room and the carers invited to stay to provide the additional support they need.
- We observed that staff respected patient confidentiality and ensured sensitive discussions took place in privacy. All patients we asked reported their dignity and privacy was maintained throughout their hospital stay.
- Staff made sure that patients' privacy and dignity was respected, including during intimate care. We saw that patients on the ward had the curtains pulled around and sensitive conversations were held in private.
- On the day case unit we saw that staff welcomed people onto the department, introducing themselves in a polite and professional manner.
- We saw that the theatre nurses spoke calmly to patients and introduced themselves to reassure the patients prior to, and following a surgical procedure.
- Patient led assessments of the care environment (PLACE) showed that 79% of patients thought that their privacy and dignity had been maintained during their time at the hospital. This was below the national average of 84%. However, our observations and patient feedback highlighted that privacy and dignity was being maintained.
- Staff supported patients to be mobile and independent postoperatively. We saw that physiotherapists encouraged patients to mobilise soon after surgery and promoted independence. Patients informed us that they were seen quickly after surgery and rehabilitation started soon after surgery.
- We observed many positive interactions between staff and patients during out inspection. We saw that staff were professional and friendly and created a relaxed friendly environment. Patients we spoke with were very positive about the way staff treated them. Patients told us staff were 'excellent', 'friendly', and 'fantastic'.
- We saw that wards displayed their thank you cards. There were numerous cards that thanked the staff for their' kindness', 'thoughtfulness' and 'care' whilst in hospital.
- All ward areas we inspected were compliant with same-sex accommodation guidelines, meaning that men and women were not receiving care and treatment within the same hospital bays.
- In the NHS England Friends and Family Test (FFT) between December 2015 to November 2016, the trust scored about the same as the England average for the percentage of people who would recommend the trust to family and friends.
- The wards displayed their friends and family test scores each month to highlight their achievements. We reviewed the November 2016 for A5, A6, A9 and SAU and the scores ranged from 89% to 98%.

- From our observations, it appeared clear that the nursing team had a good rapport with the patients and took the time to spend with patients to ensure they provided the care they required.

Understanding and involvement of patients and those close to them

- We saw that staff communicated with patients so that they understood their care, treatment and condition. Patients confirmed that staff explained their care and treatment and kept them up to date with any required information.
- Patients and families were encouraged to participate through feedback and surveys. This showed that they cared about 'getting it right' for the patients.
- Patients and those close to them told us that they were involved in planning and making decisions about their care and treatment. We observed that patients were involved in decision-making records indicated that patients were involved in the next step in the care and treatment process.
- Visiting times were flexible on the ward to take into account the needs of the patient's relatives. Wards had visiting from 12pm until 8pm to ensure relatives could visit. Ward staff informed us that visiting times could be altered to allow flexibility for families if needed.
- On the day case unit, patients informed us that they were provided with all the information they needed and felt were informed about their care.
- Staff recognised when patients and those close to them needed additional support to help them understand and be involved in their care and treatment. This was highlighted in the preoperative assessment so reasonable adjustments could be made. For example, an individual room could be made available for those patients with a mental health condition.
- There were many health and social care support services available to provide advice, care and treatment if needed. This included social workers and specialist nurses.
- For those patients with a learning disability or dementia, health passports or 'this is me' documents were used to support the needs of the patients. Staff reported that this helped them understand the individual need of the patients to best understand and support them.

Emotional support

- We saw from records and our observations that staff completed regular observational checks of patients in their care, to ensure that they were comfortable, and to answer any questions they may have. These observational checks also ensured that patient personal hygiene, nutritional, hydration, and pain needs were addressed regularly.
- Throughout our visit, we observed staff giving reassurance to patients with additional support given when it was required, especially if patients were apprehensive or anxious.
- A team of chaplains visited wards on a daily basis and were available to give confidential spiritual care and support at times of need or distress. Chaplains used an on call system for if an urgent visit was required, especially for those patients at the end of life. Staff informed us that the chaplain service reacted quickly to any referrals.
- The trust had a chapel and a prayer room, which were multi faith and always open to patients and their families.
- Holy communion was available to patients at the bedside, if they were unable to attend the chapel.
- Counselling services were available to those that needed psychological support. Counselling was also available to the staff to support them through stressful times.
- For those patients that were at the end of life, a palliative care team offered practical and emotional support to patients and their families.

Surgery

Are surgery services responsive?

Good

At the previous inspection in January 2015, we rated responsive as good. Following this inspection we have maintained the overall rating because:

- A variety of surgical procedures were available within the service, including cosmetic surgery, orthopaedics and general surgery to meet the needs of the local population.
- Bed meetings took place four times a day to ensure flow was maximised across the hospital.
- The trust monitored the number of cancelled operations on the day of surgery. Performance data showed that the number of cancelled operations on the day of surgery had improved from 11.9% in February 2016 to 8.8% in January 2017.
- Between October 2015 and November 2016, the average length of stay for surgical elective patients was better at the trust at 2.7 days, compared to 3.3 days for the England average.
- There were a number of specialist nurses within the trust to help support the care and treatment of patients.
- The trust's referral to treatment time (RTT) for the percentage of patients seen within 18 weeks was 76.9%, which was better than the England average of 71.5%.
- There was 24-hour medical cover on site to attend to patients who had deteriorating needs.

However:

- Theatre lists did not always run on time due to there not always being available beds for patients.
- Data provided by the trust showed that between September 2016 to December 2016 there were a total of 1180 bed days lost to medical outliers on surgical wards. This number of medical outliers impacted on the number of available beds for surgical patients on the surgical ward.

Service planning and delivery to meet the needs of local people

- The services provided at the hospital reflected the needs of the population they served, and they ensured flexibility, choice and continuity of care. A variety of surgical procedures were available within the service, including cosmetic surgery, orthopaedics and general surgery. The procedures carried out were determined in conjunction with the local clinical commissioning groups to best serve the local population.
- There were arrangements in place with neighbouring trusts to allow the transfer of patients for surgical specialties not provided by the hospital, such as vascular surgery.
- As part of the preoperative assessment process, patients with lower risk medical conditions could elect to have surgery at the trust's neighbouring site at Halton. This helped the service plan care and treatment for patients and ensure waiting times were kept to a minimum.
- The hospital used a total of seven operating theatres. This included an elective orthopaedic theatre that was mainly used for elective patients that were assessed as higher risk and would not be suitable to have surgery at the Halton site.
- One theatre was closed and was in the process of being transformed into a simulation suite, in order to provide further training to all medical and junior staff.
- There was an emergency general surgery and trauma theatre that was staffed 24-hours, seven day per week so that patients requiring emergency surgery including out of hours and weekends could be operated on promptly without the need to transfer to a neighbouring trust.
- In theatres, there was an extended recovery area to support those patients who required level 3 care. The area had a standard operating procedure to ensure patients received the appropriate care. The area was used if a patient deteriorated, until either surgery was performed, a bed could be utilised on intensive care, or transfer to a neighbouring trust.
- Elective surgery usually finished at 4.30pm, however, the service did operate some spinal surgery once a week up until 7pm.
- Surgical lists were planned four weeks in advance to provide patients with enough time to organise their admission to hospital.

- The trust held nurse recruitment and open days to promote their theatre services and encourage people into nursing. We were informed that the open days included simulations of surgery that included children for future recruitment possibilities.

Access and flow

- The trust had 29,590 surgical admissions between October 2015 and September 2016. Emergency admissions accounted for 7281 (24.6%), 18,069 (61%) were day admissions, and the remaining 4240 (14.3%) were elective admissions.
- Patients could be admitted for surgical treatments through a number of routes, such as pre-planned day surgery, via accident and emergency or via GP referral.
- Surgical services had a surgical assessment unit (SAU) that was used to assess and triage patients for surgical procedures up to 10.30pm, seven days per week. We visited the unit as part of the inspection and staff informed us that at times the unit was being used inappropriately, as non-surgical patients were being admitted to the unit whilst waiting for a bed. Staff reported that it was common that the unit was not able to close on time, which meant they were unable to leave the unit.
- Admission times for elective surgery were staggered throughout the day so that patients did not have to wait for a long period once admitted to the ward. By staggering admission times the hospital was able to ensure those patients with the most urgent needs were prioritised. For example, patients with diabetes were placed at the beginning of the theatre lists so that they had their surgery as quickly as possible.
- During our inspection, the theatre lists did not always run on time. We were told this was due to a shortage of beds. Staff we spoke with reported that this was the main cause of delayed or cancelled surgery. The trust had developed a standard operating procedure to provide guidance for staff to follow to ensure patients transferred from the ward to theatre reception when bed pressures were reported, to minimise theatre delays or cancellations.
- Bed meetings took place four times a day to ensure flow was maximised across the hospital. The meeting included senior managers to support and expedite timely discharges. Senior managers confirmed they attended these meetings.
- The patients we spoke with did not have any concerns in relation to their admission, waiting times or discharge arrangements. Staff explained to us that they gave apologies to patients if theatre schedules were running late, and on SAU we saw that staff updated patients as to delays in transferring to in-patient beds.
- Between October 2015 and November 2016, the average length of stay for surgical elective patients was better at the trust at 2.7 days, compared to 3.3 days for the England average.
- For surgical non-elective patients, the average length of stay was also better than the England average at 4.4 days compared to 5.1 days.
- Overall, the Warrington hospital had a slightly longer average length of stay than the trust average at 3.4 days, however this is in line with the England average.
- Between December 2015 and November 2016, the trust's referral to treatment time (RTT) for the percentage of patients seen within 18 weeks was 76.9%, which was better than the England average of 71.5%. The trust was consistently above the England average for the whole period.
- The trust monitored the number of last minute cancellations of operations. If a patient has not been treated within 28 days of a last minute cancellation then this is recorded as a breach of the standard. From October to December 2014 through to July to September 2016, the trust had significantly reduced the numbers of cancelled operations and not treated within 28 days, from 142 to 16. Of these 16 patients, only four were not treated in 28 days. We were informed the main reason for cancelling surgery was due to non-availability of surgical beds on the inpatient wards.
- The trust monitored the number of cancelled operations on the day of surgery. Performance data provided by the trust showed that the number of cancelled operations on the day of surgery had improved from 11.9% in February 2016 to 8.8% in January 2017. We were informed that performance had

improved partly as a result of using space in the SAU as a forward waiting area, meaning patients could be brought in to hospital without initially having a vacant bed. Following surgery these patients could be transferred to vacant beds on the ward through the day.

- From April 2015 to September 2016 the bed occupancy rate across the trust was over 85%. Evidence shows that when bed occupancy rises above 85% it can start to affect the quality of care provided to patients and the orderly running of the hospital. Although the bed occupancy rate was in line with the England average during this period, it did highlight that due to the demand on beds, patients transferred to wards outside their speciality. On the surgical wards A5, A6 and A9 the bed occupancy from December 2016 to February 2017 was consistently above 95%.
- At the time of the inspection we were informed that there were five medical patients outlying on surgical wards. This means that medical patients (also known as outliers) are receiving care and treatment on surgical wards that did not necessarily specialise in the care they required.
- Data provided by the trust showed that between September 2016 to December 2016 there were 1180 bed days lost to medical outliers on surgical wards.
- From September 2016 to February 2017, the trust reported that there were a low number (166) surgical outliers. This meant that 166 surgical patients were potentially receiving care and treatment on wards that were not suited to their needs.
- We saw that a plan was in place to ensure that medical and surgical outliers were seen on a daily basis and included an escalation pathway to ensure that medical reviews occurred. Records we reviewed and staff confirmed that the medical team routinely reviewed medical and surgical outliers.
- The service had introduced a 'red and green bed days' visual management system to assist in the identification of wasted time in a patient's journey. A red day is when a patient receives little or no value adding acute care. For example, a planned investigation that does not occur. A green day is when a patient receives value adding acute care that progresses the patient towards discharge. For example, when tests and investigations are completed as planned without delay. Red or green symbols were used on the electronic patient whiteboard to show if patients were receiving either value added acute care or no value added acute care. This helped staff to focus on ensuring that any constraints identified in converting a red day to a green day could be proactively managed at the daily board rounds, ensuring patients received the care they needed without any delays.
- The trust monitored the number of delayed discharges across the surgical wards. From August 2016 to January 2017, the trust reported there had been 165 patients on surgical wards that were medically fit to leave but were not able to. The main reason for delays in patients being discharged was due to waiting for further non-acute NHS care such as rehabilitation or patient or family choice of care setting.
- There was 24-hour medical cover on site to attend to patients who had deteriorating needs.
- There were plans in place that ensured there was medical staff available should an unplanned return to theatre be needed. Surgeons and anaesthetists remained on call 24 hours per day and there was a staffed emergency theatre.

Meeting people's individual needs

- Services were planned and delivered to take account of the needs of different people. Individual needs were considered at preoperative assessments to ensure their needs could be met prior to surgery. This included allergies and pre-existing conditions.
- All areas of the ward were wheelchair accessible, and all inpatient side rooms and shared bathrooms had level access showering facilities.
- There were a number of specialist nurses within the trust to help support the care and treatment of patients. These nurses specialised in a specific area. For example, there were palliative care nurses, diabetes nurses and psychiatric nurses to support patients with mental health needs.
- There were a number of link nurses to help support patients on the ward. These link nurses were trained and had a special interest in a specific area. For example, there were link nurses on the inpatient ward for dementia and diabetes.

- Information leaflets about services were readily available in all the areas we visited. Staff told us they could provide leaflets in different languages or other formats, such as braille, if requested.
- There was an interpreter service available for patients for whom English was not their first language. Staff were aware of the service and how to access it.
- Staff used a 'this is me' document for patients admitted to the hospital with dementia. This was completed by the patient or their representatives and included key information such as the patient's likes and dislikes. We saw evidence of this in the patient records we looked at.
- A discreet symbol was used on the ward whiteboards to highlight any additional needs of patients and coloured wristbands were used to denote allergies. We saw that patients with additional needs were discussed at the team safety briefs that included any safeguarding concerns.
- Staff could access appropriate equipment such as specialist commodes, larger beds or chairs to support the moving and handling of bariatric patients (patients with obesity) admitted to the surgical wards and theatres.
- Adapted cutlery was available for those patients with hand motor skills difficulties to aid their independence.
- Wards provided individual side rooms for patients with communicable diseases to minimise the spread of infection.
- On the ophthalmology day case unit, patient information leaflets were on bright coloured paper with large writing for those patients with vision impairment.
- Although there was not a learning disability lead nurse within the trust, ward staff referred patients to the safeguarding team to flag the admission to hospital. Staff informed us that often they were able to provide an individual room and provide access to allow family or carers to stay overnight to support their individual needs. This service was also available for patients with mental health needs and those patients living with dementia.

Learning from complaints and concerns

- The chief executive was the person responsible for all complaints in the trust which was delegated to the patient experience team under the leadership of the deputy director of governance and quality.
- The wards had information leaflets for patients and their representatives on how to raise complaints. This included information about the Patient Advice and Liaison Service (PALS).
- Between April 2016 to February 2017, the division reported they had received 185 complaints. The number of complaints per month was low ranging from 11 to 21 complaints a month.
- A complaints audit was undertaken in February 2017. The audit examined eight patient complaint questionnaires. The findings of the report highlighted that of the eight patient questionnaires, five patients reported they were unaware of how to make a complaint, six patients reported they did not receive an acknowledgement within three working days and six patients reported they did not receive a resolution in a time period that was relevant to my particular case and complaint.
- The Trust told us that there had been recently changes taking place in the divisional structure and staffing levels within the patient experience team, which impacted on complaints being investigated and responded to within the agreed timescales. We saw that an action plan was in place and improvements had been made in the time taken to respond to complaints.
- Data provided by the trust showed that 90% of complaints in the division were responded to within the expected parameters (usually 30 working days). The trust target was 90%.
- Information from the trust clinical operational board dashboard showed that in December 2016 there had been 11 complaints with regards to the surgical services. The main reasons for complaints were cancellation and waiting times followed by care and treatment.
- From our observations in SAU, we saw that staff provided patients with updates when waiting times had been increased.
- The patients we spoke with were aware of the process for raising their concerns with the trust.

- Notice boards outside the ward included information such as the number of complaints received during the month.
- Managers informed us that they endeavoured to resolve complaints quickly at ward level and met with patients and their families to rectify any concerns they had immediately.

Are surgery services well-led?

Good

At the previous inspection in January 2015, we rated well led as good. Following this inspection we have maintained the overall rating because:

- Senior managers were clear on their strategy to provide high quality services for patients, which included working collaborative within the organisation, and in partnership with other trusts to deliver high quality services.
- There was a clear governance structure to support governance and risk management and staff had clearly defined roles, responsibilities and reporting structure.
- On the wards and theatres, there were daily briefings to discuss day-to-day issues, share information regarding incidents and risk areas, to increase staff awareness and avoid reoccurrence.
- We saw that Local Invasive Standards for Invasive Procedures (LocSSIP's) had been developed in partnership with the North West theatre network. The standards were in place to ensure high quality, safe care and treatment for all patients.
- All staff we spoke with were positive about their relationships with their immediate managers. Staff felt they could be open with colleagues and managers and felt they could raise concerns and would be listened to.

However:

- Although there were formal audits completed that included infection control. We saw no evidence that managers had a formal system or process of oversight, that ensured the cleanliness of equipment, and system checks were maintained. However, during the unannounced inspection we saw that the service managers had reacted quickly to our concerns, and new systems and processes implemented with management oversight to ensure compliance with standards and policy.

Leadership of service

- The senior managers had the skills, knowledge, experience and integrity that they needed to lead effectively. The new divisional structure was embedded and led by a senior management team and were aware of their current performance and direction of the trust.
- The new divisional and clinical business unit structure had been developed in 2015. The new structure created two divisions and eight clinical business units (CBU's) to oversee clinical and business activity. The CBU's were led by clinicians, managers and senior nurses to provide a robust clinical, operational and nursing alignment. Managers informed us that this provided a better balance and involvement in relation to the direction of the service as the structure contained both clinicians and managers.
- Ward managers, overseen by matrons, led the surgical wards and there were theatre co-ordinators and a theatres manager in place to oversee the day-to-day running of theatre services.
- Theatres and ward-based staff told us they clearly understood the reporting structures and they received good support from their line managers.

Vision and strategy for this service

- The hospital had a clear mission, vision and strategy, which was to provide high quality, safe integrated healthcare for all patients. We found the hospital strategic direction was well described by the senior management team and were focused on quality of services, the people delivering them, and the sustainability of the service through the financial pressures the trust faced. We saw that the vision and values of the trust were posted on the walls around the hospital.
- Senior managers were clear on their five year plan, which included a cost improvement programme and working collaborative within the organisation, and in partnership with other trusts to deliver high quality services.

- Staff we spoke with were clear on the direction of their service and the financial pressures the trust faced.

Governance, risk management and quality measurement

- There was a clear governance structure to support governance and risk management and staff had clearly defined roles, responsibilities and reporting structure. At ward level staff reported they were aware of the reporting structure.
- Senior managers, nurses and clinicians were clear on the risks associated to their division. These included balancing finances with quality, ensuring they met the cost improvement programme target, and staffing shortages across the division.
- Managers reported that quality impact assessments were completed and approved by the board prior to any cost improvement plan was introduced, and there was support from a transformation team pre and post changes to monitor, and evidence the quality of any changes.
- There was a clinical governance system in place that allowed risks to be escalated to divisional and trust board level through various committees and steering groups. There were action plans in place to address the identified risks.
- We reviewed the divisional risk registers and saw that key risks had been identified and assessed with review dates specified.
- In ophthalmology we saw that an action plan had been developed to ensure that patients received a follow up appointment. The action plan had been developed following a delay in follow up appointments for patients undergoing eye surgery. We saw that the action plan included the introduction of telephone reminders to patients.
- On the wards and theatres, there were daily briefings to discuss day-to-day issues and to share information on incidents and risk areas.
- All managers across both operating sites highlighted they had monthly managers meetings to discuss performance of the division and share knowledge and experience.
- We saw that the monitoring of audits took place monthly, and there were clinical audit meetings to discuss findings and results.
- We saw that Local Invasive Standards for Invasive Procedures (LocSSIP's) had been developed in partnership with the North West theatre network. We saw that these procedures included a standard for the safety briefing prior to commencement of an operating theatre list and the WHO checklist. We saw the appropriate standards followed throughout our inspection at Warrington.
- We saw examples of local safety standards to ensure the safety of patients undergoing treatment. For example, we saw a standard operating procedures for the application of topical anaesthesia for cataract surgery provided a step by step process to follow to eliminate any surgical errors.
- Although, there were safety standards in place to eliminate errors in surgical procedures, the trust had two never events in March 2017 at the Halton site. These were currently under investigation by the trust as to the route cause of the errors.
- We saw that the service leaders had taken immediate action to ascertain the reasons for the never events and extra support, training and guidance given to all staff to ensure future compliance with the standard operating procedures. The trust provided an action plan of the steps they were taking to minimise the occurrence of never events that included a review of their standard operating procedures.
- Although there were formal audits completed that included infection control, We saw no evidence that senior managers had a formal system or process, that the cleanliness of equipment and system checks were maintained to ensure safe care and treatment for patients.. However, during the unannounced inspection we saw that the service managers had reacted quickly to our concerns, and new systems and processes implemented with management oversight to ensure compliance with standards and policy. We saw the action plan included a daily theatre cleanliness and equipment check by the lead nurse/matron.
- Performance information was relayed to wards through performance dashboards. The dashboards provided senior nurses with information regarding workforce

statistics such as budget expenditure, workforce profile, recruitment and staff sickness. Although the dashboards provided good information about the workforce they did however, lack any patient centred measures, For example, VTE assessment compliance, infection control compliance, incidents and falls. The focus of a dashboard is to engage staff, empowering them to improve quality of patient care by being able to monitor performance and compliance using the dashboard over a specified period.

Culture within the service

- All staff we spoke with were positive about their relationships with their immediate managers. Staff felt they could be open with colleagues and managers and felt they could raise concerns and would be listened to.
- Staff at all levels were aware of the duty of candour in regards to being open and honest with patients and we saw that open and honest letters were sent to patients following complaints or incidents.
- We saw that a full range of incidents were reported using the trust electronic system, and staff told us that they were encouraged to report incidents so that lessons could be learnt.
- Staff told us that there was a friendly and open culture within the trust and many staff had worked there many years and progressed through training opportunities.
- In the NHS staff survey 2016, the percentage of staff both white and black and minority ethnic (BME) groups who reported experiencing bullying from staff in the last 12 months was 18% and 22%. This was below the average median for acute trusts.
- The survey also reported that 93% of both white and BME groups believed the organisation provided equal opportunities for career progression or promotion. This was significantly better than the average median for trusts.

Public and staff engagement

- Trust board meeting minutes and papers were available to the public online, which helped them understand more about the hospital and how it was performing.
- The trust had news releases on its website pages to keep members of the local community up to date with current events. We observed that the news releases on the website were current and up to date.
- The trust had Facebook and Twitter accounts to share information with patients and receive feedback. We saw that stopping smoking and information on their latest drop in session was provided.
- The hospital participated in the NHS friends and family test, giving people who used services the opportunity to provide feedback about care and treatment. The friends and family test showed the percentage of patients and families that would recommend the service. We saw that all surgical wards displayed this information at the ward entrances.
- The trust's friends and family test performance measured the percentage of people who were likely to recommend the trust to friends and family. Results showed that scores were generally about the same as the England average between December 2015 to November 2016.
- Information on the number of incidents, complaints and general information for the general public was displayed on notice boards in the ward and theatre areas we inspected.
- The trust participated in the NHS staff survey to gather their views. The survey asks 34 questions and the results analysed and compared with other trusts across England. The results from the 2016 NHS staff survey showed that the trust performed better than other trusts in 10 questions, about the same is 17 questions and worse in seven questions. Areas that the trust performed better included staff satisfaction with their level of responsibility and involvement and support from their immediate managers. Areas where the trust scored worse included the quality of non-mandatory training and the response rate in the survey, which was 33%. The England average was 41%.
- The service had introduced a patient feedback mechanism 'Your Ideas' and in response to feedback have made some changes. For example, from feedback relating to a ward being noisy at night, the service had developed a 'Have a good night' poster. The poster

provided staff, visitors and patients with advice to support patients to have a restful night. This included, mobiles to be switched to silent and for staff to offer patients ear plugs and to wear soft soled shoes.

- At the time of inspection there was a theatre consultation taking place with regards to the operational working patterns at night from a shift system to an on call system for the emergency theatre. From our discussions with staff this had been on-going for over 12 months and had an impact on their morale and some reported they felt de-motivated. Senior managers informed us that a new formal consultation had started in May 2016 and had not yet been resolved.
- The trust carried out a divisional temperature check audit during 2016 in which staff were asked eight questions in relation to the service. This included how likely they were to recommend the trust as a place to work. We reviewed the data provided by the trust for specialist surgery. The data showed that 96% of staff felt they had been treated fairly and consistently in the last month, however only 71% of staff would recommend the trust as a place to work.

Innovation, improvement and sustainability

- We saw that leaders and staff strived for continuous learning, improvement and innovation. Managers were sited on the current clinical and financial pressures, and looked for ways to develop effective clinical networking and integrated partnerships with other trust services. For example, in theatres we saw that local safety procedures for invasive procedures had been developed by working within a North West collaborative.
- In Ophthalmology they had commenced cataract surgery under local anaesthetics and eye stents in glaucoma surgery, improving efficiencies and patient experience.
- The trust was rated as one of the best in the North West by the Advancing Quality Alliance (AQuA for providing hip and knee replacement care, with a score of 97.7%.
- A patient safety initiative was introduced in Orthopaedics. The introduction of the 'Red Cast';The red band around the cast is intended to act as a visual highlight that extra care needs to be taken with the patient, remind staff to frequently change their position, and encourage patients to be mobile to relieve pressure on the cast.
- In trauma and orthopaedics the service had been redesigned to offer protected beds on ward A9 to reduce the occurrence of these beds being used for medical outliers. The redesign also included increased ortho-geriatrician cover on the trauma ward and seven day trauma specialist nurse support.

Critical care

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

Information about the service

Critical care services are divided into two main areas. The main intensive care unit is an open area which has a total of 14 bed spaces. The high dependency area has six beds, including two isolation rooms that produce positive or negative pressure.

There are 20 bed spaces, although the unit is normally funded for the use of 18. However, between January 2016 and December 2016, only 16 bed spaces had been available due to shortages in nursing staff. This was increased back to 18 in January 2017.

The unit is part of the Cheshire and Mersey Critical Care Network (CMCCN). Between April 2015 and March 2016 there had been approximately 800 admissions to the service from the local area.

We visited the service as part of our announced inspection which took place between the 7 and 10 March 2017. We also undertook an unannounced visit on the 23 March 2017.

During our visit we looked at all areas that made up critical care services. We also visited the recovery area in theatre as patients were sometimes managed in the 'stabilisation bay'. This was used when there was no immediate critical care bed available.

We took time to interview different grades of staff, including members of the management team as well as patients and relatives.

Summary of findings

We rated this service as 'requires improvement' because:

- We were not assured that critical care services were able to provide a member of staff who was up to date with advanced life support training on every shift. Advanced life support training for adults was not provided for any nursing staff. Additionally, only 55% of medical staff and 79% of acute response team staff had completed training updates.
- At the time of inspection there was limited evidence that sufficient controls were in place to prevent the service exceeding full capacity. This was because critical care services were not currently using a formal escalation policy.
- We found that appropriate actions had not always been taken in a timely way to mitigate the level of risk and there were a number of risks that had not been formally identified.
- Records indicated that between January 2016 and December 2016, there had been 75% delayed discharges (greater than four hours following the decision being made that a patient is fit for discharge to a ward).

However,

Critical care

- The unit used a combination of best practice and national guidance to determine the care that they delivered. These included guidance from the National Institute for Health and Care Excellence (NICE) and the Intensive Care Society (ICS).
- The most recently available and validated ICNARC data (April 2016 to September 2016) showed that the patient outcomes and mortality were similar to benchmarked units nationally.
- Staff treated patients in a caring and compassionate way; maintaining their privacy and dignity at all times. Both relatives and patients were positive about their time in the unit and spoke highly of the way in which they had been cared for.
- Staff informed us they felt that there was an open and honest culture within the department. We observed all team members working well together during the inspection.

Are critical care services safe?

Requires improvement

We rated safe as 'requires improvement' because:

- We were not assured that critical care services were able to provide a member of staff who was up to date with advanced life support training on every shift. Advanced life support training for adults was not provided for any nursing staff. Additionally, only 55% of medical staff and 79% of acute response team staff had completed training updates at the time of inspection.
- At the time of inspection we were not assured that there were sufficient controls in place to prevent the service exceeding full capacity. This was because critical care services were not currently using a formal escalation policy.
- We were not always assured that the service had provided appropriate numbers of nursing staff to match the dependency of patients.
- Level 3 safeguarding training for children had not been provided for any critical care staff despite procedures being in place to admit adolescents (16 to 18 year olds). This was not in line with the intercollegiate document (safeguarding children and young people; roles and competencies for healthcare staff, 2014).
- We had concerns that incidents of mortality were not always being reviewed thoroughly or in a timely way.
- We found that patient records had not always been fully completed. This was because in a sample record check, the time that a patient had been admitted and a full medical review had not always been documented.
- There had been several occasions in February 2017 that fridges which were used to store medication had not always been checked in line with the medicines management policy.

However,

- There was evidence of a positive culture of reporting most types of incidents, both clinical and no-clinical. Critical care services had not reported any serious incidents or never events between January 2016 and February 2017.
- All care and treatment was led by a Consultant Intensivist.

- Records indicated that between April 2016 and September 2016, the number of hospital acquired infections had been similar to other services nationally.
- Controlled drugs were managed in accordance with national guidance. General medicines and patient's own medication were stored securely.
- Records indicated that overall compliance with mandatory training for nursing staff was 97%. This was above the Trust target of 90%.

Incidents

- The Trust had a policy for incident reporting which was available to all staff on the intranet. Staff knew how to locate this and were able to access it when required.
- Critical care services had not reported any serious incidents or never events between January 2016 and February 2017. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- Incident reports were completed electronically and staff knew how to use the system. All staff, including agency nurses and locum doctors, had access to this system. Staff gave us examples of types of incidents that had been reported, which included both clinical and non-clinical incidents.
- None of the staff that we spoke to were able to tell us about examples of near miss incidents having been reported. Near miss incidents are those which have not actually happened, but if they had, would have potentially caused harm to a patient, relative or a member of staff. Additionally, on reviewing incident reports between January 2016 and December 2016 there were no examples of these. This meant that there was a possibility that there had been missed opportunities for learning. However, the trust have provided evidence that some near misses are being reported and also that these have led to changes.
- We had concerns that incidents of mortality were not always being reviewed thoroughly or in a timely way. The service held monthly mortality review meetings that were used to review all patient deaths that had occurred in the unit. However, the management team informed us that four out of twelve of these meetings had been cancelled due to operational demand. Mortality reviews are important as they are used to identify any areas of improvement by reviewing the diagnosis as well as the care and treatment that had been delivered to the patient. Additionally, mortality reviews were not undertaken with members of multidisciplinary teams who had also been involved in the care of the patient. This meant that there was potential for learning opportunities to be missed.
- Between April 2016 and September 2016, there had been 97 incidents reported in total. Out of these, 59 had been graded as no harm, 37 as low harm and one reported as moderate harm. We found that these had been reviewed by the critical care services management team and had been allocated to appropriate people for further investigation when needed.
- There was no formal guidance detailing timescales in which a reported incident should be actioned and closed, although members of the management team informed us that they would do this as soon as possible. We reviewed how long this process had taken for incidents that were reported between October 2016 and February 2017 and found that there were some occasions when this had not been done in a timely manner. On 19 occasions it had taken 30 days or more to complete this process. On two occasions it had taken 40 days, and on one occasion, 125 days. This meant that we were not always assured that actions were taken to prevent further incidences of a similar nature in a timely manner.
- We found that a small number of incidents had been investigated in more detail using a concise investigation report or a route cause analysis (RCA) methodology. An RCA is a tool that is used to investigate an incident in more detail, helping staff identify the main causes of the incident and make improvements when needed. We reviewed a sample of completed RCA's and found that they had been completed in a timely manner, had action plans for areas that required improvement and timeframes within which they were to be completed.
- Staff confirmed that they had received feedback when they had reported an incident and were able to give us examples of when learning had been disseminated through meetings such as safety huddles which took place at the beginning of every shift.
- The Trust had a duty of candour policy which was available on the intranet. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant

persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. The management team understood this requirement but were unclear on when it should be formally discharged.

Safety thermometer

- Critical care services recorded incidents of hospital acquired harm including pressure ulcers, falls, catheter associated urinary tract infections and venous thromboembolism (blood clots).
- The service did not currently have a formal quality or safety dashboard that monitored patient harm. However, a monthly performance report was produced from the airway, breathing and circulation clinical business unit which included this information and was used to inform senior managers of any incidences or concerns. Data contributions were also made every quarter to the intensive care national audit and research centre (ICNARC) which allowed comparison with similar units nationally. Results from April 2016 to August 2016 showed that there had been a low number of incidences, which was similar to other units.
- The unit had an 'how are we doing' board which displayed the number of incidences of patient harm that had occurred in the unit. This was visible to members of the public as well as members of staff.
- There were examples of when the management team had taken positive action to reduce the numbers of patient harms. For example, there had been a high number of incidences of ventilator acquired pneumonia (VAP) in 2015. The management team had implemented a VAP 'always event' (always events are protocols which staff should follow for every patient). Subsequently, the number of reported VAP incidences had significantly reduced in 2016.

Cleanliness, infection control and hygiene

- There was a trust-wide infection and prevention control policy that was available on the intranet and staff knew how to locate it when needed.
- The trust had an infection control lead and there was an infection control link nurse who was involved in managing infection control in the unit. The management team completed a monthly infection control report which was presented to the Trust infection and prevention control sub-committee. This identified any incidences of hospital acquired infection as well as compliance with mandatory training and results from monthly audits.
- The unit submitted data on a regular basis to the Intensive Care National Audit and Research Centre (ICNARC). The latest validated report for the period April 2016 to September 2016 showed that there had been no reported incidents of methicillin-resistant staphylococcus aureus (MRSA) or clostridium difficile (CDIFF). There had been one reported blood stream infection. These results were better than comparable units nationally.
- The management team had introduced a process for reducing incidences of methicillin sensitive staphylococcus aureus (MSSA) in 2014. Records indicated that between April 2016 and December 2016, there had been no reported incidences of MSSA.
- Patients were screened regularly for infection and we saw that if tests returned positive that they were moved and managed in an appropriate doored cubicle.
- A housekeeper was available during normal working hours and was responsible for the general cleanliness and upkeep of the unit. We found the unit to be visibly clean and tidy. The housekeeping team communicated with the nursing staff so that the correct cleaning agents were used after a patient had left, and that they wore the correct personal protective equipment (PPE) when needed. Additionally, nursing staff were responsible for cleaning any equipment that had been used. We observed 'I am clean' stickers being used once equipment had been made ready for use.
- We observed a number of occasions when bed spaces were cleaned appropriately following patients being moved to a different area.
- Hand gel dispensers were located at all entrances to critical care and staff consistently reminded visitors to use them when entering and exiting the unit.
- We found that staff were compliant with 'bare below the elbow' guidance and that personal protective equipment (PPE) was used on a regular basis in line with trust policy. PPE was also provided for visiting relatives when needed.
- Sink units were available in every bed space and we saw staff washing their hands before and after treating patients.

- The unit completed hand hygiene audits on a monthly basis. Records indicated that between the periods of January 2016 and December 2016 levels of compliance were high, 100% on most occasions.

Environment and equipment

- Critical care was located on the first floor of the hospital, in close proximity to theatres. The service was secured with swipe card access and visitors had to gain access via an intercom.
- The main intensive care unit (ITU) was open plan and provided a spacious and light environment for patients requiring level 3 care. The high dependency area (HDU) was a separate six bedded area that included two rooms which produced positive or negative pressure, both of which had their own gowning areas for staff to wear the appropriate personal protective equipment (PPE) before entering. These were used to either isolate infectious patients or to manage patients who had a compromised immune system and were at risk of infection.
- The ITU and HDU areas met HBN-04-02 building standards. These are the building standards for critical care units as designed by the department of health. All of the bed spaces had equipment to manage a patient who required level 3 care so the environment could be 'flexed' to meet the needs of the patient. This was in accordance with the Department of Health (2000) guidelines.
- We sampled a range of medical equipment and found that appropriate service and portable appliance test (PAT) stickers were in place and in date. The Trust had an electronic biomedical engineering department (EBME) who were responsible for all equipment that was used within the service. Equipment servicing was monitored through the use of a spreadsheet which listed expiry dates for individual pieces of equipment.
- However, the service did not have a capital replacement plan for equipment. This meant that an individual business case had to be submitted for equipment that needed replacing. Additionally, the risk of equipment failure had been highlighted on the critical care risk register for over 12 months and the management team had recognised the need for two ventilators to be replaced as well as five monitors. A business case for these had not yet been submitted.
- The management team informed us that if there was an equipment failure, there was portable equipment that could be used, although not for a long period of time. This could potentially have an impact how many patients the service could safely manage. This had been highlighted on the departmental risk register.
- Critical care had four hemofiltration machines which were used to treat patients who required dialysis. Staff informed us that there were sufficient numbers of these to meet the needs of patients.
- The unit had several resuscitation and difficult airway trollies available for use. We found that all

equipment was in date and that they had been checked on a regular basis.

- Clinical waste was managed and stored appropriately. There were bins available for both domestic and clinical waste which were easily identifiable. There was also a separate system for infectious waste which was disposed of in a separate area.
- Sharps bins were appropriately stored and clearly labelled.
- There were hoists available to support staff when moving and handling patients. Moving and handling training was included for all staff in their annual mandatory training update.

Medicines

- The Trust had an up to date policy for the safe storage, recording of, administration and disposal of medicines. Staff were aware of this and were able to access it when needed.
- Incidents involving medicines management were recorded using the incident reporting system. Records indicated that between April 2016 and September 2016, there had only been 11 incidents reported. Examples of these included the incorrect route of administration, drugs not given and prescription errors. Eight of these incidents had been graded as no harm and three as low harm.
- Critical care services had access to a 0.5 whole time equivalent (WTE) pharmacist. The intensive care society guidelines (ICS) state that the standard should be 0.1 WTE per level 3 bed or per two level 2 beds. This meant that there was a shortfall of 0.8 WTE. There were no current plans to improve this.

- Staff informed us that the pharmacist for critical care services visited the unit three times per week to review patients' medication. They were also available outside of these times, which included an on call facility both during the night and at the weekend.
- We checked a sample of seven prescription cards and found that allergies were documented, that they had all been completed correctly and that there was evidence of pharmacist review in all cases.
- We observed three members of staff administering medicines. This was done following the correct procedures on all occasions.
- The unit had two locked clinical areas where general medicines were stored securely. A pharmacy technician visited the unit regularly to complete a stock check, reconcile any discarded medicines and re stock when needed. The hospital had an electronic medicines management system which allowed staff to source a drug from another ward if there was a shortage and a pharmacist was unavailable.
- Controlled drugs were managed in accordance with national guidance. We took time to check cupboards, finding that the quantity of drugs tallied with what was recorded in the register and that they were in date. Additionally, all records had been countersigned and the amount administered and disposed of had been recorded.
- Patient's own medication was stored appropriately in lockable cupboards which were available at each patient bedside. This medication was added to the patient's prescription card and administered by a member of staff. If a patient had a controlled drug, this was stored and recorded in one of the appropriate controlled drugs cupboards.
- Drugs requiring refrigeration were stored appropriately. Fridge temperatures were within normal ranges and on checking a sample of medicines we found that they were all in date. However, the medicines management policy stated that fridges should be checked daily. We found that for the month of February 2016, these checks had not been completed on 6 occasions in the main intensive care unit and on 12 occasions in the high dependency unit.

Records

- All patient records in critical care were paper based. This included admission and discharge forms, observation records, medical notes and risk assessments. When a patient was admitted, there was a designated member of staff who was responsible for adding the correct record templates to patient records for staff to complete.
- The hospital had recently introduced an electronic records system, but this had not yet been implemented in critical care. The management team informed us that there were plans for this in the near future and all staff were to receive appropriate training in its use.
- Patient records were stored securely at each patient bedside. All staff were responsible for updating these regularly, particularly when they had provided care and treatment or if anything regarding the patients' care plan had been amended.
- We sampled seven patient records and found that they had not always been completed correctly. For example, the time of admission was not documented in six of the records, which also meant that we were unsure if patients had been admitted within the 4 hour standard following the decision to admit was made. We also observed a consultant ward round, finding that medical notes were not being updated after the patients had been reviewed. This meant that it was unclear what the outcome of the patient review was.
- However, we found that patient observations, a diagnosis and management plan and the summary of events leading to admission were completed appropriately on all occasions.
- The Trust wide audit team completed a monthly records audit. However, the management team were unable to tell us about results from this. This meant that if there had been areas for improvement, there was a risk that the management team would have been aware and the required improvements would not have been made.
- When a patient was discharged from the unit, nursing and medical staff were responsible for completing separate discharge information sheets. This included all pertinent information, for example, about any pressure ulcers, mobility issues, nutritional needs and prescribed medicines. We observed two discharges from the unit and found that these records were completed fully on both occasions.

Safeguarding

- The Trust had an up to date safeguarding policy which was available on the intranet. Staff knew how to access this.

- The hospital had a safeguarding matron who was responsible for reviewing safeguarding referrals as well as providing support and advice to staff if they had any safeguarding concerns. We observed the safeguarding matron following up a patient that had been referred in a timely manner during the inspection.
- There was also a designated safeguarding link nurse for the unit. There were contact numbers for the on call local authority safeguarding team if referrals needed to be made during these times.
- We spoke to seven members of staff, all of who were able to give us examples of what they considered to be a safeguarding concern. We were informed that in the event of a concern, this would be escalated to the nurse in charge. When reviewing a sample of incident reports, we were able to find examples of when patients had been referred and reviewed appropriately.
- All critical care staff were required to complete safeguarding level 2 training for adults and children. Records indicated that 97% of staff were up to date with this at the time of inspection.
- There was a standard operating procedure for the management of adolescents (16 to 18 year olds). We were informed that on the rare occasion that an adolescent was admitted to the unit, a referral was made to the safeguarding matron and that they would be managed in a side room. However, no critical care staff (nursing or medical) had access to level 3 safeguarding training. This meant that if an adolescent was admitted to the unit for any length of time, they were not always cared for by a member of staff who had completed the appropriate training. This was not in line with the intercollegiate document (safeguarding children and young people; roles and competencies for healthcare staff, 2014).
- Staff in the unit did not currently have access to an electronic safeguarding flagging system that was being used in other parts of the hospital as all patient records were paper based. This would be used to alert staff if there was a safeguarding concern about a patient. Staff informed us that they were reliant on the nurse and medical handovers to transfer this information as part of the admission and discharge procedure. Safeguarding concerns were also discussed during the twice daily safety huddle.

Mandatory training

- There was a dedicated practice education facilitator for critical care services. They were responsible for monitoring compliance with mandatory training for all nursing staff.
- Training was available in two ways. Some modules were completed face to face and others on the intranet via e-learning. The Trust target for all training was 90%.
- Records indicated that overall compliance with mandatory training for nursing staff was 97%. This included topics such as hand hygiene, fire awareness and manual handling. Staff were required to complete these every twelve months.
- Immediate life support training for adults and children was included as part of the mandatory training programme for all staff. Staff completed this yearly and records indicated that 97% of staff were up to date with this.
- However, we were not assured that critical care services were able to provide a member of staff who was up to date with advanced life support training on every shift. Advanced life support training for adults and children was not provided for any nursing staff. Additionally, only 55% of medical staff and 79% of acute response team staff had completed training updates at the time of inspection.
- In addition to mandatory training, staff had been identified to complete role specific training. Compliance with this was generally high and included modules such as dementia awareness, mental capacity and conflict resolution training. However, records indicated that only 79% of staff had completed blood transfusion training.

Assessing and responding to patient risk

- Nursing and medical staff in critical care were trained in managing the deteriorating patient. A paper chart was kept at the end of every bed and included the patients' physiological signs such as blood pressure and pulse rate. This was used to identify if a patient had deteriorated over a period of time.
- There was an acute care response team (ACT) which included a number of doctors and nurses. They were led by members of the management team from critical care, providing 24 hour cover, seven days a week and were responsible for responding to deteriorating patients and medical emergencies throughout the hospital.
- The Trust used a track and trigger system to identify deteriorating patients. There was an operating policy for this which was available on the intranet. This system

used the national early warning score (NEWS) which was calculated using a range of basic physiological signs such as blood pressure, pulse rate and respiration rate. There were clear guidelines to follow for all staff in the hospital about when to escalate a deteriorating patient. For example, if a patient had a NEWS of 5 to 6, staff were to contact the ACT team immediately.

- Compliance with the track and trigger system was audited on a quarterly basis. Records indicated that audit results between September 2015 and March 2016 had been mixed. For example, there were areas of good compliance which included the NEWS being calculated correctly on 92% of occasions. However, patients had only been escalated to the ACT team appropriately on 25% of occasions. Additionally, observations had been increased accordingly for the same group of patients on only 45% of occasions.
- An action plan had been implemented to improve areas of low compliance. However, we found that the actions for improvement were not robust. Subsequently, we reviewed a similar audit undertaken between April 2016 and July 2016, finding that the areas of low compliance highlighted in the last report had not improved.
- There were two critical care outreach nurses who worked within the ACT team. They had support from a consultant intensivist and were available between 7.30am and 8pm, 7 days a week. Their roles and responsibilities in addition to those of the ACT team were following up discharged patients from critical care within 24 hours, as well as following up specific cohorts of patients such as those who had undergone surgery for a fractured neck of femur, had sustained fractured ribs, had an acute stage 3 kidney injury and patients who had a tracheostomy or laryngectomy. The main aim of patient follow ups was to prevent admission or readmission to critical care by managing a patients' condition on the ward.
- Records indicated that between January 2016 and December 2016 there had been 653 patients who had required follow up by the outreach team. For this period, only 82% of these patients had been seen. It was unclear if these patients had received a follow up visit within 24 hours as there was limited audit data available. The management team informed us that there were no formal plans to introduce this type of audit.
- All patients who had deteriorated in the hospital and required ventilation were managed in a stabilisation bay that was located in theatre recovery. There was a clear standard operating procedure (SOP) in place for staff to follow when this area was used. The SOP stated that patients should not be managed in this area for more than four hours and that all admitted patients should have input from a consultant intensivist.
- Most admissions to critical care had been completed within 4 hours from the decision being made to admit. However, there had been a number of occasions when admission had been delayed, which was mainly due to capacity issues.
- Records indicated that between January 2016 and December 2016, 37 patients had been managed in the stabilisation bay. Out of these, only 12 patients had breached the four hour standard, all of who were subject to an extended stay in this area which ranged between eight and 24 hours. This was important as it is recognised that delayed admission to critical care when needed is associated with a significant increase in both mortality and morbidity.
- We checked a sample of records for these incidences, finding that all patients had been reviewed by a consultant intensivist, in line with the SOP.
- Transfer equipment including a portable ventilator was available for use if a patient required transferring to another unit. Patient transfers were anaesthetist led and there was an operating department practitioner (ODP) who would support the transfer. All ODP's in theatre had undergone transfer training.

Nursing staffing

- There were sufficient numbers of staff at the time of inspection to provide safe care and treatment for patients who required both level 3 and level 2 care. Patients requiring level 3 care needed a staff to patient ratio of one to one and those needing level 2 care, one to two. The unit had been established to provide 13 registered nurses, a supernumerary co-ordinator, 3 healthcare assistants (daytime) and 2 healthcare assistants (evening), 24 hours a day, seven days a week.
- Critical care was also established for a supernumerary co-ordinator on every shift. This was compliant with intensive care society (ICS) guidelines which state that there should be a supernumerary member of staff for all units with more than 10 beds.

Critical care

- At the time of inspection we were not assured that there were sufficient controls in place to prevent the service exceeding full capacity. This was because critical care services were not currently using a formal escalation policy.
- This was important as an escalation policy identifies key actions that are taken in the event of the service approaching full capacity. The aim of this is to prevent a situation where there are insufficient numbers of staff to care for patients and to ensure that alternative arrangements are made for any potential emergency admissions when the unit is at full capacity. The management team were able to provide evidence of an escalation policy that was in draft, but had not been fully implemented at the time of inspection.
- Between January 2016 and December 2016, critical care services had reduced the number of available beds from 18 to 16. The management team informed us that this was because of a significant shortfall in the registered nursing establishment.
- The management team also informed us that they had struggled to meet the planned establishment on regular occasion and that they had informally reduced the planned number of staff from 13 to 12 registered nurses. However, the number of required registered nurses that had been specified in the admission policy had not been altered to reflect this.
- This meant that between October 2016 and December 2016, we were not always assured that the correct number of staff had been available to care for patients. During this period, there had been a number of occasions when occupancy rates had increased above 100%. The trust provided additional information for the period January to July 2017 to demonstrate that there were 11 further shift when the staffing did not meet the minimum numbers.
- The number of beds available had been increased back to 18 in January 2017, as there had been a successful recruitment drive for a significant number of registered nurses. However, at the time of inspection, 7 of these had not yet started. The management team informed us that despite the recent recruitment, there were still 2.46 WTE registered nurse vacancies.
- In January 2017 and February 2017, the correct number of staff had matched patient dependency on only 80% of occasions. We were informed that during periods of high occupancy, the co-ordinator or the nurse educator were used to uplift the staffing numbers when available, although there was no evidence of this on staffing reports.
- Additionally, the management team had calculated that there was a need of a further 8 WTE registered nurses to ensure that the correct number of staff were available on all occasions. This had been discussed informally, but a business plan for this had not yet been completed.
- Critical care services were also funded for three health care assistants for every shift. However, records indicated that between October 2016 and January 2017, this had not been achieved on most occasions. Staff informed us that the role of healthcare assistants was important as they completed jobs such as providing domestic care to patients, supporting them at meal times and assisting with repositioning patients. There were currently 3 WTE health care assistant vacancies.
- Staff sickness levels had reduced from 7.9% in February 2016 to 2.6% in January 2017.
- Critical care had relied on a high percentage of bank and agency staff between January 2016 and February 2017. The use of bank staff who were employed by the Trust had varied between 8% and 16%. However, the use of agency staff had reduced from 12% in January 2016 to 4% in February 2017 which was as a result of a recent recruitment drive.
- All agency staff received an induction which was completed by a member of the management team or a senior nurse. This included an orientation and an introduction to the systems and processes that were followed in the critical care service. All agency nurses that were used had critical care backgrounds. Compliance with mandatory training as well as disclosure and barring service (DBS) checks were completed by the agencies that they were employed by.
- We attended a safety huddle that all nurses attended at the beginning of every shift and was led by the shift co-ordinator. We found that this was well structured and was used to disseminate any issues or updates that staff needed to be aware of. Additionally, nurses then completed a handover of individual patients that they were responsible for.

Medical staffing

- Critical care had been established to provide eight consultant intensivists who covered 24 hours a day, seven days a week. The service planned to provide two

consultants between 8am and 5pm, Monday to Friday and one consultant between the same hours at the weekend. Outside of these hours a consultant was available on call and had sole responsibility for critical care. We were told that they were easily contactable and met the intensive care society (ICS) standard of being able to attend within 30 minutes if required.

- At the time of inspection, there was a consultant on maternity leave and there was one WTE vacancy which had been advertised for the last 12 months, but recruitment for this had been unsuccessful. This meant that all shift patterns had to be filled by six consultants. Medical staff informed us that they felt under pressure to fill these extra shifts.
- We reviewed medical rotas between October 2016 and January 2017, finding that the planned establishment of consultants had been met on most occasions. However, there had been a small number of times when the service had only been able to provide one consultant when the planned number had been two. Additionally, the consultant to patient ratio increased to 1:18 out of hours and at the weekend as there was only one consultant available. On these occasions, the ICS guideline of between 1:8 and 1:15 had not been met.
- Medical staff informed us that consultants were easy to contact out of hours, although it had been rare that they had to attend.
- There was not always evidence of patients having been reviewed twice a day by a consultant. This was not in line with ICS standards. All medical staff attended a morning ward round, 7 days a week. However, in the evenings, patients were not always reviewed fully. We sampled 42 completed day sheets for seven different patients, finding evidence of patient review on only 60% of occasions.
- Consultants were supported by a team of junior and middle grade anaesthetic doctors, two of who were always available 24 hours a day, seven days a week.
- The service met the ICS standard of having a maximum resident doctor to patient ratio of 1:8 available at night time. There were two resident anaesthetic doctors who were had sole responsibility for critical care. Additionally, there were two further on call anaesthetic doctors covering other specialities who were able to provide support if required.
- Critical care did not currently use locum doctors, but the Trust had an induction programme in place if needed.

Major incident awareness and training

- The Trust had an up to date business continuity policy as well as a local emergency preparedness resilience policy. Within this, there were specified roles that critical care staff would undertake in the event of a major incident. There were action cards which included specific prompts for staff to follow. However, the paper versions of these that staff knew how to locate had been out of date since 2007. Additionally, major incident training had not been provided for critical care staff to attend.
- All staff were required to complete fire safety as part of their annual mandatory training update. This included evacuation plans in the event of an emergency. There had been checks completed by the fire warden and risk assessments were up to date. However, no scenarios had been undertaken, for example, to simulate the practicalities of evacuating a ventilated patient.
- There was access to a back-up power generator in case of a power failure. We were informed that this was subject to regular testing by the hospital maintenance team.

Are critical care services effective?

Good

We rated effective as 'good' because:

- The unit used a combination of best practice and national guidance to determine the care that they delivered. These included guidance from the National Institute for Health and Care Excellence (NICE) and the Intensive Care Society (ICS).
- The most recently available and validated ICNARC data (April 2016 to September 2016) showed that the patient outcomes and mortality were similar to benchmarked units nationally.
- The unit had an induction policy and a robust induction programme for new staff to complete. All new staff completed a corporate induction and were assigned a named mentor. They were also given a list of key competencies to complete.

- There were a number of nursing and medical handovers each day. These included safety huddles which were used to disseminate any important information to staff. We attended one of these and found it to be both structured and informative.
- Staff gave appropriate examples of when a mental capacity assessment was required and how this would be completed. They were also able to describe the process to instigate a DoLs, although this did not apply to critical care patients on a regular basis.

However:

- There were a range of local policies, standard operating procedures and clinical guidelines that were out of date. This meant that there was a risk of them not reflecting up to date guidance.
- Critical care did not have a formal multidisciplinary team meeting in which all members of the team would attend. Additionally, all team members did not attend the daily ward round. This meant that nursing and medical staff had to handover patient information informally when needed.
- Staff had an awareness of the Mental Capacity Act (MCA) and DoLs. However, we saw that on one occasion there had been no consideration to undertake a full MCA assessment.
- We found that the malnutrition universal screening tool (MUST) was not consistently being used.

Evidence-based care and treatment

- The unit used a combination of best practice and national guidance to determine the care that they delivered. These included guidance from the National Institute for Health and Care Excellence (NICE) and the Intensive Care Society (ICS).
- There were a range of local policies, standard operating procedures and clinical guidelines that were available for staff to follow. We checked a sample of these, finding that the majority which were paper based were out of date, with the date of expiry varying between 2012 and 2015. This meant that there was a potential risk that these did not always reflect up to date guidance. A member of nursing staff was currently in the process of going through all of the standard operating procedures, updating them and adding them to the electronic system for staff to access.
- Critical care had an annual audit programme. Compliance with most evidenced based guidance was measured through a number of audits which benchmarked performance against the required standard.
- Results from these were positive in the majority of areas. For example, between January 2016 and December 2016, compliance with urinary catheter insertion was 100% and compliance with peripheral cannula insertion was 95%. However, there were areas of varied compliance, such as compliance with ventilator bundles and standards of tracheostomy care. A formal action plan to make improvements had not been implemented, although we did see that some positive actions had been taken. This included reminders to follow the tracheostomy care checklist that was available for all staff to follow.
- However, audits measuring compliance with national guidelines such as NICE CG83 (rehabilitation after critical illness) had not been undertaken fully. This meant we were unsure how effective rehabilitation had been in the past 12 months and that there was the potential for missed opportunities for learning which could lead to service improvement. However, an audit measuring compliance with this had recently started, although there had not been any official results or actions for improvement produced at the time of inspection.
- The unit made regular data contributions to the Intensive Care National Audit and Research Centre (ICNARC). This meant that the service compared the care delivered and mortality outcomes with similar services throughout the country. The unit had an audit clerk who was responsible for collecting and making data contributions.
- The service was also a member of the Cheshire and Mersey Critical Care Network (CMCCN). This meant that they were subject to an annual peer review which assessed a range of standards applicable to critical care.
- A peer review had been undertaken for 2016/17, but this had not yet been published. The 2015/16 report stated that the service was 94% compliant with the required service specifications. This was similar to other services within the network. The review had highlighted areas for improvement. These included recommendations to improve flow from critical care, reduce delayed discharges, employ a full time practice educator and

increase the number of allied health professionals, particularly physiotherapists and dietitians. The management team were able to identify these gaps, although a formal action plan for improvement had not been devised.
- Critical care had adopted the sepsis 6 tool that had been implemented trust wide in response to a national confidential enquiry into patient outcome and death (NCEPOD 2015). Staff were aware of their responsibility to seek urgent medical review for patients who showed signs and symptoms of sepsis.

Pain relief

- We reviewed a sample of seven patient records and found that all patients in the unit had been assessed in regard to pain management. Staff used a pain scoring tool alongside observing for the signs and symptoms of pain.
- Pain management was led by the consultant intensivists. Additionally, the Trust had a specialist pain management team who were available for support and advice throughout the week.
- Patients and relatives that we spoke to confirmed that they felt pain had been managed appropriately.

Nutrition and hydration

- Guidelines were available for nutritional support for all patients on admission. This was to ensure that they received adequate nutrition and hydration. There was fluid balance monitoring for patients which included daily totals of input and output. We reviewed seven patient records and found that these had been completed appropriately.
- We were informed that there was access to a dietetic service and there was usually one WTE dietitian available for critical care. This indicated a 0.5 WTE shortfall against ICS standards. Additionally, the dietitian was currently on long term absence. Staff informed us that because of this, a dietitian only visited the unit to review patients twice per week and that referrals had to be made if support was required outside of these times.
- We found that the malnutrition universal screening tool (MUST) was not consistently being used. We saw one example of a patient who was acutely unwell. Despite medical consideration that a naso-gastric tube (a tube which is inserted into the stomach) should be inserted to assist with feeding, an appropriate referral to the dietetic service had not been made and that the MUST had not been completed. However, we were assured by staff that the patient was receiving appropriate levels of nutrition.
- If a dietitian was unavailable, there was a folder available for staff to use providing clear guidance and protocols to follow including guidelines for the use of prabinex, which was the main nutritional supplement used for patients.
- All patients had their weight measured on admission. This was done as an actual weight if the patient was mobile. Otherwise, a patients' weight was estimated following best practice guidance.

Patient outcomes

- The most recently available and validated ICNARC data (April 2016 to September 2016) showed that the patient outcomes and mortality were similar to benchmarked units nationally.
- Between April 2016 and September 2016 the unit performed similar to comparable trusts for early readmissions to the unit (within 48 hours of discharge). The unit's performance for late readmissions (after 48 hours) was also consistently similar to other trusts. This was important as it measures how safely patients were discharged from critical care and how effectively they had been managed outside of the unit, particularly if they have had a period of deterioration.
- Records indicated that the number of times patients had received cardiopulmonary resuscitation was consistently similar to that of comparable units.

Competent staff

- There was one whole time equivalent (WTE) practice education facilitators that were employed by the unit. They were responsible for organising staff training (including mandatory training) and appraisals.
- All nursing staff that worked in the unit were assigned to a team that had a band 7 lead and were responsible for completing appraisals for their staff. Nursing staff had an appraisal every year so that they had the opportunity to discuss their progress and training needs. We saw that 85% of nursing staff were up to date with this at the time of the inspection. This met the trust target which was also 85%.
- The unit had an induction policy and a robust induction programme for new staff to complete. All new staff completed a corporate induction and were assigned a

named mentor, had a list of key competencies to complete and were given between a four and six week supernumerary period (this meant that they were not included in the daily staffing numbers to look after patients so that they could learn). Following this period, all nursing staff were required to complete ICU step one competencies over a period of 12 months. This included a number of assessments that included topics such as the use of equipment and the safe administration of medicines.

- All nursing staff were subject to an annual check of their registration with the Nursing and Midwifery Council (NMC).
- 48% of the trained nurses on the unit had achieved a post registration award in critical care. The Intensive Care Society standard was 50%. The management team informed us that a critical course was held at a local university. However, they had only secured two places for staff to attend on the next available course despite submitting a business case for eight members of staff.
- Critical care staff had access to a simulation suite that was based at the Halton site. This was used to simulate scenarios such as managing the deteriorating patient and resuscitation.
- The use of agency staff had varied between January 2016 and December 2016. We were informed that regular staff were used when possible so that they were aware of local policies and procedures. We saw evidence of local induction checklists being completed for agency staff.
- Members of the outreach team ran training sessions that included topics such as managing the deteriorating patient and tracheostomy care. Staff from other departments told us that this training enabled them to manage patients that had been discharged from the unit with confidence. This was available to staff of all levels from the unit and throughout the rest of the hospital.
- Regular training days for medical staff were facilitated on a rotational basis by the trust wide educational team. Medical staff stated that they were well supported and had a good appraisal and revalidation process with good opportunities for training.

Multidisciplinary working

- There were a number of nursing and medical handovers each day. These included safety huddles which were used to disseminate any important information to staff. We attended one of these and found it to be both structured and informative.
- A member of the management team attended a hospital bed meeting in the morning and further meetings through the day if required. This supported with access and flow in critical care services, although staff informed us that it was difficult to facilitate timely discharges on a regular basis.
- A member of the critical care outreach team was responsible for following patients up who had been discharged to a ward. We spoke to a number of staff on various wards, who spoke highly of the support that they received from the outreach team. Staff informed us that they felt that the outreach service was effective at stabilising and managing patients outside of critical care. However, audits were not currently being completed to measure the effectiveness of this service.
- There was a microbiology ward round which took place in the afternoon, between Monday and Friday. A microbiologist was also available on call 24 hours a day, seven days a week if advice was needed. Microbiology ward rounds are important as the use of antibiotics are reviewed, as well as compliance with infection control management. However, the service did not currently include an antimicrobial audit as part of their annual audit plan.
- Referrals were made for patients who required input from an occupational therapist or a speech and language therapist. These services were available Monday to Friday, during normal working hours. There were protocols in place for staff to follow when these services were unavailable, for example if a swallowing assessment needed completing.
- Patients who had undergone surgery received regular input from surgical staff during their stay in critical care. Additionally, there was input from medical staff if required.
- Critical care did not have a formal multidisciplinary team meeting in which all members of the team would attend. Additionally, all team members did not attend the daily ward round. This meant that nursing and medical staff had to handover patient information informally when needed. The management team had not made any plans to introduce multidisciplinary team meetings.

Critical care

Seven-day services

- A consultant intensivist was available seven days a week, including on call outside of normal working hours.
- There were pharmacy, dietetic and physiotherapy services available between 9am and 5pm from Monday to Friday. Outside of normal working hours, there was an on call facility for these services if required.
- Additionally, there were speech and language therapists as well as occupational therapists available during normal working hours. However, they did not visit critical care routinely. This meant that referrals had to be made if patient input was needed.
- Staff informed us that there were no problems in obtaining diagnostic or laboratory support when required. The service met the most of the NHS services, seven days a week priority clinical standards. These state that there must be access to services such as ultrasound, computerised tomography (CT) and magnetic resonance imaging services (MRI). However, the hospital were unable to provide a seven days a week service for echocardiography (a scan of the heart).

Access to information

- Critical care used paper based records. This included patients' physiological signs, medication charts and all medical notes.
- The Trust were in the process of introducing a new electronic records system. However, at the time of inspection, this had not been implemented in critical care. The management team informed us that plans were in place for this and that staff would receive training prior to its implementation.
- Staff had access to care bundles and patient pathways. When a patient was admitted, the necessary paperwork was added to patient records. There were paper copies of policies and procedures available, although staff were in the process of updating and adding these to the intranet.
- Staff were able to access diagnostic test results such as x-rays and blood test results on an electronic system.
- On discharge from the unit, a paper nursing and medical summary was completed and handed over to the relevant medical teams. It was the responsibility of the ward staff to transfer any relevant information on to the electronic system if a patient was transferred to an area of the hospital that used the electronic records system.
- If a patient was discharged home, they were provided with a discharge letter. A copy of this was also sent to the patients' GP. This included information about the care and treatment that had been provided, as well as any new medications that had been prescribed.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- There was a Trust policy for best interest decisions, mental capacity and deprivation of liberty safeguards (DoLs). This was available on the intranet and staff were able to locate this.
- Staff gave appropriate examples of when a mental capacity assessment was required and how this would be completed. They were also able to describe the process to instigate a DoLs, although this did not apply to critical care patients on a regular basis. Mental capacity act training was available for all nursing and medical staff.
- However, we saw on one occasion there had been no consideration to undertake a full two stage mental capacity assessment for a patient, despite them having regular periods of confusion and refusing treatment. A mental capacity assessment is used to evaluate if a patient is able to retain and use the information given to them when making a decision about their treatment.
- Light restraint was used if a patient became agitated during their stay. We saw that incidences had been reported regularly using the electronic reporting system in line with the Trust policy. However, staff had not received formal training in the use of light restraint. This meant that there was a potential risk of avoidable patient injury, although staff informed us that they sought support from security who had undergone appropriate training if required.
- Hand mitt restraints were used for agitated patients and there was an operating procedure that met national guidance for their use. These were designed to prevent patients from removing tubes and wires that were attached to them.
- The unit used a confusion assessment method for intensive care units (CAM-ICU). This was used in association with the Ramsay score (RSS) which measure the agitation or sedation level of a patient. The CAM-ICU

tool uses yes and no questions for non-speaking mechanically ventilated patients. We reviewed seven patient records, finding that this had been used correctly on two out of three occasions when it was required. The management team had not audited the use of this tool.

- Sedation breaks were implemented when appropriate. A sedation break is where the patient's sedative infusion is stopped to allow them to wake and has been shown to reduce mortality and the risk of developing ventilator related complications. The sedative was then re-started if the patient became agitated, was in pain or showed signs of respiratory distress.

Are critical care services caring?

Good

We rated caring as 'good' because:

- Staff treated patients in a caring and compassionate way; maintaining their privacy and dignity at all times. Both relatives and patients were positive about their time in the unit and spoke highly of the way in which they had been cared for.
- Staff communicated with patients and relatives effectively ensuring that they understood all aspects of the care and treatment that was being provided.
- The Trust held an annual memorial service for relatives and friends of patients who had passed away in critical care services. Staff informed us that this had been well attended.
- We saw positive examples of staff providing emotional support to relatives, explaining information about a patients' condition in a way in which that they were able to easily understand.

Compassionate care

- Staff took steps to ensure that patients' privacy and dignity were maintained at all times. We saw that when treating a patient the curtains were fully drawn around the cubicle. The side rooms also had curtains around the bed spaces and were used when required.
- We saw both nursing and medical staff comforting and communicating with patients on a regular basis. The unit tried to ensure that patients' were looked after by the same members of nursing staff and this was done whenever possible.
- We saw examples of patients regaining consciousness and staff managing them in a compassionate way ensuring that they did not become agitated.
- We spoke to a number of relatives who all spoke very highly of the quality of care that their loved ones had received. One relative told us that "staff were excellent and that they would do anything to help".
- There was a member of staff who had recently been awarded employee of the year by the Trust. They had co-ordinated and facilitated a complicated discharge for a patient who had been in critical care for a long period of time.

Understanding and involvement of patients and those close to them

- Staff communicated with relatives on a regular basis, discussing treatment plans and allowing them to be involved in their relatives care. Relatives that we spoke to told us that they were aware of their loved ones condition and that this information had been communicated in a clear manner.
- We reviewed a sample of patient records and found documented evidence that care and treatment had been discussed with family members. During the inspection we also saw examples of relatives being involved in decision making processes.
- The unit had introduced the use of patient diaries which were used for patients who were sedated. Intensive Care patient diaries are simple but valuable tools which help recovering patients come to terms with their experience of critical illness. The diary is written by healthcare staff, family and friends. Research has shown that patient diaries help prevent depression, anxiety and post-traumatic stress.
- There was an annual memorial service held for friends and relatives of patients who had passed away in critical care. Staff informed us that this had been well attended. We saw examples of when relatives had provided positive feedback about this, thanking staff for everything that they had done.

Emotional support

Critical care

- Conversations regarding a patient's condition, care and treatment and prognosis were managed in a sensitive way. We saw an example of treatment being withdrawn and relatives being communicated with in a clear and compassionate manner by members of staff.
- Staff provided emotional support to patients who were having their levels of sedation reduced. Staff recognised that patients could become agitated during this period and provided constant reassurance to them.
- There were a number of private rooms that were used to give relatives privacy when needed. We saw examples of these rooms being used by staff when discussing information about patients with visiting relatives.
- The trust had a chaplaincy service who offered emotional support to patients and relatives. This service was available 24 hours a day, 7 days a week.

Are critical care services responsive?

Requires improvement

We rated responsive as 'requires improvement' because:

- Between March 2016 and December 2016, occupancy rates had been consistently high, with monthly averages ranging from between 78% and 96%. We also found that on a high number of occasions, daily occupancy had exceeded 100%.
- The unit had struggled to meet the standard set by the Department of Health in managing mixed sex accommodation appropriately. We saw examples of this during the inspection.
- Records indicated that between January 2016 and December 2016, there had been 75% delayed discharges (greater than four hours following the decision being made that a patient is fit for discharge to a ward).
- Critical care were unable to provide accommodation for relatives. However, staff informed us that they had access to folding beds if required, although there was no access to facilities such as a shower room for relatives who wanted to stay.
- There had been a low number of complaints made about critical care services between January 2016 and December 2016. However, we found that these had not always been managed in a timely way.

However:

- We saw a positive example of staff interacting and managing a patient with learning disabilities. This included providing extra support and resources for the duration of their stay.
- The palliative care team had undertaken training sessions for medical and nursing staff and were available to provide additional support to staff when managing patients who were at the end of life.
- The trust provided a chaplaincy and a bereavement service to support relatives and patients when required.

Service planning and delivery to meet the needs of local people

- The unit had struggled to meet the standard set by the Department of Health in managing mixed sex accommodation appropriately. This standard states that this criteria does not apply to patients who require level 2 or level 3 care. However, when a patient requires level 1 care and a decision to discharge the patient has been made, they should be provided with same sex accommodation.
- This was a regular issue because of the design of the unit and a high number of delayed discharges. We saw four examples of this during the inspection. There was access to two doored cubicles, which were often unavailable to support staff in managing mixed sex accommodation. However, when these incidences had occurred, they had been escalated and reported appropriately using the electronic reporting system. Additionally, the service had recently introduced an escalation plan for staff to follow in the event of a delayed discharge. This was to support staff in reducing the number of mixed sex breaches.
- Also, there was limited access to bathroom facilities for patients. These were located near the main entrance, which meant that if patients from the high dependency area required the bathroom, they had to walk through the open plan intensive care area.
- Staff discussed the possibility of same sex accommodation on admission so that they were aware that there had been breaches of this standard. When patients were subject to same sex accommodation, they were asked to complete an impact questionnaire which had been designed to measure how much they been affected by this. Staff informed us that there was a clear mental impact to patients. This was because they were able to observe other critically ill patients during their wait.

- There were two rooms for relatives that were available to use as waiting areas or meeting rooms. These areas were used to maintain the privacy of friends and families, either while they were waiting to see a patient or if medical and nursing staff wanted to speak to them privately.
- Critical care were unable to provide accommodation for relatives. However, staff informed us that they had access to folding beds if required, although there was no access to facilities such as a shower room for relatives who wanted to stay.
- There was limited access to a nurse led follow up clinic for patients who had been discharged from critical care. The management team informed us that the process had been recently changed as the attendance of these clinics had been low. The current criteria for attendance was for patients who had required level 3 care and had stayed in the unit for three days or more. However, as there was only one nurse available to run this service, not all patients who met the criteria were given appointments. When a clinic was facilitated, a member of the psychology team also attended so that a further referral could be made if required.
- The service had links with a local home ventilation unit. Home ventilation units are used for patients that require longer term care or have problems weaning (coping with the withdrawal of artificial ventilation).

Meeting people's individual needs

- There was a nurse lead for delirium management. However, there had not been a specific audit of the total number of incidences of delirium or compliance with the use of the CAM-ICU tool which was used to measure the confusion and agitation levels of patients. We reviewed incident reports between January 2016 and December 2016, finding that there had been a high number of patients who had become agitated during their stay in critical care. When asked, the management team were unaware of this. This meant that there was the potential for service development opportunities being missed as well as incidences of delirium that could have potentially been avoided.
- However, we found that staff were aware of the issues around sensory and sleep deprivation in the critical care environment and adjusted the lighting to simulate the difference between day and night time. Additionally, monitors were silenced to reduce the noise during protected sleep times for patients which was in line with the standard operating procedure (SOP) for delirium prevention and management.
- All patients who required care and treatment in the unit for over 72 hours were provided with a patient diary. Patient diaries had been developed to support patients reflecting retrospectively on their period of being sedated during critical illness. Patient diaries are written for patients during their time of sedation and ventilation. It is written by relatives, nurses and others. The patient can read their diary afterwards and is more able to understand what has happened.
- The Trust had a strategy for supporting patients who lived with dementia. Records indicated that 56% of staff had completed dementia awareness training. However, 'this is me' documentation was not currently being used, despite this being implemented across the Trust.
- We saw a positive example of staff interacting and managing a patient with learning disabilities. This included providing extra support and resources for the duration of their stay. However, there was no evidence of a learning disability passport being used. This was important as patient passports travel with patients and inform staff of their individual need, such as how best to communicate with them and any other special requirements that they may have.
- The palliative care team had undertaken training sessions for medical and nursing staff and were available to provide additional support to staff when managing patients who were at the end of life. A standardised document had been introduced for patients, which replaced all other documentation when they had been placed on this pathway. This document contained important aspects of care, including nutrition and hydration, mouth care and regular repositioning.
- We saw one occasion when this documentation had been used, however, we found that it had not always been completed correctly. This was because there was a limited documentation of patient checks having been completed at the required intervals.
- The trust provided a chaplaincy and a bereavement service to support relatives and patients when required. Chaplains visited critical care to support patients and relatives when needed and there was a multi faith room available for patients and relatives to use.

- There was a translation service available and an interpreter was able to attend the unit if needed. Advice leaflets in a range of different languages were available on request.

Access and flow

- Critical care services had an admission and discharge policy which was available on the intranet. The admission policy listed the procedures for staff to follow for elective and emergency admissions as well as the management of maternity admissions.
- A member of the management team attended daily hospital bed meetings to discuss access and flow to and from the service. Staff informed us that access and flow issues in critical care were usually as a result of the wider problems that the hospital faced.
- Between March 2016 and December 2016, occupancy rates had been consistently high, with monthly averages ranging from between 78% and 96%. We also found that on a high number of occasions, daily occupancy had exceeded 100%.
- Between January 2016 and December 2016, there had been 37 occasions when patients requiring ventilation had experienced a delay in admission to critical care. 12 of these patients had experienced delays between four hours and 24 hours. 11 of these patients had subsequently been transferred to another critical care service.
- If an agreed admission to critical care had been delayed, patients requiring ventilation were managed in the 'stabilisation bay' which was located in theatre recovery. There was a standard operating procedure (SOP) for staff to follow in the event of this happening.
- Additionally, theatre staff informed us that there had also been a low number of occasions when there had been a delay for patients requiring level 2 care (patients who were not ventilated) following surgery.
- Between January 2016 and December 2016, there had been 5% of operations (four out of 79) cancelled as a result of critical care being at full capacity. This was in line with the NHS standard which states that no more the 5% of elective surgical procedures should be cancelled.
- Records indicated that between January 2016 and December 2016, there had been 75% delayed discharges (greater than four hours following the decision being made that a patient is fit for discharge to a ward). The majority of these patients waited for more than four hours but less than 24 hours. However, out of 653 discharges, 116 patients had been delayed for between 24 hours and 48 hours and 38 patients had waited for longer than 48 hours.
- During the same period, there had been 27 out of hours discharges (between 10pm and 7am). This data had been submitted to the Intensive Care National Audit and Research Centre (ICNARC). Results indicated that this was better than similar services nationally.
- A small number of patients were able to be discharged home following their stay. There were protocols in place for staff to follow in the event of this happening.
- The management team informed us that if there was capacity, level 1 patients were accepted from other areas of the hospital, particularly at times when they faced high demand. Examples of this included patients who required non-invasive ventilation. This was as a result of the respiratory ward being at full capacity. However, there was no formal procedure for admitting and managing these types of patients in the admissions policy.
- The management team informed us that they had considered ways in which to alleviate the pressure from critical care. However, there was no evidence of any formal plans for improvement. Additionally, access and flow had not been identified as a formal risk and had not been highlighted on the departmental risk register.

Learning from complaints and concerns

- The Trust had an up to date complaints policy that was available on the intranet. Staff were able to access this when needed.
- We were informed that any concerns or complaints were escalated to the nurse in charge. There was written information available in waiting areas informing relatives of the process to follow if they wanted to make a complaint.
- There had been a low number of complaints made about critical care services between January 2016 and December 2016. However, we found that these had not always been managed in a timely way. An example of this was a complaint being logged in June 2016, but remained open in November 2016. All formal complaints were investigated by the Trust wide team.

Critical care

- The management team informed us that when complaints had taken an extended period of time to investigate, any learning was disseminated as soon as possible through daily safety huddles which all staff attended.
- Between January 2016 and December 2016, no complaints had been referred to the Parliamentary and Health Service Ombudsman (PHSO). Referrals of complaints to the PHSO are made if the person making the complaint feels that the outcome of an investigation undertaken by the Trust has been unsatisfactory.
- We saw evidence of complaints and concerns having been discussed as part of the monthly governance meetings. This was a set item on the agenda.

Are critical care services well-led?

Good

We rated well-led as 'good' because:

- The Trust had an overall vision and strategy. The management team in critical care were able to identify with this.
- Critical care services had a clear leadership structure. All leaders were visible during the inspection and staff told us that they were both approachable and supportive.
- Staff informed us they felt that there was an open and honest culture within the department. We observed all team members working well together during the inspection.
- Staff said that patient care was the priority and that they felt this view was shared by staff throughout the department.

However,

- We found that on occasions appropriate actions had not always been taken in a timely way to mitigate the level of risk and there were a number of risks that had not been formally identified.
- We found that on a number of occasions between October 2016 and February 2017 there were occasions when reported incidents had not been actioned and closed in a timely manner.

Vision and strategy for this service

- The Trust had an overall vision and strategy. The three core elements to this were quality, people and sustainability. Additionally, the Trust had a five year forward plan which highlighted key areas for improvement. The management team in critical care were able to identify with this.
- Critical care had a formal vision and strategy to improve the services provided. This was included as part of the divisional business plan. However, it was unclear how this strategy was being monitored and measured. This was because the management team informed us that they were unaware of plans to implement a formal improvement strategy.
- Staff informed us that they were not sure what the vision and strategy for critical care was but were able to give some examples of improvement initiatives. Staff felt that they provided an excellent service for patients.

Governance, risk management and quality measurement

- Critical care had access to an electronic risk management system which held the departmental risk register. This had been reviewed periodically during 2016. A member of the critical care nursing team was responsible for adding identified risks and putting mitigating actions in place. All identified risks were scored and had a date for further review. The management team were able to identify the key risks that were listed on the system.
- However, we found that appropriate actions had not always been taken in a timely way to mitigate the level of risk for those which had scored highly. An example of this was the risk of medical device failure which could impact on patient safety. This had a risk score of 15 and had been identified in February 2016, although no formal actions had been taken to reduce the level of risk posed at the time of inspection.
- Additionally, there were a number of risks that had not been identified. For example, a risk of delayed admission to the service due to poor access and flow, breaches of the mixed sex accommodation standard and low levels of compliance with advanced life support training. Also, the risk to patient safety by reducing the number of beds in critical care during 2016 had not been considered as a formal risk.
- Despite these risks not being formally highlighted, there was evidence that the management team had taken

some actions. For example, there was a draft escalation policy which was in the process of being implemented and there was an escalation plan in place for staff to follow in the event of a delayed discharge.

- If a risk in critical care scored above 12, it was added to the divisional risk register, although this system was reliant on all risks being identified at departmental level. We were therefore unsure if the senior management team were fully aware of all the issues that critical care currently faced.
- The unit held several divisional and departmental meetings every month which discussed a variety of topics. We sampled minutes of the management meetings, finding that they had been well attended and were well structured. There had been discussions about topics such as incidents, complaints, safeguarding concerns and adherence to NICE guidance.
- Monthly performance reports were produced by the airway, breathing and circulation clinical business unit (CBU). This included some safety information for critical care services and was sent to the senior management team for review.
- All clinical incidents that had been reported were investigated by a member of the management team. The critical care management team were supported by a risk manager from the airway, breathing and circulation CBU as well as the Trust risk management team.
- However, we found that on a number of occasions between October 2016 and February 2017 there were some occasions when this had not been done in a timely manner. On 19 occasions it had taken 30 days or more to complete this process. On two occasions it had taken 40 days, and on one occasion, 125 days. This meant that we were not always assured that actions were taken to prevent further incidences of a similar nature in a timely manner.
- There was an audit calendar for critical care services which was primarily based on data that was required for submission to the Intensive Care National Research and Audit Centre (ICNARC). This included compliance with care bundles such as the insertion of catheters and central lines. However, the management team did not collect data for other key areas. For example, there had not been formal audits measuring the effectiveness of the critical care outreach team, compliance with NICE guideline CG83 (rehabilitation after critical illness) and delirium prevention which included the use of the CAM-ICU tool. This meant that the management team had limited oversight of these areas and also meant that there was the potential for missed learning opportunities.

Leadership of service

- Critical care operated under the clinical business unit (CBU) of airway, breathing and circulation. The CBU had a clinical lead, a risk manager and a newly appointed operations manager.
- The service had a matron and a consultant clinical lead who were responsible for overseeing critical care and reported into the CBU. They both had a critical care background and had worked in the unit for a number of years. They also ran the acute care team (ACT) who were responsible for responding to emergencies and following up patients that had been discharged from the unit.
- The service had a practice educator facilitator who had a critical care background and was responsible for overseeing training and development within the department.
- All leaders were visible during the inspection and staff told us that they were both approachable and supportive.
- Critical care was established for a supernumerary co-ordinator on every shift. They were responsible for managing the operational aspects of the unit on a daily basis. This was in line with and met the Intensive Care Society (ICS) guidelines. However, staff informed us that during periods of high occupancy, they were sometimes included in the overall staffing numbers which meant that they were not able to undertake there supervisory responsibilities effectively during these times.
- In addition to the management team, there were a number of band 7 nurses who had been allocated team members, including two band six nurses and a number of band 5 nurses. The band 7 nurses worked closely with the management team and were responsible for disseminating information and completing the appraisals for the members of their team. They were also named mentors for new starters.

Culture within the service

- Staff informed us they felt that there was an open and honest culture within the department. We observed all team members working well together during the inspection.

- Staff said that patient care was the priority and that they felt this view was shared by staff throughout the department.
- We were informed that over the last 12 months there had been a high use of agency and bank staff which had been due to staffing shortages. Additionally, the service had been consistently close to full capacity and that this had sometimes been exceeded. Staff told us that this had made critical care a stressful place to work. However, they were more positive following a recent recruitment drive as they had seen a difference in staffing numbers.
- This was reflected in sickness rates decreasing from 7.9% in February 2016 to 2.6% in January 2017. Additionally, during the same period, staff turnover had also consistently decreased from 7.9% in February 2016 to 4.1% in January 2017.
- Between January 2016 and December 2016 results from the trust-wide friends and family test showed that 96.5% of staff that completed the survey would recommend critical care as a place to work. However, the number of staff that had completed this on a monthly basis was low.

Public engagement

- The unit had undertaken patient and relative satisfaction surveys to improve the services that were provided. This data was submitted to the Cheshire and Mersey Critical Care Network (CMCCN) on a bi-yearly basis. The results from a survey undertaken in March 2016 were not available at the time of inspection. Questions that were usually asked as part of this survey included 'were you kept up to date with your relatives condition' and 'did you feel that your relatives' privacy and dignity was maintained'.

Additionally, all patients were given a Trust satisfaction survey to complete when they were discharged from the hospital.

- Staff gave patients an impact questionnaire to complete if they had been subject to a breach of the Department of Health mixed sex standard. This was used to assess how much they had been affected by this. Results from this were used when possible to improve service delivery.

Staff engagement

- The management team had organised a 'Big ICU Day' event which was held on an annual basis. This event had been used to discuss the service with all staff and had been well attended. Following the last event, the management team had agreed and implemented two 'always' events, for the prevention of ventilator acquired pneumonia (VAP) and a checklist for the care of patients with tracheostomies. These were both in use at the time of inspection.
- Information was cascaded to staff through a number of different methods. It was done by email, information in staff areas, daily huddles, team meetings and appraisals. However, we were informed that there was a monthly nurses meeting but this had not been facilitated regularly due to the unit being at full capacity.
- The management team completed an annual 'temperature check' to measure satisfaction of staff who worked in the unit. Additionally, any staff who left critical care were asked to complete a leavers interview. However, staff informed us that in 2016, there had not been any leavers who had attended this. Leavers interviews are important as it helps the management team understand if there are specific reasons why staff want to seek employment elsewhere.

Innovation, improvement and sustainability

- The practice education facilitator had developed a new recruitment programme for nursing staff. They were required to undertake a simulated exercise using the simulation suite as part of the process to test if they had the correct competencies for the role. This had been presented at the British Association of Critical Care Nurses (BACCN) conference and had received positive feedback.
- The service had been recently shortlisted in the Nursing Times Awards for its vision, leadership and commitment to delivering enhanced patient safety in the ICU through a 5-year vision.
- The management team had not always considered the long term improvement of critical care services. For example, there was an established tier of senior middle grade doctors within the service. However, there was no evidence of consideration to how this could be sustained and improved in the future.
- The service currently had 48% of registered nurses who had achieved a critical care nursing qualification. This was slightly below the Intensive Care Society (ICS)

standard of 50%. The management team informed us that a business case had been submitted for eight places on a university course for further nursing staff to attend. However, due to financial restrictions, only two places had been agreed. This meant that if there was a continual turnover of nursing staff, there was a risk that the number of staff who had completed this course would fall significantly below the ICS standard.

Maternity and gynaecology

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

Information about the service

Warrington and Halton NHS Foundation Trust offers pregnant patients and their families' antenatal, delivery and postnatal care in the Warrington and Halton areas.

The maternity facilities are based at the Warrington site. The services provide antenatal and post-natal care (inpatient and outpatient), labour ward, ultrasound scanning, two obstetric theatres and an Alongside Midwifery Led Unit (AMU), which is in its early development stage.

The AMU offers intrapartum and immediate postpartum care to low risk patients. It is distinct from, but co-located to, the main labour ward. The AMU consists of three ensuite birthing rooms, furnished and equipped to promote normal birth with no medical intervention. Two of the rooms have a fixed birthing pool. The rooms are homely and inviting, and offer families a 'home from home' environment with facilities to promote normal birth and early bonding between families and their babies. The AMU opened in April 2015.

A team of community midwives also provide antenatal care, homebirth and postnatal care.

Between October 2015 and September 2016, 2,754 patients delivered their babies at the trust. This number had decreased by 275 births since April 2013 to April 2014. The service is managed through the Trust's Women's and Children's Health division and is led by a Clinical Director and a Head of Midwifery (HoM).

Gynaecology services are based at both the Warrington and Halton sites.

Gynaecological theatre procedures are undertaken in the main theatre suites at Halton or Warrington sites. Most elective gynaecology surgery are undertaken at the Halton site.

The service does not undertake routine termination of pregnancy, these are commissioned to an external local provider specialising in termination. However, the trust does undertake termination of pregnancy for fetal anomalies and chromosomal problems. Sixteen TOP's were carried out between April 2015 and March 2016.

During our visit, we spoke with 14 patients, seven junior, six consultant doctors and 44 staff including senior and junior midwives and nurses, health care support workers, ward clerks, domestic staff and housekeepers, sonographers and pharmacy staff across both sites.

We observed care and treatment to assess if patients had positive outcomes and looked at the care and treatment records for 15 patients. We also reviewed 11 medicine prescription charts. We reviewed information provided by the trust and gathered further information during and after our visit. We compared their performance against national data.

Maternity and gynaecology

Summary of findings

At the last inspection in January 2015, we rated the service as Required Improvement overall. Following this inspection we have maintained the rating of requires improvement because:

- Staffing levels and skill mix remained a day-to-day issue within the service. However, staffing levels had improved and the midwife/patient ratio had increased from 1:31 to 1:29 since the last inspection.
- Shift leaders on the labour ward and other wards were often not supernumerary due to staffing levels and workload.
- We observed and staff informed us that during certain times, especially at staff handover and shift changes, patients were not actively cared for by specifically allocated staff in the induction bay area. This was due to the uncertainty among staff on the maternity ward (C23) and labour ward around who had responsibility of care.
- Staff informed us that labour ward had ultimate responsibility for caring for patients in the induction bay area but due to reduced staffing levels and increased workload, this was not always possible. However, the decision of care was only confirmed after each handover, leaving a period of time when care was minimised and unknown. This had an adverse effect on staffing levels on ward C23, as staffing numbers did not take into account caring for patients on induction bay.
- The emergency call bell system in the induction bay was not adequately heard on ward C23, therefore, raising concerns about patient safety, especially in an emergency.
- The maternity services did not have a current robust data collection system, such as a maternity dashboard, to benchmark outcomes, review clinical and quality performance and implement clinical changes to improve patient care. However, a standardised regional maternity dashboard was under review for implementation.
- The risk register did not provide assurance that action plans were comprehensive, robust and adequate to improve patient safety, risk management and quality of care, as many risks were static in their ratings.
- There was no dedicated Triage area or Triage team in the maternity unit.
- Due to medical staffing levels and access and flow issues, there were often delays in patients being admitted, reviewed and /or discharged from hospital.
- Outlier patients posed access and flow issues on the gynaecology ward.
- There was no dedicated obstetric staff for the daily elective caesarean section list. This led to cancellations and delays in treatment and care.
- The service did not record staff competencies for medical devices training.
- Patient records were not securely stored in locked trolleys.
- Breastfeeding initiation rates of less than 60% were below the national rate of 83%.
- Home birth rate was 0.1%, which was below the national rate of 2.3%.
- We observed privacy and dignity concerns in both the obstetric theatre and gynaecology wards, which did not meet the individual patient's needs.
- The Termination of Pregnancy service did not audit their performance.

However:

- There had been some improvements since our last inspection in January 2015: working relationships between medical staff and midwifery staff, overall culture was improving, WHO checklist and consent forms, laparoscopic hysterectomies were undertaken and mandatory training for nurse and midwifery compliance rates had improved.
- The appointment of the new Head of Midwifery had a positive effect on staff and the future of the service.

Maternity and gynaecology

- The Alongside Midwifery Led Unit (AMU) was in its early stages of development but there was a real focus on normal labour and birth.
- The service had recently relaunched the Maternity Services Liaison Committee (MSLC) with a newly appointed chair.
- Staffs were caring, kind and patient and were committed to providing good care to patients.

Are maternity and gynaecology services safe?

Requires improvement

We rated safe as requires improvement because:

At the previous inspection in January 2015, we rated safe as requires improvement mainly due to frequently low safe staffing levels, shift leader unable to be supernumerary, levels of mandatory attendance below trust target, unsecure storage of records, security system on postnatal ward and regular safety checks for emergency equipment not completed. We have maintained this rating following this inspection because:

- Staffing levels and skill mix remained a day-to-day issue within the service, especially on the combined antenatal and postnatal ward (C23) and gynaecology ward (C20). However, midwifery staffing levels had improved and the midwife/patient ratio had increased from 1:31 to 1:29 since the last inspection One to one care on labour ward was not affected by reduced staffing levels, this was managed well my team leaders.
- We observed and staff informed us that shift leaders on the labour ward and other wards were not supernumerary on a daily basis due to staffing levels and workload.
- We observed and staff informed us that during certain times, especially at staff handover and shift changes, patients in the induction bay area were not actively cared for by specifically allocated staff. This was due to the uncertainty among staff on the maternity ward (C23) and labour ward around who had daily responsibility of care.
- Staff informed us that labour ward had ultimate responsibility for caring for patients in the induction bay area but due to reduced staffing levels and increased workload, this was not always possible. However, the decision of care was only confirmed after each handover, leaving a period of time when care was minimised and unknown. This also had an adverse effect on staffing levels on ward C23, as staffing numbers did not take into account caring for patients on induction bay.

Maternity and gynaecology

- The emergency call bell system in the induction bay was not adequately heard on ward C23, therefore, raising concerns about patient safety, especially in an emergency. This was highlighted to staff during the inspection. However, no immediate action was taken to address this at the time.
- There was no dedicated obstetric staff for the daily elective caesarean section list. The on call medical team covered the elective operative work as well as covering the labour ward and gynaecology emergencies. This stretched the service especially as the middle tier medical cover was below national numbers. Staff informed us that this sometimes led to cancellations and delays in treatment and did not assure us that the trust were doing all that was reasonable to mitigate risk.
- There was no dedicated Triage area or Triage team in the maternity unit. Antenatal day assessment unit (ANDU) saw some patients but did not have official triage status, while the majority of patients were seen on the labour ward.
- The service did not record staff competencies for medical devices training. This was highlighted to senior staff during the inspection.
- There were some gaps in the daily checking of equipment. The required safety checks for emergency equipment were highlighted as a concern at the last CQC inspection.
- Patient records were not securely stored in locked trolleys. This was also highlighted at the last CQC inspection.
- We observed identifiable patient information displayed on the IT system in a public corridor within a ward area. This was highlighted to staff during the inspection but continued to remain a concern throughout the week.
- Not all gynaecology clinic staff that cared for patients under 16 years old had completed appropriate safeguarding training.
- Antenatal clinic did not have an emergency call bell system. This did not assure us that patient safety was maintained at all times or that the premises were safe to use for the purpose intended.

However:

- There were clear systems and processes in place for staff to report incidents.
- The maternity service had a good practice education programme for midwifery and nursing staff.
- All areas were clean and tidy and infection control practices were followed.
- Medicines were safely stored and checked daily.
- Records were completed to a good standard and availability of records was good for all clinical areas.
- Staff attended daily safety brief meetings and safety huddle meetings to discussed workload, staffing and lessons learnt.
- We observed good safeguarding practice within the maternity service. Compliance rates for nursing and midwifery staff were above the trust target rate.
- We observed dedicated theatre staff in all theatres.
- All surgical WHO checklists were fully completed, online.
- Theatre and anaesthetic equipment were routinely checked and recorded. This had improved since the last CQC inspection.
- Community midwives had new customized home birth kits bags, which include baby resuscitation equipment and other essential equipment for a home birth.
- Community midwives stored and transported oxygen and Entonox for homebirths according the trust and national guidelines.

Incidents

- Between January 2016 and December 2016, there were 724 incidents recorded within the Women's Health Division. Of these, there were 157 gynaecology incidents; all graded either as minor or negligible harm.
- Between January 2016 and December 2016, there were no incidents classified as Never Events for maternity and gynaecology. Never Eventsare serious, largely preventable patient safety incidents that should not occur if the available preventative measures had been implemented.

Maternity and gynaecology

- Between January 2016 and December 2016, in accordance with the Serious Incident Framework 2015, the trust reported 11 serious incidents (SIs) in maternity and gynaecology.
- One serious incident in gynaecology was reported in April 2016. We requested the Root Cause Analysis (RCA) for this. The trust informed us that the RCA was unavailable as the investigation report was still in draft. It was due to be reviewed at a panel meeting later in March 2017.
- We observed a good reporting culture for incidents via the trusts electronic system. Staff confirmed that the system for reporting incidents was easy to access and they were clear about their responsibilities with regard to reporting incidents.
- Sharing of learning from incidents was via staff newsletters, meeting minutes, staff safety brief meetings and scenarios used in mandatory training.
- Staff informed us that the service sent incident related newsletters to staff containing updates and outcomes.
- Monthly multidisciplinary incident reporting group meetings took place. We were provided with meeting minutes from November and December 2016 and January 2017. Attendee numbers were between four to five staff. Items on the agenda included incidents reported, 72-hour rapid reviews and incident case studies. Actions were highlighted and a named lead was assigned to each action.
- Monthly Perinatal meetings took place to review specific patient cases and discuss action plans from previous meetings. This provided assurance that the service was discussing all the aspects of recent stillbirths and neonatal deaths, possible causes and avoidable factors in order to prevent deaths in the future. It also provided an opportunity to acknowledge good care and management.
- Some staff we spoke to were unsure about the Duty of Candour. The Duty of Candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients or other relevant persons of 'certain notifiable safety incidents' and provide reasonable support to that person.

Safety thermometer

- Noticeboards outside clinical areas included 'How are We Doing' information. This included safety thermometer information about pressure ulcers, falls, infections, complaints and incidents. The information was current however, there were no numbers included to represent how many times specific incidents occurred. Incidents that occurred were highlighted by one red dot or green dots if no incidents occurred. Staff, we spoke to, were unclear how this information was used to improve practice.
- A gynaecology safety thermometer dashboard, provided by the trust, contained detailed information about staffing levels. It did not contain information such as pressure ulcers or falls to help improve, measure, monitor and analysing patient harms and 'harm free' care.

Cleanliness, infection control and hygiene

- There were no methicillin-resistant staphylococcus aureus (MRSA), methicillin-sensitive staphylococcus aureus (MSSA), clostridium difficile (C.diff) or Escherichia coli (E.coli) reported by the service between April 2016 and December 2016.
- From January 2016 to October 2016, there were 16 recorded surgical site infections on the gynaecology ward (Ward C20). All infections were categorised as "wound" infections.
- All areas were visibly clean and well organised. Wall-mounted hand gel and sanitizers were readily available on entry to clinical areas and staff we observed used sanitizing hand gels and hand washing procedures prior to providing patient care. All staff we observed adhered to the 'bare below the elbows' policy in clinical areas.
- Personal protective equipment (PPE) was readily available and included gloves and aprons. Posters displaying 'hand washing techniques' were displayed throughout the department. Sharps bins were securely stored in the locked utility room.
- Cleaning schedules and checks for piped oxygen and suction were in place and clearly displayed in the locked utility room. Since January 2017, there had been eight omissions in signature checks. Equipment included "I am clean" stickers.

- Washable privacy curtains did not display dates when last changed. Staff informed us that the curtains were changed when needed including when a deep clean was necessary. Some curtains were changed during the inspection.
- Staff compliance rates for infection control training were 88.7%. The trust target 85%.
- A total of 12 hand hygiene audits were carried out on the gynaecology ward at Warrington, between 2015 and 2016 with an average score of 99.6% overall.
- Gynaecology theatre scrub room had latex free gloves available and instructions on good "scrubbing" technique displayed.
- Hand hygiene audits between April 2016 and March 2017, showed midwives had a compliance rate of 99% to 100%.
- The trust provided us with a labour ward cleaning audit from October 2016. The outcome score was 96%. A similar audit also took place in January 2017 on labour ward, scoring 91%.
- The trust also provided us with one health & safety audit for antenatal clinic (ANC) from January 2017. The outcome scored 100%.

Environment and equipment

- We observed and staff informed us that during certain times, especially at staff handover and shift changes, patients in the induction bay area were not actively cared for by specifically allocated staff. This was due to the uncertainty among staff on the maternity ward (C23) and labour ward around who had daily responsibility of care.
- Staff informed us that labour ward had ultimate responsibility for caring for patients in the induction bay area but due to reduced staffing levels and increased workload, this was not always possible. However, the decision of care was only confirmed after each handover, leaving a period of time when care was minimised and unknown. This also had an adverse effect on staffing levels on ward C23, as staffing numbers did not take into account caring for patients on induction bay.
- During our inspection, we observed that the emergency call bell system in the induction bay only rang out on the labour ward. It was not directly connected to the ward C23. Staff on the ward C23 said, "They could just about hear bell to attend to a patient". During our visit, we tested the volume of the call bell on ward C23: neither CQC staff, a paediatric doctor who was working at the far end of the ward area or ward midwives could hear the bell. This was highlighted to staff at the time. This did not assure us that patient safety was maintained at all times or that the premises were safe to use for the purpose intended.
- However, the trust provided evidence, since the inspection, which suggested they had recognised that the environment was not optimum in the induction of labour area and that it needed development.
- The service did not record staff competencies for medical devices training. During the inspection, we spent time on a ward with various levels of management staff to local a training competency tool or spreadsheet but staff informed us, that such a tool did not exist, as this information was not collected. This did not assure us that staff were competent and trained to use all equipment in a safe manner. This was highlighted to senior staff during the inspection.
- However, the trust submitted evidence, since the inspection, to demonstrate work that had commenced to improve the recording and monitoring of medical devices and staff competencies. This needed to be embedded into practice, assessed and monitored to evaluate the impact.
- Antenatal clinic did not have an emergency call bell system. Staff said they had highlighted this to senior management on previous occasions as a concern but no action had been taken. This did not assure us that patient safety was maintained at all times or that the premises were safe to use for the purpose intended.
- There was no dedicated High Dependency (HDU) room on the labour ward, even though staff did call one of their rooms a "HDU" room. Senior staff confirmed that it was used for higher levels of monitoring for patients with conditions such as raised blood pressure (pre-eclampsia). We were informed that labour ward staff were supported by the Medical Emergency Team (MET). Most midwives on the labour ward were not previously nurse trained or had specific HDU training.

Maternity and gynaecology

- There were no established transitional care facilities available for babies on the maternity wards, which meant babies who required treatment such as phototherapy, or intravenous antibiotics were transferred to the neonatal unit. This was not in line with best practice as it meant the mother and babies were separated.
- Outpatient's gynaecology clinic had a separated dedicated seating area. One waiting area included patients for colposcopy & hysteroscopy appointments and early pregnancy assessment unit (EPAU) appointments. However, maternity staff informed us that sometimes if the antenatal clinic waiting area was busy, maternity patients could sit near to gynaecology patients in one of the waiting areas. Staff told us that this was inappropriate and insensitive to patient's needs.
- At Warrington, on the gynaecology ward, the trusts electronic board system showing the location of patients was located on the corridor. We were told the board should not show patient names, however; due to technical problems, patient names were visible at time.
- At Halton hospital, on the gynaecology day-case ward, the electronic board was in a clinical room, however; there was a 'wipe-clean' board on view in the ward with patient's details on public view.
- Signage to the gynaecology department was not clear. We assisted a patient, who was unfamiliar with the name of the 'Women's Health' area, to locate the department she was looking for.
- The gynaecology ward at Warrington (C20) had 14 inpatient beds and a separate dedicated bay for clinic patients, however; this was used as an escalation bay when bed shortages in the hospital. The ward has provision for emergency attenders who required a medical review.
- The Early Pregnancy Assessment Unit (EPAU) and Gynaecological Rapid Access clinics were situated at the end of the area in a separate space. The ward also consisted of outpatient procedure rooms for colposcopy and hysteroscopy and scan facilities.
- The main gynaecology outpatient clinic was a dedicated outpatient area with a dedicated scanning room from January 2017.
- The labour ward had five birthing rooms with "jack and Jill" style bathrooms (shared bathroom with two doors).
- The Alongside Midwifery led Unit (AMU), which originally was part of the labour ward, consisted of three delivery rooms. Two birthing pools were available on the AMU. Equipment for the evacuation of a patient in an emergency was provided.
- There was a large ensuite bereavement room for families to stay after the loss of their baby, situated privately beside the labour ward.
- The labour ward had a resource training room for staff training.
- Staff we spoke to, in all areas, told us there was appropriate and adequate equipment available for consultations and treatments including cardiotogography (CTG) monitors for monitoring baby's heartbeat.
- However, we observed that there was a lack of equipment for (overweight and obesity) patients. For example, there was only one CTG monitor that catered for overweight patients. This was shared within the entire maternity unit. Staff said could be a delay in monitoring if the monitor was in use in another area. Staff informed us that they had sent patients to the ultrasound scan department in the past, if there was a potential cause for concern around the safety and wellbeing of the baby.
- However, the trust provided evidence, since the inspection, which indicated an increase in special equipment available.
- Maintenance arrangements were in place to ensure that specialist equipment were serviced and maintained as needed.
- Emergency resuscitation equipment was available in the gynaecology ward and shared with the outpatient areas, which included antenatal clinic, situated across a short corridor. The contents of the trolley were secured with a security tag. There were daily checks carried out for items not tagged. There was a full monthly check of the trolley unless items used in-between to treat a patient. Since January 2017, there had been nine omissions in daily checks.

Maternity and gynaecology

- There were two obstetric theatres, one used for daily elective surgery and the other was set up for emergency work.
- Most resuscitation equipment on the maternity wards, including labour ward and obstetric theatres were checked daily. However, we did see some gaps in the checking of neonatal resuscitation equipment in January and February 2017, in the antenatal day assessment unit (ANDU).
- All treatment items such as, needles, dressings and intra-venous fluids were all stored securely in locked rooms or store cupboards.
- Fridge temperatures were checked daily, all recordings were within the normal temperature range.
- At Warrington, there was a separate gynaecology theatre available for emergency procedures, within the trust main theatre suite.
- Recovery area in the gynaecology and obstetrics theatres were in a designated space and care was provided by trained dedicated theatre staff.
- Security systems in and out of the maternity wards were secure. Staff said they were vigilant to visitors entering and leaving the ward and CCTV was available in the corridor leading to the wards. This was an improvement from the previous CQC inspection.

Medicines

- There were processes in place for management and storage of medicines in the gynaecology and maternity wards. Pharmacy staff visited at designated times to monitor the stock levels.
- Medicines were stored appropriately in locked cupboards including controlled drugs. There were twice daily checks of controlled mediation by staff.
- Patient records for medicine administration were completed appropriately.
- Operating department practitioner (ODP)staff, in theatre, informed us that medicines in the gynaecology theatre were checked every morning by two anaesthetics.
- Anaesthetic drugs were drawn up in syringes after the team brief and before each individual patient arrived in the anaesthetic room, according to national guidelines.
- In gynaecology theatre, drug fridge temperatures were checked every evening and a log was maintained. Medicines cupboard was checked every morning however, there was no log to record the contents of the cupboard or record the daily check.
- The service did not undertake routine termination of pregnancy, these were commissioned to an external local provider specialising in termination. However, the trust did undertake termination of pregnancy for fetal anomalies and chromosomal problems, in line with RCOG guidelines. The termination of pregnancy (TOP) service had a system in place to ensure that two doctors completed a HSA1 form.
- There were no gynaecology specific patient group directions (PGDs) for nursing staff. PGDs allow healthcare professionals to supply and administer specifiedmedicinesto pre-defined groups of patients, without a prescription (NICE 2013).

Records

- Patient records consisted of a combination of paper records and electronic records.
- Patients' records we reviewed were accurate, legible and up to date.
- Records of patients attending the Early Pregnancy Assessment Unit (EPAU) were stored on the trusts electronic system.
- Compliance of mandatory training for information governance was 92.8%. (Trust target 85%).
- There were only four occasions when patient's records were not available for clinics, in gynaecology outpatients department between January 2016 and December 2016.
- We reviewed four sets of patient record that had under gone a termination of pregnancy (TOP) at various weeks of pregnancy for different baby abnormalities. Specialist consultants had reviewed all patients in a timely manner. Management plans and postnatal documentation was evident in all notes. Checklists were all completed, which included information about blessings, cremation and burial and information for GP and community midwives. Bereavement support and involvement was documented in two of the sets of notes.

- Risk assessments for specific risks relating to the health, safety and welfare of patients such as venous thromboembolism(VTE) were available in their records and were up to date.
- The Child Health Record "Red book" was issued at birth and staff told patients about the purpose of the book and how to maintain the record.
- Midwives conducting a patient's antenatal booking appointment completed the patient's handheld notes during the appointment. The handheld notes were then photocopied and the original given to the patient to keep throughout her entire pregnancy. The midwife then transferred the information from the photocopied notes onto the IT booking system. Midwives said this was time consuming.
- On the combined antenatal and postnatal ward (C23), patient records were stored in an unlocked filing cabinet outside each bay area. The medical and nursing notes for each patient in that bay were accessible in these cabinets at all times. These records contained confidential information and were not stored securely. This did not meet with relevant guidance on the storage of confidential records and data protection. This was also a concern raised at the last CQC inspection.

Safeguarding

- Safeguarding (children) level three training compliance for midwives was 88% and 91% for Health Care Assistants (HCA's). This was above the trust target of 85%.
- Between February 2016 and January 2017, safeguarding (children) Level 3 training was completed by 69% of gynaecology nurses. Medical staff compliance rate was 85%.
- Safeguarding (Children) Level 3 training was reviewed and updated annually by the service. Level 3 training was produced in line with the intercollegiate document 2014 and was guided by new legislation and guidance.
- In the last four years, the safeguarding training topics focused on female genital mutilation (FGM), child sexual exploitation (CSE), domestic abuse, mental health and substance misuse.
- A Level 3 Safeguarding Children Training programme had been developed for 2017, which included child death process, substance misuse in young people, early help services and learning from serious case reviews.
- A 2018 safeguarding programme was under review and the proposed topics included FGM, CSE, domestic abuse and unaccompanied asylum seekers.
- For the same period, safeguarding (children) Level 2 training was completed by 53% of gynaecology nurses in the ward (C20) area. Compliance for gynaecology nurses in the clinic areas was 64%. Medical staff compliance rate was 71%. The trust set a target of 85% for completion of safeguarding training.
- Between February 2016 and January 2017, safeguarding (adults) training was completed by 47% of gynaecology nurses in the ward (C20) area. Compliance for gynaecology nurses in the clinic areas was 57%. Medical staff compliance rate was 71%. This was below the trust set a target of 85%.
- However, information provided by the trust since the inspection, indicated an improvement in all areas of safeguarding training.
- The trust employed a safeguarding lead nurse matron. The women and children's division also employed a part time interim safeguarding lead midwife, who worked closely with the lead nurse and led paediatric consultant for safeguarding. There were also "champion" midwives for safeguarding in each maternity clinical area.
- The safeguarding lead midwife informed us that there was a draft "Safeguarding Supervision" guideline under review at the time of our inspection. One to One safeguarding supervision support for staff was also in development stages.
- There were a team of seven safeguarding supervisors who meet every four to six weeks to discuss any safeguarding issues and concerns and we were informed that they were about to start monthly drop in sessions for staff to discuss cases and concerns.
- Staff, we spoke with, were aware of their roles and responsibilities in safeguarding and knew how to raise matters of concern appropriately.

- We reviewed records and attended a meeting regarding a patient with learning needs. All necessary steps were taken to ensure patient mental capacity was assessed and that the patient understood her rights. There was a good trigger plan completed in the records and staff had adhered to these.
- We observed no system in place in the gynaecology handheld records that alerted staff if a patient was vulnerable or had a previous safeguarding concern. However, information provided by the trust since the inspection, stated that there was a flagging alert arrangement on their computer records system that identified vulnerable patients or those with safeguarding concerns.
- Gynaecology staff told us that patients under 16 years old were seen in the gynaecology outpatient department by paediatricians. This area was led by health-care assistants who chaperoned doctors during consultations. Health-care assistants in gynaecology clinic had received safeguarding training level two but not all staff had completed level three training. From September 2015 to March 2017, 313 under 16 year's old patients attended appointments.
- Patients less than 16 years were seen in the EPAU. Staff were trained to safeguarding level three. Any patient under 16 years old requiring inpatient gynaecology care was nursed on the paediatric ward with the support of the gynaecology team.
- Any patient between 16 years and 18 years generated an email alert to all staff. At the time of inspection, a 17-year-old patient had been admitted to Halton hospital. The patient was nursed in a cubicle and the parent was resident.

Mandatory training

- The trust set a target of 85% for completion of all mandatory training.
- The maternity service employed a practice development midwife to oversee the staff mandatory training programme and preceptorship package for new staff.
- The mandatory training programme included three annual face-to-face mandatory training days and e-learning packages.
- Day one of mandatory training included obstetric emergencies, skills and drills, sepsis and the deteriorating patient, antenatal screening, baby resuscitation, mental health and baby heart monitoring.
- Up to the end of February 2017, day one training compliance for midwives were 94%, 87% for medical staff, 78% for anaesthetises and 78% for health care Assistants (HCA). This was an overall compliant rate of 90%, which was above the trust target.
- Day two training consisted of bereavement, stop smoking, promoting normal birth, reducing the risk of stillbirth, adult resuscitation, medicines management, suturing and diabetes update.
- Up to the end of February 2017, adult resuscitation training compliance for midwives was 95%, 89% for medical staff, 86% for anaesthetises and 72% for HCA's. This was an overall compliant rate of 92%, which was above the trust target.
- Day three training consisted of safeguarding level three, infection control, infant feeding, blood transfusion, manual handling and fire lecture.
- Up to the end of February 2017, day three training compliance for midwives was 88% and 91% for HCA's. The practice education midwife did not record the rates for the medical staff. However, a senior medical staff member told us that they had not received any training in Female Genital Mutilation (FGM) and had completed some safeguarding e-learning but did not know what level training.
- From January 2016 to December 2016, breastfeeding training compliance rates was 84% for midwives, 75% for HCAs and 67% for neonatal staff.
- Staff informed us that there were plans in 2017 for all new maternity staff to undertake the Acute Illness Management (AIM) course. AIM is a multi-professional course to teach clinical staff a structured and prioritised approach in the assessment and management of the acutely ill patient. The aim was for midwives to commence this training in April 2017 and for a third of all midwives to have completed this training by the end of 2017.
- Corporate induction training was completed by 100% of gynaecology nurses. Women and Children's Health division medical staff compliance rate was 94%.

- Completion rates for dementia awareness training were between 64% and 67% for gynaecology nurses. Only 18% of medical staff for the Women's and Children's Health division had completed this training.
- Between February 2014 and January 2017, equality and diversity training was completed by between 85% and 95% of gynaecology nurses. The medical staff compliance rate was 59%.
- Between February 2016 and January 2017, fire safety training was completed by 78% of gynaecology nurses. Information governance training was completed by between 67% and 85% of gynaecology nurses. The medical staff compliance rate was 53%. Resuscitation training was completed by 59% of gynaecology nurses in the ward (C20) area. Compliance for gynaecology nurses in the clinic areas was 86%.
- Information provided by the trust, showed us that local induction training was completed by less than one percent of gynaecology nurses in the ward (C20) area. Compliance for gynaecology nurses in the outpatient clinic areas was 31%. The medical staff compliance rate was 37%.
- Varied levels of some mandatory training compliance across the different professions were also a concern raised at the last CQC inspection.
- There was some discrepancy between the clinical director and the clinical medical staff we spoke too, about the availability of training for medical staff and ease of attendance. Some staff told us it was difficult to attend training due to medical staffing levels and increased capacity within the unit.
- Up to the end of January 2017, local induction was completed by 100% of agency staff for obstetrics and gynaecology. However, this included only one member of staff. For the same period, local induction was completed by 100% of locum medical staff. However, again, this only included one member of staff.
- Medical staff informed us that the trust provided good in-house weekly training sessions that they attended. They also informed us that a lot of their mandatory training was completed on line and mainly completed at home in their own time.

Assessing and responding to patient risk

- There was no dedicated obstetric staff allocated to the daily elective caesarean section list. The on call medical team covered the elective operative work as well as covering the labour ward and gynaecology emergencies. This stretched the service especially as the middle tier medical cover was below national numbers. However, there was a national shortage of middle grade doctors.
- The trust provided evidence, since the inspection, stating that middle grade doctor cover was now on the risk register, however, one long-term middle grade locum cover had been appointed.
- Medical staff informed us that this caused delays resulting in some patient's procedures being cancelled or commencing elective work at 5pm when the on call staff were starting their shifts. Staff informed us this happened about once a month, which staff said compromised patient safety. This did not assure us that the trust were doing all that was reasonable to mitigate risk for patient safety.
- Senior medical staff did assure us that consultant posts were covered by locum staff and a consultant was always available in Antenatal clinic (ANC) if required.
- There was no dedicated Triage area or Triage team in the maternity unit. Antenatal day assessment unit (ANDU) saw some antenatal patients but did not have official triage status, while the majority of patients were seen on the labour ward. We were given an example from medical staff about a patient who had phoned at 2pm concerned about reduced baby movement's .After communication between the doctor and labour ward team, the patient was told that she could be seen at 8:30pm that evening. This was not escalated at the time to consultant level as we were told that the senior labour ward midwife "could not be by-passed and her word was law". This did not assure us that the "Saving Babies Lives" pathway was being followed correctly and that patient safety was a priority. It also suggested that there was still a culture, which was not very flexible in recognising patient safety and needs.
- However, the trust provided evidence, since the inspection, which suggested they had made improvements to develop the ANDU and Triage service offered to women. This needed to be embedded into practice.

- Care pathways were in place that included details of care and treatment. Examples were guidance for the management of urinary incontinence, management of acute pelvic inflammatory disease and guideline for outpatient hysteroscopy clinic.
- A National Early Warning Score System (NEWS) was in place to identify patients whose condition was deteriorating. We were told, by critical care staff that the gynaecology ward were the best department in the hospital for escalating a concern about a deteriorating patient. However, the trust informed us that they did not undertake any audits or reviews of their NEWS system and outcomes.
- A Neonatal Early Warning Score (NEWS) chart was in place for newborn babies. These were used at shift handover to identify any babies requiring increased observation or intervention.
- 'Safety huddles' occurred daily at 9.30am, 6pm and 8pm in the maternity unit. Senior staff from the gynaecology ward were hoping to join the 6pm huddles if capacity allowed.
- In the event of an emergency, at Halton, an escalation process was in place for a deteriorating patient. A Resident Medical Officer (RMO) was present for reviewing patients. Over the previous 12 months, two gynaecology patients were transferred to Warrington as an emergency.
- A guideline for "the risk assessment in the antenatal period" was available to staff. This guideline outlined the process of clinical risk assessment during the antenatal period to ensure patients were offered a choice of place of birth, depending on all risk factors.
- The was a standard operating procedure (SOP) for all patients who were 18 weeks pregnant and above, who attend the Antenatal Day Unit (ANDU) with pregnancy related queries and complications and who require assessment, treatment or admission. The SOP supported staff to decide which admissions were suitable for review in ANDU in order to provide an effective, efficient and safe midwifery-led assessment service.
- There was a guideline for the care of patients attending the emergency department or admitted to other non-maternity wards during pregnancy and the postnatal period to help to ensure that they receive the most appropriate care. The guideline highlighted that the on call consultant obstetrician should be told about all sick pregnant patient in hospital whether they have a medical or an obstetric problem, which was a Confidential Enquiries into Maternal Deaths (CEMACH) recommendation.
- There were dedicated nursing and operating department practitioners (OPD) staff in both the maternity and gynaecology theatres.
- We observed operatives procedures in both theatres during our inspection. All surgical WHO checklists were completed in full online. Pathways for dealing with anaesthetic emergencies were displayed on the theatre walls.
- In the gynaecology theatre, ODP staff checked the anaesthetist equipment every morning.
- Weekly "Patient Care Indicators" reports were completed and displayed on ward C23 (combined antenatal and postnatal ward). This included summaries and rates of infection, staffing levels, complaints, delays in induction of labour, early warning scores, documentation, Situation, Background, Assessment, Recommendation (SBAR) and Venous thromboembolism (VTE) assessments, third degree tears and postpartum haemorrhage (PPH).
- Between May and October 2016, completion of AMU antenatal risk assessment for place of birth was 35% and the intrapartum (labour) risk assessment for place of birth 50%. These low rates had been included in the AMU action plan and were being reviewed on a monthly basis by the consultant midwife. Since the inspection, the trust provided evidence indicating improvements in the completion of risk assessments.
- If low risk patients on AMU needed transferring to labour ward, AMU staff informed us that there were pathways in place to assist in the transfer process.
- Data provided by the trust informed us that there had been two transfers of patients from gynaecology service at Halton to the gynaecology service at Warrington due to complications. Both were reported as incidents and reported as being appropriately managed.
- There was an escalation policy and standard operating procedure (SOP) for management of the deteriorating

patient at the Halton site, which was located on the trust intranet HUB. There was also a SOP and policy for transferring patients from the Halton site to the Warrington site. When assessing patients, staff used a scoring system called NEWS (National Early Warning Score).

- Midwives informed us that risk assessments were completed for the appropriate monitoring of baby's heartbeat using a cardiotocography (CTG) machine for low risk patients. This was in line with NICE and RCOG guidance. This was an improvement since the last CQC inspection, where most low risk patients were offered continuous CTG monitoring.
- Guidelines relating to sepsis in labour had recently been reviewed and updated due to the unnecessary increase use of antibiotics for patients and unexpected increase in admissions to the neonatal unit for babies. There was now a red laminated NICE red flag guideline to assist staff in the appropriate treatment required for prolonged rupture of membranes. Previously, patients has been incorrectly categorised and had received antibiotics unnecessarily.
- We observed reception and ward staff confirming the identity of patients on arrival to the departments.

Midwifery staffing

- Staffing levels and skill mix remained a day-to-day issue within the service, especially on the combined antenatal and postnatal ward (C23) and gynaecology ward (C20). However, midwifery staffing levels had improved and the midwife/patient ratio had increased from 1:31 to 1:29 since the last inspection. One to one care on labour ward was not affected by reduced staffing levels, this was managed well my team leaders.
- The Maternity Service used the Birthrate Plus workforce planning tool for calculating midwifery staffing levels, based on specific activity, case mix, demographics and skill mix.
- A combination of methods such as the Safer Nursing Care Tool (SNCT): a systematic evidence based approach and exercising professional judgement) was used by the trust to determine gynaecology staffing levels.
- General staffing levels were last reviewed and revised in April 2016, with the roll out of E-rostering (online management of shift patterns), the implementation of longer 12-hour working shifts and allocation of staffing to the Alongside Midwifery Led Unit (AMU).
- Noticeboards were displayed to show the number of midwifery and nursing staff expected and actual to show a full compliment.
- We reviewed staff working rotas for Ward C20 (gynaecology) for august 2016, Total planned nurse hours required for day shifts was 1260 hours. The total actual staff hours provided was 510 hours. Planned staffing hours for care staff was 835 hours. Actual hours provided was 682 hours. Nursing planned and actual hours for night duty were similar; however, there was no planned or actual hours recorded for care staff on night duty.
- We observed a reduction in midwifery planned and actual staffing hours for day shifts on ward C23 in August 2016. However, labour ward and AMU were adequately staffed for day and night duty shifts.
- There was also a reduction of planned and actual staffing hours for all staff on C20, C23, labour ward, AMU in November and December 2016. Reasons given for the shortage of staff included vacancies, maternity leave cover, sickness, escalation in times of bed pressures and staff being moved around from different areas of the unit to cover acute activity. However, staff informed us that managers worked clinically and community midwives were redeployed to cover peaks in activity, as per staffing escalation policy.
- In December 2016, the trust reported that the antenatal and postnatal ward had 100% staffing levels for midwifery staff.
- From off duty records we observed, the Gynaecology ward at the Warrington site had a 34% shortfall in nursing staffing levels in December 2016. Staff informed us that the trust had recruited staff from overseas with a requirement for these staff to work initially for the bank prior to permanent positions. Two of the band five nurses had been recruited through this process. Staff also informed us that staff worked additional hours, support was given from ward managers and the use of bank staff was used to increase staffing hours to the planned staffing requirement.

Maternity and gynaecology

- A "People Measurement" tool used by the trust showed that in January 2017, women and children's division recorded a sickness rate of 4.89%. This was above the trust target of less than 4.2%.
- Divisional staff turnover was 6.72% (below trust target of 10%) however; nursing and midwifery staff had a turnover rate of 8.83%. Return to work interview compliance was 58.76% (below the trust target of more than 85%) and use of agency staff was 1.8% (below trust target of less than 3%). However, the trust provided evidence since the inspection to indicate an increase in the return to work compliance rate.
- Nursing and midwifery vacancy rate was 5% (trust target was below 5% for the same period). Combined data for the division was classified as "significant concerns" on the measuring tool.
- At the time of inspection, both the band seven shift co-ordinator and the matron in the gynaecology ward were attending to patient needs.
- Bank staff were needed when the gynaecology escalation bay was open. This bay was normally closed at weekends, however; during recent bed pressures, the bay has been open every day.
- Staff informed us that at times inexperienced staff could be left in charge of ward areas. Examples were given where a junior midwife with two care assistants cared for a full ward with babies requiring increased observation.
- Band 5 staff told us that they could be working a night shift with another Band 6 midwife but the band 6 midwife could also be asked to care of the patients in the induction bay so the junior staff often felt vulnerable and unsupported.
- Changes to staffing were made at short notice to cover shortages with no evidence of advanced planning or assessment of skill mix.
- We observed a nurse and midwifery handover that included passing on all relevant current patient information as well as a safety brief. Nursing and midwifery staff worked 12-hour shifts, therefore handovers were completed twice daily formally.

Medical staffing

- There were eight combined Obstetrics/Gynaecology consultants and two specific gynaecology consultants with middle grade doctors, juniors and trainees to support.
- Medical staff told us there were always gaps in the rota for middle grade doctors. This was due to sickness, part time staff and maternity leave. In house staff or long-term locums that were known to the trust were used to cover the gaps. Medical staff said this caused some delays for patients due to doctors covering more than one area. This gap in middle grade doctors was also an issue raised at the last CQC inspection. Senior medical staff informed us that the problem was due to the allocation of staff from the medical school deanery and was a national concern.
- As of December 2016, the trust reported a medical vacancy rate of 4% in Maternity and Gynaecology. Medical turnover rate was 25.9% and medical sickness rate was 1.3%. However, information provided by the trust since the inspection, stated that the medical turnover rate had indicated a decline.
- Between April 2015 and March 2015, the trust reported a medical bank and locum usage rate of 5.2% in the women and children's services.
- In October 2016, the proportion of consultant staff reported to be working at the trust was about the same as the England average (38% to 39%) and the proportion of junior (foundation year 1-2) staff was about the same (4% to 6%). However, staff informed us that there were a reduced number of junior and middle grade doctors at present.
- Medical staff felt supported by the consultants and enjoyed working in the unit.
- Obstetric cover was provided 24 hours a day by staff employed on dedicated on-call rotas. On-call specialist trainees in obstetrics and gynaecology were resident on duty using a shift rota system 8:30am to 1pm, 1pm to 5pm, 5pm to 8:30pm and night shift 8:30pm to 8:30am.
- A consultant obstetrician was available to provide 24-hour cover through a combination of resident on duty and on call rota allocation. This had been consistent for at least the last 18 months and within the national safer childbirth guidelines 2007.

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- Consultant cover for obstetrics and gynaecology was provided in sessions; 8:00am to 1pm, 1pm to 5pm, 5pm to 7pm resident on call weekdays, 9:00am to 12.00 (3 hours) Resident on Call Saturday, Sunday, Bank Holidays, and then 7pm to 8:00am on call cover from home .
- At Halton, there was a senior house officer (SHO) on-site until 5pm each weekday. A Resident Medical Officer (RMO) was present 24 hours a day.
- At Warrington, doctors were available throughout the day and on-call cover at night as well as access to night nurse practitioners and associate practitioners. However, medical cover for gynaecology after 5:30pm was by the labour ward on call team.
- There was a dedicated anaesthetist allocated to provide 24-hour cover on the labour ward. This meant they were available in the case of an emergency.
- On trainee medical staff member informed us that there were usually three junior medical staff on call at any one time during the day. However on the day we spoke to the staff member, we were informed that due to sickness, there was only one medical staff member on call who was covering the gynaecology ward, antenatal day assessment unit (ANDU) and the combined antenatal and postnatal ward.
- Staff informed us that it was sometimes difficult to get patients reviewed on the wards by senior registrars or consultants, as they were usually busy on labour ward.

Major incident awareness and training

- The women and children's health division had a business continuity plan in place. The framework included a range of actions and considerations required to ensure a continuation of services, such as failure of specialist equipment, or a surge in sickness due to an infection outbreak.
- The trust informed us that within the CBU, there were three staff that were part of the trust major incident manager on-call rota. All three completed on call induction training, were invited to on-call review and update sessions and two staff had competed the additional major incident training. All on-call managers were required to keep up to date with the on call policy as part of their on call role. However, when we spoke to staff on the maternity wards, they were not aware who these three dedicated staff were and were not aware of their own role, within the wider hospital, should a major incident occur. They had not taken part in any drills.
- Staff we spoke to provided recent examples responding to incidents. These included evacuation following a flood from the toilets near the EPAU waiting area and a fire evacuation from the gynaecology ward when a patient was smoking in the bathroom.

Are maternity and gynaecology services effective?

Requires improvement

We rated effective as requires improvement because:

At the previous inspection in January 2015, we rated effective as requires improvement mainly due to little evidence shown that actions had been taken to improve audits that showed poor performance, no goals set for safety standards, midwifery staff were not up to date with annual appraisal and lack of multidisciplinary working. We have maintained this rating following this inspection because:

- The maternity services did not have a current robust data collection system, such as a maternity dashboard, to benchmark outcomes, review clinical and quality performance and implement clinical changes to improve patient care.
- The Early Pregnancy Assessment Unit (EPAU) opened weekdays, there was no weekend clinic. Therefore, patients would need to access the scanning services via accident and emergency in the evenings or weekends.
- Breast feeding rates provided by the trust showed that 58% of patients were breastfeeding after delivery and 57% were breastfeeding at discharge from hospital. The 2010 Infant feeding Survey states that the breastfeeding initiation rate at birth in England was 83%, therefore the trust was below the national average.
- The homebirth rate was 0.1%. In 2013, 2.3% of patients gave birth at home in England and Wales (Office of National Statistics).

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- The maternity service did not have an established enhanced recovery pathway.
- There was no data available on the current recording system relating to the incidents of third and fourth degree perineal tears and postpartum haemorrhage (PPH) that occurred on the labour ward. This highlighted that the service were not reviewing elements of care that other trusts locally and nationally were reviewing.
- In 2016, the Neonatal Audit was below the national Neonatal Audit programme (NNAP) standards for all of the five standards. Three standards were just below the standard benchmark grade. The remaining two standards were significantly below the benchmark set nationally. However, these two standards were not directly linked with the maternity unit.
- There was little assurance from minutes of meetings to suggest that midwives or gynaecology nurse representation was evidence at senior or local meetings.
- Mental Capacity Act training for staff was below the trust target
- Gynaecology nursing and junior medical staff informed us that due to the outlier patients on the gynaecology wards, which included trauma, orthopaedics and general medicine patients, they did not always feel competent to care for all these specialties.
- The TOP service had not performed any audits to benchmark their service.
- There were still occasions when cardiotocography (CTG) monitoring of the baby's heartbeat was performed without a clinical indication. This was also a concern lighted in the last CQC inspection.

However:

- Policies and procedures were up to date and complied with relevant national guidance. However, policies were not easy to find and access on the trust intranet system.
- The service undertook regular audits and used the outcome data to review resources, safety and areas of improvement. However, monitoring performance and improving practice was limited due to the current system to collect and correlate the information, lack of a robust dashboard and issues with the new electronic patient system.
- Midwives and medical staff said that teamwork and communication between them had improved since the last CQC inspection.
- The new Head of Midwifery (HOM), in conjunction with the consultant midwife, were focused on developing "normality" during labour based on current evidence based information. We observed an increased emphasis on caring for low risk women and midwifery led care within the maternity services.
- The trust provided evidence since the inspection, to indicate some improvements and initiatives had commenced to develop "normality".
- Staff were up to date with their professional development annual appraisal reviews. This was an improvement from the previous inspection.
- Multi-disciplinary working between medical and midwifery staff had improved since the last CQC inspection.
- A surveillance system of CTG monitoring in labour by means of "Fresh Eyes" was used where a second member of staff reviewed the baby's recorded heart rate regularly.
- Bespoke community midwifery skills and drills training took place to ensure skills were adequate for the home birth setting.
- Many staff were trained in complimentary therapies and provided specialist clinics to low risk patients and well as providing therapies during labour.
- A mental health specialist clinic ran weekly by a lead mental health obstetric consultant, mental health midwife and a mental health specialist nurse.
- Gynaecology employed nurse specialist in colposcopy and hysteroscopy.
- The maternity service was research active and promoted evidence based practice.
- Many forms of paint relief, including some complimentary therapies were available to patients.
- We observed procedure specific consent forms for elective and emergency caesarean sections and gynaecology services.

- The gynaecology service provided laparoscopic hysterectomies to patients within the hospital. This service had been introduced since the last CQC inspection.
- Patients, on the gynaecology ward, were assessed using the Malnutrition Universal Screening Tool (MUST) tool.
- Gynaecology patient identified as needing assistance with feeding were identified and a 'red tray' system was in place and fluid balance charts were completed for patients who needed nutrition or hydration monitoring to ensure adequate intake.

Evidence-based care and treatment

- Care and treatment was evidence-based and provided in line with best practice guidance including the National Institute for Health and Care Excellence (NICE). Standard operating procedures (SOP's) were also in place to support staff.
- However a women's and children's health "NICE guidance compliance report" from January 2017, showed that out of six NICE regulation standards, the service was compliant in two standards, partially compliant in two standards and not compliant in two standards. Three standards were on the risk register. These included antenatal and postnatal mental health, preterm labour and birth and non-invasive prenatal testing to determine baby's blood group status. Action plans were in progress for the standards that were not compliant.
- The maternity service employed a research midwife who was research active and promoted evidence based practice.
- The trust was taking part in the NHS England "Saving Babies Lives-Reducing Stillbirths Care Bundle" programme. This included the assessment of smoking and carbon monoxide monitoring, detection of baby's growth below their expected rate, the use of the reduced baby movement leaflets and checklist and baby monitoring.
- The trust had used customised individual growth charts and closer monitoring of reduced baby growth through increased number of scans. This was in line with RCOG Green top guideline 2013.
- The trust was one of 16 maternity units across England, Scotland and Wales to take part in the Obstetric Anal Sphincter Injury (OASI) Care Bundle (RCOG) to address some of the underlying causes and problems. The intervention package included a guide, multidisciplinary skills development module for health care professionals and campaign materials (such as leaflets and newsletters designed to raise awareness).
- The trust took part in local and national audits. The women's health audit programme contained 17 maternity, obstetrics and gynaecology audits up to January 2017. At the time of our inspection, all 17 audits were completed. Action plans were completed for seven of these, 10 action plans were in progress but were within the timescale for completion.
- A retrospective audit took place from 1 October 2015 to 30 September 2016 to monitor compliance with national standards for the national Sickle cell and Thalassemia programme. The Key Performance Indicators(a measurable value that demonstrates how effectively the service is achieving key objectives) met the acceptable national standard and compliance rates. However, it did highlight data collection and analysis issues due to the introduction of the trusts new electronic patient IT system.
- The World Health Organisation (WHO), five steps to safer surgery checklist was in place for surgical interventions. This tool ensures safety ofsurgeryby reducing deaths and complications and improving communication among theatre staff.
- A WHO checklist audit took place in July 2016. The observation of the use of the WHO checklist was performed prior to each procedure and the teams were compliant with the checklist. The care pathway demonstrated good compliance with the process. The new format of recording the information online was working well since it was introduced in November 2015. Data showed 100% compliance in 1251 patients across three sites. Maternity cases had shown a significant improvement in data completion since the introduction of the new IT System. An action plan was implemented and completed.
- Staff informed us that the maternity service did not have an established enhanced recovery pathway (ERP). ERP consists of best evidence based practices delivered by a

multidisciplinary team with the intention of helping patients to recover faster after surgery. It involves staff training, reorganisation and procedure specific care plans. However, we were informed that they were working towards a new guideline.

- Information provided by the trust since the inspection suggested that improvements had been made but yet to be embedded into practice.
- A surveillance system of CTG monitoring in labour by means of "Fresh Eyes" was used where a second member of staff reviewed the baby's recorded heart rate regularly.
- A "Fresh Eyes" assessment audit took place in October 2016. Fifty-one patient's notes were reviewed. Findings showed that 98% of women had fresh eye assessment in labour. Results reflected improvement in fresh eye documentation from the previous audit and improvement in the hourly assessment rate. Presence of a student midwife was associated with higher number of full assessments and documentation of "Fresh Eyes". The presence of a doctor to review a cardiotocograph (CTG) was not associated with full assessments and documentation of "Fresh Eyes". There was no difference between daytime and nighttime admissions. The action plan stated distribution of findings to midwives and doctors and to re-audit in 12 months' time.
- A weekly meeting to discuss CTG monitoring was in progress however; there was poor midwifery attendance at the meeting we attended. This was also highlighted in the last CQC inspection.
- The Alongside Midwifery led Unit (AMU) six-month interim report between May and October 2016 was published by the trust in December 2016**.** One hundred and seventy one patients were admitted to the unit (12% of total births in the unit). The service anticipated that 25-30% of women would access the unit per year based on patient demographics and benchmarking against other AMUs in the region.
- Audits, from the maternity service, demonstrated that despite the active promotion of the AMU, and introduction of a robust risk assessment to determine appropriate place of birth, patients were still being admitted to the labour ward unnecessarily. Audit results identified that a significant number of patients who were admitted to the labour ward have not had the intrapartum risk assessment completed and as a result have been treated as "high risk" and cared for on the obstetric unit. Recommendations were made in order to ensure all patients were appropriately risk assessed on admission and admitted to the appropriate place of birth. A key finding showed that all births that occurred on the AMU were appropriate and the majority of transfers from the low risk to high-risk intrapartum pathway were appropriate.
- However, information provided by the trust, since the inspection indicated that the completion of risk assessments had improved.
- The trust reported that they did not undertake any audits for patients receiving pain-relief within recommended timescale of 30 minutes of request (Safer Childbirth 2007).
- The gynaecology service provided laparoscopic hysterectomies to patients within the hospital. This service had been introduced since the last CQC inspection.
- Since the recent recruitment of the new Head of Midwifery (HOW), in conjunction with the consultant midwife, there was an increased focus on developing "normality" during labour based on current evidence based information. It was recognised within that trust that this aspect of the service required some improvement. This was also highlighted in the last inspection.
- A management and referral pathway and guideline was in place when a baby abnormality was detected. This included a timeline for when patients should be seen by a consultant, written information for parents and hospital contact details. However, there was little information for patients when discharged for hospital. The guideline was due for review since February 2016.
- Staff informed us that the TOP service had not performed any audits to evaluate practice or benchmark the service. The last audit undertaken was October 2014, which was "Management of Intrauterine death and late TOP". The recommendations concluded a re-audit. However, there was no evidence this was undertaken.
- We reviewed the guideline for the management of a late intrauterine death between 18 and 24 weeks of

pregnancy and a stillbirth less than 24 weeks of pregnancy. This included a list of investigations required, administrative and emotional support checklist. The review date was November 2017.

- Gynaecology undertook a national audit to assess the outcomes for patients undergoing urogynaecology surgery at Warrington Hospital over a four-year period 2012 to 2015. The service met the 100% NICE clinical guideline urinary incontinence target.
- A six-month retrospective audit from 1 April 2016 to 30 September 2016 took place to monitor compliance against UK National Screening Committee standards for HIV, hepatitis B and syphilis screening in the antenatal period. The trust exceeded the achievable performance threshold of greater than 99.0% for all three standards. Performance demonstrated that failsafe systems for booking bloods were effective.
- The screening midwives undertook a 12-month retrospective audit for the timely assessment of women with Hepatitis B from 1 January 2016 to 31 December 2016. The Trust met the acceptable performance threshold of greater than 70.0%.
- A Hepatitis B vaccination given to infants of Hepatitis B Positive Mothers audit took place between January 2016 to December 2016 to demonstrate that the trust was monitoring compliance with regional and national guidelines. Eight patients and 10 babies took part. All 10 babies were vaccinated within 24 hours of birth, usually within 6 hours, which met national standards.
- A Maternity Quality Indicators audit took place in May 2016 to assess clinical practice and documentation in order to assess practices in line with maternity local and national guidelines. The audit used five randomly selected sets of health records. The outcome scored 100% in three areas. Five areas showed improvement from the previous audit. Four areas showed deterioration, three areas produced exactly the same percentage of compliance as previous audit. None of the twelve areas audited scored less than the minimum expected compliance of 75%. An action plan was implemented but the version we received was not completed.
- Local Supervising Authority (LSA) audit report took place in September 2016. The report stated that the supervisors of midwives (SoM) were a strong, well-established and experienced team. All six standards were met with some recommendations including: "ensure the SoM caseload is more equally distributed, existing supervisor folders for individual midwives should move to paperless system, the current strategy for supervision needs to be reviewed and adapted to reflect the changes to supervision".
- Some medical staff informed us that regular audit meetings were held within the trust but due to workload and clinical commitments, it was not easy to attend them, as the time was not "protected time".

Pain relief

- A choice of pain relief was available to patients, who informed us that they had been able to discuss the choices available and where possible their wishes were respected.
- Complimentary therapies, such as hypnotherapy, aromatherapy and acupuncture were available to assist with pain relief and aid psychological wellbeing during pregnancy and labour.
- A 24-hour epidural service was available with the trust.
- Community midwives offered Entonox and pool facilities to labouring patients at home. They did not offered pethidine as a form of pain relief in the community setting.
- Pain relief was offered to all patients on admission for a Termination of pregnancy (TOP).

Nutrition and hydration

- Breast feeding rates provided by the trust showed that 58% of patients were breastfeeding after delivery and 57% were breastfeeding at discharge from hospital. The 2010 Infant feeding Survey states that the breastfeeding initiation rate at birth in England was 83%, therefore the trust was below the national average.
- Staff informed us that they had achieved full Level three 'Baby Friendly Initiative' (BFI) status and were due for reassessment next week. Staff informed us that the accreditation certificate was displayed in the antenatal clinic (ANC). However, we did not see any certificate or BFI accreditation success in any of the clinical areas. BFI

is a recognised United Nations International Children's Emergency Fund UK initiative which consists of three stages of assessment, including parents feedback, with regard to support for breastfeeding.

- Staff informed us that patients, with babies on neonatal unit, tended to express their breast milk and store their on the neonatal unit, not on the postnatal ward.
- There were water coolers and drinks machines available in the outpatient waiting areas.
- Patients, on the gynaecology ward, were assessed using the Malnutrition Universal Screening Tool (MUST) tool. The tool is a five-stepscreening toolto identify adults, who are at risk ofmalnutrition. It includes guidelines that can be used to develop care plans.
- Gynaecology patient identified as needing assistance with feeding were identified and a 'red tray' system was in place. The "Red Tray" system is a simple way of alerting health care staff to the fact that a person requires help with eating.
- Fluid balance charts were completed for gynaecology patients who needed nutrition or hydration monitoring to ensure adequate intake.
- There was no area on the gynaecology ward for staff to take breaks resulting in using the ward office. We observed small break room in the ANC that also doubled up as an office for some specialist midwives. This did not assure us that the wellbeing of the staff was maintained or that the specialist midwives had adequate and appropriate space for private and sensitive patient conversations via the phone.

Patient outcomes

- The maternity services did not have a current robust data collection system, such as a maternity dashboard, to benchmark outcomes, review clinical and quality performance and implement clinical changes. This did not provide assurance that patient safety issues were identified in advance so that timely and appropriate action could be taken to ensure a patient-centred, high quality, safe maternity care service.
- We were informed that the service recognised the lack of a dashboard to effectively collect and correlate patient outcomes and were waiting on the development of a regional dashboard across the Cheshire and Merseyside area.
- The service undertook regular audits and used the outcome data to review resources, safety and areas of improvement. However, monitoring performance and improving practice was limited due to the current system to collect and correlate the information, lack of a robust dashboard and issues with the new electronic patient system.
- A dedicated member of staff generated local statistics, by hand, from the birth register book and cross-referenced data with information collected from the new electronic patient IT system. Therefore, there was reliance for full completion of the register book by all staff. Failure to do so, could affect the outcome findings, policy and processes relating to implementing practice changes. Staff reported this was labour intensive, time consuming and not a very efficient or effective way to review the overall performance of the service.
- Emergency caesarean section rate was below the national rate of 15%, eight out of the 12-month period between January and December 2016. However, the highest rate was 20.56% in October 2016 and 19.57% in November 2016.
- For the same period, the elective section rate was above the national rate of 15%, seven of the 12 months. The highest rate was 18.87% in March 2016. Senior medical staff informed us that caesarean section rates were continuously reviewed and the main theme and trends for the increased rates were due to different management styles and management decisions for senior medical staff.
- From January 2016 to December 2016, the induction of labour rate was 40%. National induction of labour rates is 18% (Hospital Episode Statistics: NHS Maternity Statistics – England, 2013-14).
- In response to the rising rates of induction of labour, a retrospective audit was undertaken in February 2017 by the consultant midwife to identify the clinical indication for induction, determine whether any trends were evident in the reasons for induction, and whether any

practice issues were identified. Despite the higher than nationally recommended rate of induction observed, the audit did not identified any trends or areas of concern. However, recommendations were made which included to continuously monitor the induction rates.

- Between January 2016 and December 2016, the forceps rate was 8.03%. This was below the national average was 6.8% (Maternity statistics for England 2014).
- The current homebirth rate was 0.1%. The national average is2.3% in England and Wales (Office of National Statistics). Senior staff informed us the rates were being reviewed in order to try to increase the uptake of homebirths. This included a change of model of care, new community midwifery teams and rotation of community midwives into the AMU.
- During the inspection we were informed by staff that there was no data available relating to incidents of third and fourth degree perineal tears and postpartum haemorrhage (PPH) on the labour ward. This highlighted that the service were not reviewing elements of care that other trusts locally and nationally were reviewing.
- In 2016, the Neonatal Audit was below the national Neonatal Audit programme (NNAP) standards for all of the five standards. Three standards were just below the standard benchmark grade. The remaining two standards were significantly below the benchmark set nationally. However, these two standards were not directly linked with the maternity unit.
- Data from the trust showed that the stillbirth rate reported in 2015 was seven. In 2016, this was reduced to three stillbirths. Up to 7 April 2017, there were no stillbirths recorded. These reduced numbers were an improvement since the last CQC inspection and within national rates.
- Admissions to the maternity High Dependency Unit (HDU) between February 2016 and February 2017 were 28 patients. Fourteen patients were admitted for bleeding related issues and six patients were admitted with high blood pressure.
- From January 2016 and December 2016, there were eight patients admitted to the trust Intensive Care Unit (ICU). The main reasons for admission were infection, pneumonia and bleeding. The average stay was no more than two days.
- Between March 2016 and November 2016, there was an increase of unexpected admissions of babies to neonatal intensive care unit (NICU) with suspected sepsis (infection). Staff informed us that the cause for the increase was due to the rigid interpretation of the NICE guideline relating to the prolonged rupture of membranes and the subsequent use of antibiotics for patients and babies. Identified risks were displayed on staff notice boards and shared at staff safety brief meetings. Education was provided to help staff interpret the risk factors and complete a datix incident report when appropriate.
- Ninety-six patient referrals were made to the stop smoking midwife in 2015. Since the national introduction of compulsory carbon monoxide testing (NHS 2010) in the antenatal period, referrals had increased to 276 patients in 2016.
- The stop smoking midwife informed us that the rate of patients smoking at booking was 10.4%. This was below the national average of 12% (hscic 2015). The trusts were unable to provide smoking rates at delivery due to IT data collection problems.
- Birth outcomes, from the interim performance report on the Alongside Midwifery Led Unit (AMU), between May 2016 and February 2017, showed that 84% of first time mothers and 95% of second time mothers gave birth on the unit. Eleven percent of all patients were admitted to the maternity service, were to AMU, however, the trust predicted target was 25-30%.
- Seventy one percent of patients admitted to the AMU gave birth without any interventions. Forty seven percent of patients used water during labour as a form of pain relief, 45% gave birth in water.
- One hundred percent of patients on AMU were on the appropriate pathway.
- Sixty three percent of patients breast-fed following delivery on AMU. The 2010 Infant feeding Survey states that the breastfeeding rate at birth in England was 83%.

- The AMU interim performance report highlighted an improvement in the completion of risk assessments, patients on the appropriate pathways, an increase in physiological delivery of the placenta (no drugs used) and a decrease in poor clinical outcomes. Areas for improvement included improved documentation, increase the number of patients assessed on AMU, transferred to labour ward when baby's heart rate is a concern and number of patients discharged from AMU.
- For the same reporting period, the rate of postpartum bleeding (PPH – bleeding after birth) over 1500mls on AMU was 1.5%. There were three cases of shoulder dystocia (shouldersfail to deliver shortly after the baby's head). All eligible babies received optimal (delayed) cord clamping and skin-to-skin contact (national recommendations).
- Baby admission rates from AMU to the neonatal unit (NICU) were 3.1%. There were no babies born with Apgar scores (a score of ten that represents the best possible condition of a newborn baby) less than 4 at 5 minutes, and the rate of babies born with medical complications included one baby that required cooling (a procedure to improve babies who have lacked oxygen at birth) (0.7%).
- However, information provided by the trust since the inspection, indicated that the neonatal admission rate from AMU to NICU had decreased.
- All cases on AMU of shoulder dystocia, PPH greater than 1000mls, admissions to NICU, and adverse patient or baby outcomes were subject to multidisciplinary incident reviews and external reviews where indicated.
- The overall intrapartum transfer rate from AMU to the labour ward between May and October 2016 was 25%, which was below the rate suggested in the birthplace study (2011).
- The majority of transfers from AMU were appropriate and there were no cases where patients should have been transferred to the high-risk pathway. Of the 42 patients transferred from the low risk to high-risk intrapartum pathway, 57% physically changed geographical location to the labour ward. The remaining 43% patients remained on the AMU. The reason for not transferring patients was often not documented in the records. Of those transferred, 50% achieved a vaginal birth, 29% assisted instrumental birth, 17% caesarean section, and 4% failed instrumental Caesarean section.
- In October 2016, a labour ward audit took place to determine compliance with risk assessments for place of birth. Only 7% of patients had completed an intrapartum risk assessment. Thirty two percent of patients were on an inappropriate high-risk pathway, 35% of patients admitted to labour ward were suitable for AMU. Thirty-five percent of patients had baby monitoring discussed and 32% had a CTG without a clinical indication. This did not assure us that all staff were following the national and trust guidelines.
- However, information provided by the trust since the inspection, indicated an improvement in the completion of risk assessments and a reduction in the number of patients receiving CTG without clinical indications.

Competent staff

- Up to February 2017, 93% of midwives and health care assistants (HCA) had completed an annual appraisal. This was above the trust target of 85%. An appraisal gives staff an opportunity to discuss their work progression, professional and personal development and future aspirations, objections and goals. This was an improvement from the last CQC inspection.
- Gynaecology staff were supported in their development using the appraisal process, which was undertaken annually. There was 100% compliance for appraisals for nursing staff in the gynaecology department. This was above the trust target.
- A preceptorship and development programme (to guide and support all newly qualified practitioners to make the transition from student to develop their practice further) was offered to all newly qualified staff. This enabled all new staff to work in all clinical areas to gain experience and increase confidence. The programme for each member of staff was between 18 months and two years.

- All new staff received a document to complete their competencies when achieved. It also contained information such as the role and responsibilities of the new midwife, accountability, supervision, revalidation, reflection, training expectations and job description.
- Regular monthly preceptor meetings with held between the practice education midwife and new staff on the preceptor programme.
- Gynaecology staff informed us that they attended training for immediate life support (ILS) training as part of mandatory training requirements with a compliance of 100%.
- Community midwives informed us about bespoke skills and drills training that were held during the year, appropriate for the home setting. A flat on the hospital site was used for the training to make it realistic for the community midwives and the midwives were trained in small groups, again to make it realistic. The training included risk assessment for place of birth, record keeping, transfer into hospital, water use in labour, delivery of the placentas, suturing and contents review of new homebirth kit bags. Practical homebirth scenarios were also re-enacted.
- Newborn life support training (NLS) was provided external to the trust for band seven labour ward midwives. All nine of the band seven midwives had completed the training.
- Due to shortness of staff, we observed a staff member, from another speciality, scrubbed in theatre when they had not done so for a long period. We also observed a HCA from the ward being asked to scrub in theatre, however she declined as she had not done so for some time and felt she was not safe to do so.
- At the time of our inspection, community midwives were not part of the escalation process for staffing within the maternity unit nor did they rotate into the labour ward to maintain skills and competencies. Some community midwives told us they had not undertaken a homebirth or pool birth in many years and some midwives informed us that they had never undertaken a pool birth. This was raised as a concern to the senior service leads during our inspection.
- However, in response to the concerns raised, the trust responded promptly to address the community midwifery skills and competencies. Information, provided by the trust since the inspection, indicated that training had been completed and competencies had increased for community midwives.
- Community midwifery management staff, at the time of the inspection, informed us that they were confident that their community staff were competent and skilled, as they had undertaken a bespoke community midwife skills and drills training day as well as attending the three-day mandatory training programme.
- We were informed that two community midwives worked bank shifts on labour ward and that two other midwives highlighted themselves as benefiting from working on the AMU to keep upskilled and came into work on the labour ward and AMU for a block period of one month.
- We were also informed that from April 2017, community midwives were to start to rotate into the AMU to keep up to date, increase continuity of care and increase overall birth rates.
- Maternity ward staff informed us that only recently had they been trained and supported to undertake a standard blood test from babies to monitor their blood sugar levels. The paediatric doctor undertook other standard tests for babies such as a blood test (serum bilirubin or SBR) for measuring for jaundice levels. All babies who required phototherapy treatment for jaundice were cared for on the neonatal unit (NICU). Babies also attended NICU for intravenous (IV) antibiotics. This did not assure us that all staff were maintaining their skills and working within their RCM training and competency levels.
- However, the trust provided evidence since the inspection, to indicate an improvement in the unnecessary admissions to the neonatal unit. This needed to be embedded into practice and audited in the future.
- The ratio of supervisors to midwives to midwives met with the national recommendations of one to fifteen. The primary role of the SoM is to ensure the safety of patients and babies and in the provision of high quality midwifery care.
- A Supervisor of Midwives (SoM) was available 24 hours a day, 7 days a week in the maternity service.

- Specialist roles within the maternity service included: consultant midwife, governance manager, infant feeding coordinator, practice development midwife, audit midwife, teenage pregnancy midwife, substance misuse midwife, research midwife, antenatal screening coordinator, bereavement midwife, smoking cessation midwife, practice education facilitator.
- One midwife was trained in acupuncture and two more were undergoing the training. There was a weekly acupuncture clinic in antenatal clinic (ANC) that provided relief for backache in pregnancy. Patients could be referred from the community midwives, physiotherapist and consultant midwife.
- Six midwives were diploma trained in aromatherapy and reflexology complimentary therapies. They in turn had cascaded their training and knowledge into developing their own in house package where 98% of midwives have been completed the trained. Once a week a "post-dates" aromatherapy clinic takes place, in ANC where patients who were past their due date were offered a membrane sweep (an internal examination to help start labour) and aromatherapy oils plus a routine antennal check. All patients have risk assessments completed and guidelines are in place for staff to follow.
- Complimentary therapies were also offered to low risk patients who had previously experienced a caesarean section and would like a normal delivery. Staff informed us that these therapies also reduced the likelihood of being induced to start labour contractions. Risk assessments were completed to access suitability.
- Five midwives were trained to deliver hypnobirthing (a form of self-hypnosis for labour and natural childbirth).
- Staff informed us that unannounced, multidisciplinary skills and drills scenarios took place in maternity services to simulate obstetric emergencies such as shoulder dystocia, cord prolapse, and post-partum haemorrhage.
- Gynaecology had specialist-trained nurses in colposcopy and the rapid access clinics.
- Gynaecology staff informed us that due to the outliers on the gynaecology wards, which included trauma, orthopaedics and general medicine patients, they did not always feel competent to care of these specialties.
- Junior medical staff informed us that while they enjoyed the work on the labour ward because they received good support and were not asked to do anything beyond their capabilities, this was not always the case when they worked on the gynaecology wards.

Multidisciplinary working

- Midwives and medical staff said that teamwork and communication between them had improved since the last CQC inspection. They informed us that they now attended multi-disciplinary meetings together and felt happy discussing patient care and service improvement, which included challenging practice around evidence, based information.
- All staff we spoke with told us that departments worked well together and supported each other across departments. There were processes in place to refer to physiotherapy, for example if there were patients from the trauma and orthopaedic speciality.
- However, we attended a cardiotocography (CTG) meeting, which lacked midwifery involvement and attendance. This meeting was informal between the outgoing and incoming on call medical team, which was more like a patient handover meeting rather than an educational meeting. There were no opportunities to ask questions. No formal notes were taken. There was no formal timetable or schedule for these meeting.
- We reviewing MDT perinatal morbidity and mortality meeting minutes, where we observed a lack of midwifery involvement and attendance. Midwives informed us that it was not always easy to attend meetings due to the clinical demands on the unit.
- We requested minutes from the last three maternity consultant and medical meeting minutes. The trust provided us with minutes from the multidisciplinary team meeting held in December 2016. No attendees were listed on the minutes.
- We were provided with minutes from two women's business health meetings held in December 2016 and January 2017. Ten people attended the meeting in December 2016; there was no midwifery or gynaecology representation at the meeting. Fifteen people attended

the meeting in January 2017, only one midwifery representative attended. There was little assurance to suggest that midwives or gynaecology nurse representation was evidence at senior or local meetings.

- Staff informed us that all baby abnormalities and management were discussed at MDT meetings held every three months. Staff that attended included specialist consultants, sonographer, paediatricians, bereavement midwife, screening midwife, and antenatal assessment day unit (ANDU) midwives.
- There was an example of when a patient had been discharged and had not received the required follow up by community midwives from another provider. This showed a breakdown in communication between the hospital staff and community midwives in the local area. However, we saw evidence to suggest that this concern was raised and discussed between the two providers steps were being taken to improve discharge communication.
- There was a midwife with a lead role for supporting patients with mental health issues. They could assist patients to get access to specialist services and the inpatient mental health services could be used if required. A mental health specialist clinic ran weekly by a lead mental health obstetric consultant, mental health midwife and a mental health specialist nurse.
- Antenatal clinic staff had access to a phlebotomist to take patients' blood samples every morning. However, this service was not available in the afternoons.
- For patients who attended for diagnostic colposcopy and hysteroscopy, the nurse specialist liaised with a neighbouring trust where treatment took place. Staff told us that this system worked well.

Seven-day services

- The Antenatal Day Assessment Unit (ANDU) was opened seven days a week from 8am to 6pm. Out of hour's patients went directly to the labour ward.
- Antenatal clinic opened Monday to Friday, 8am to 5pm; however, some evening booking appointments were offered to accommodate patients who could not easily attend during the day. There was consultant and senior registrar cover in ANC every day.
- Women could self-refer to ANDU or be referred by the community midwife, labour ward, emergency department, GP, or other referral agencies. The direct line phone number was provided in the patient's hand held notes.
- The antenatal day unit provided a seven-day service between 9am and 6pm, offering some late appointments in the evenings.
- The Alongside Maternity Led Unit (AMU) was opened seven days a week, 24 hours a day.
- The EPAU was open Monday and Friday 9am until 5pm. On Tuesdays, Wednesdays and Thursdays, EPAU clinics were in the morning only. There were no clinics at weekends. This meant that patients would need to access the scanning services via accident and emergency in the evenings or weekends.
- The scanning room was available 24 hours a day. The sonographer was available when the EPAU was open; otherwise, medical staff with ultrasound skills completed any out of hour's scans.
- Patients in the Halton area were able to access day case surgery services at Halton hospital but needed to meet criteria of the American Society of Anaesthesiologists (ASA) guidelines. In addition, the day-case ward was open Monday to Friday only from 7:30am until 7:30pm. If a patient needed to stay overnight, they were transferred to the neighbouring ward.
- We were told that pharmacy services were available at Halton between 9am and 5pm and between 9am and 7pm at Warrington Monday to Friday. Saturdays and bank holidays services operated from 10am and on Sundays from 11am until work was finished (generally between 3pm and 5pm).

Access to information

- Staff accessed information from the trusts electronic systems, intranet and paper records that were readily available.
- Policies and procedures were available on the trusts extranet where the most current versions were stored.
- Patient discharge letters included information website and helpline details.

- Information leaflets and posters were available and accessible for patients.
- There were leaflets in other languages other than English available on the trust intranet "hub".
- A translation service was available either face-to-face or accessed via the telephone. Staff informed us that they did not rely on family members for interpretation.
- There was specific information in an easy read format, such as pictures for patients with learning disabilities. However, not all staff was aware where the information was kept on the maternity ward.
- Community midwives informed us that they used two different IT systems, which did not interlink with each other; therefore, it was time consuming to use both systems. They also provided examples of incorrect sensitive patient information being incorrect transferred from one IT system to another that had to be escalated to their manager.
- Midwives were all allocated electronical devices to access information within and outside the hospital premises.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Mental Capacity Act training compliance rates over the last 12 months for doctors was 53%, midwives 59% and nursing staff 58%. The trust target for all training was 85%. This did assure us that staff were up to date and adequately skilled to feel confident in their roles and responsibilities in identifying and protecting patients at risk and follow best practice when providing care.
- However, staff informed us that they had received some mental health training on their annual mandatory training days and had a non-judgemental attitude towards women with mental health issues, learning disabilities or substance misuse.
- We were informed that staff worked closely with social services that were happy to visit the wards to provide MDT support.
- Maternity services had a specialist mental health midwife, a dedicated obstetrician for mental health and mental health nurse, who all facilitated a weekly mental health clinic. They also provided support to staff on the wards.
- We reviewed records and attended a multidisciplinary meeting regarding a patient with special needs. All necessary steps were taken to ensure the patients' mental capacity was assessed and that the patient understood her rights. There was a good trigger plan completed in the records and staff had adhered to these. We observed good input from the safeguarding lead.
- There were picture booklets that staff could use with patients with learning difficulties.
- We observed procedure specific consent forms for elective and emergency caesarean sections and gynaecology services. This was an improvement from the previous CQC inspection.
- All consent forms we reviewed in theatres were completed appropriately.
- For TOP procedures, we saw evidence that two doctors reviewed the documentation and signed the HSA1 form, if they agreed that the reason for the termination of pregnancy met one or more grounds of the Abortion Act 1967. Legislation requires that for an abortion to be legal, two doctors must each independently reach an opinion in good faith as to whether one or more of the legal grounds for a termination is met.
- A quality of consent and documentation audit took place in December 2016. It looked at the consent process and consent forms for elective procedures and treatments at the obstetrics and gynecology departments at Warrington and Halton Hospitals. A total of 21 patient notes and consent forms were reviewed. Compliant rate was meet however documentation showed that patient information leaflets about the procedure was provided to only 76% of patients, 38% of patients was referred for anesthetic opinion prior to the procedure taking place. The action plan was to re-audit in December 2017.
- A consent form audit took place in January 2017 by the theatre team. The audit focussed on the two-stage consent process. Twelve patient case records were reviewed. Recommendations included re-emphasise within the division that patients should be given the yellow copy of the consent form or clearly state if patients do not want the copy and illegible writing to be improved. The procedure for consent was not identified

on four consent forms. This was discussed with theatre staff at safety briefing meetings. A re-audit with a larger sample size was planned for February 2017 with the report completed for 31st March 2017.

- For a patient with a hearing impairment, the Deaf Centre was contacted to access a signing expert. For non–English speaking patients, the trust interpreter service was accessed for consent.
- In February 2017, an email, with a link, was sent to all staff in the Women's and Children's Division to remind them about the Court of Protection (COP) advice about not delaying in applying to the court in obstetric cases where mothers lack capacity and are refusing care believed to be in her best interests.

Are maternity and gynaecology services caring?

Good

We rated caring as good because:

At the previous inspection in January 2015, we rated caring as good mainly due to staff treating patients with dignity and respect, kind and polite interactions observed, patient's involvement with birth plans and recognition by all staff to increase normality of labour. We have maintained this rating following this inspection because:

- The majority of staff were kind and polite in their interactions with patients and families.
- Patients said they were involved in their birthing plans and their choices were listened to and respected.
- Patients we spoke to informed us that they were happy with the care they had received and spoke positively about the staff that were caring for them.
- Gynaecology staff informed us about a wedding they had arranged on the ward for an unwell patient and had subsequently won "Team of the Year" within the trust for this
- The bereavement team had been successful in the National Butterfly Awards.
- The Friends and Family Test results were similar to national averages.
- Gynaecology staff told us about fund raising events they held in order to buying personnel toiletries and supplies for patients who were without on the wards.
- A visitor arrived on the gynaecology ward to say thank you and show their appreciation to staff during our visit.

Compassionate care

- Patients we spoke to said staff were kind and caring. They said they had been treated with patience and respect.
- Patients said staff introduced themselves, were friendly and included them in their care. Patients were very positive about the care they received from all staff.
- Thank you cards, received from patients, were displayed in office areas.
- We observed two phone calls between staff and patients that were compassionate, empathic and caring.
- We observed that patients were treated with respect and promptly in all areas. Privacy and dignity of patients was maintained during consultations. In the outpatient areas, consultations took place in individual closed rooms with chaperones present and notices to 'knock before entering'.
- On the ward, consultations took place either in a closed treatment room or behind privacy curtains around patient beds, however; curtains were not sound proof.
- We observed that during busy times, doors to bays or corridors were open, however staff attempted to keep them shut where possible.
- During the inspection, a hospital volunteer completed a 'privacy and dignity' survey as we had observed some aspects of care where privacy was not always maintained, especially on the gynaecology ward. This was highlighted at the time of our inspection.
- The week prior to inspection, the gynaecology ward had received a hospital award for "Team of the Year in Excellence in Patient Care 2017". They were nominated following a wedding that was held on the ward for a palliative care patient. Staff decorated the ward and stayed over their shift times to create a special day for the patient.
- We were told that the ward staff had carried out fund-raising activities in order to raise funds to purchase

items on the ward. These have included toiletries and nightwear for patients who dot have any with them as well as small food hampers, such as juice, and a ward hairdryer.

- At the time of inspection, a former patient visited the gynaecology ward to thank all the staff for their excellent care during her stay. In addition, she requested details of senior management in order to contact them and pass on her gratitude about the ward.
- From November 2015 to November 2016, antenatal Friends and Family Test (FFT) was generally similar to the England average. In November 2016, the performance for antenatal clinic was 97.7% compared to a national average of 96%.
- For the same reporting period, FFT for birth was generally similar to the England average. In November 2016, the performance for birth was 97.3% compared to a national average of 96.6%.
- For the same reporting period, postnatal FFT performance was generally similar to the England average. In November 2016, the performance was 93.6% compared to a national average of 93.7%.
- For the same reporting period, postnatal community FFT was generally better than the England average. In November 2016, the performance for postnatal community was 100% compared to a national average of 97.5%.
- The current FFT (a survey which asks patients whether they would recommend the NHS service to friends and family who need similar treatment or care results) results were displayed outside the gynaecology ward showing that 96.2% would recommend the service.
- The trust performed about the same as other trusts for 15 out of 16 questions in the CQC Maternity survey 2015. The only indicator they performed worse than other trusts on was "If you raised a concern during labour and birth, did you feel that it was taken seriously?"
- The trust reported no Local Patient Surveys had been undertaken

Understanding and involvement of patients and those close to them

- Patients could be reviewed by staff, with those close to them if preferred as well as a chaperone.
- Colposcopy advocated a 'vocal local' approach with a nurse carer present to talk to the patient during the procedure as well as the trained nurses.
- Varieties of leaflets were available in all areas containing information specific to certain conditions or treatments.
- Community midwives and staff on the AMU informed us that they involved patients as much as possible in their birth choices and plan.
- The consultant midwife, midwifery lead for AMU and the Head of Midwifery informed us that they were keen to promote a "normal birth"which involved and included patients to make informed decisions about how they would like to give birth.
- Maternity patients said they had been included in their own care and been able to discuss and choose the mode of delivery. Where possible their choices had been respected and when they had not, discussions with the patient had taken place and explanations had been clear.
- Partners could be present on the AMU, labour ward and bereavement room. However, there were no facilities for partners on the ward or induction bay area.

Emotional support

- There were two nurse practitioners for colposcopy, one of which was also the nurse specialist cancer rapid access. These staff provided wellbeing support as well as providing clinical care. A local charity organisation was also accessed if needed to provide support.
- Any patient, following a miscarriage or stillbirth was referred to the bereavement midwife for clinical, practical and emotional support. The bereavement midwife allocated time to comfort and advise parents through sensitive issues such a memory items such as photos, pictures, cuddling their baby as well as proving support and advise around burial.
- Staff were supportive to parents and those close to them following the loss of a baby, and offered emotional support to provide comfort and reassurance. The trust provided memorial services for newborn babies and the families.
- The bereavement service had won the "Best bereavement birth professional" in the National Butterfly Awards 2016.

Maternity and gynaecology

- All patients following a termination of pregnancy (TOP), for baby abnormality, were offered counselling and a blessing from the hospital chaplain, involvement from the local or family church if requested.
- The consultant midwife offered "Birth Choice" one to one appointments and monthly workshops to discuss and support families who had experienced a traumatic birth, are experiencing fear of childbirth, or to discuss vaginal delivery following a pervious caesarean section. We attended one of these small group sessions in the evening. It was delivered in a sensitive, practical and professional manner, allowing plenty of time for families to discuss their concerns.
- Gynaecology staff caring for patients, who had experienced a TOP, had developed a checklist to ensure consistent care was provided when different staff were looking after the patient.
- A designated screening midwife offered support and counselling to patients who had received bad news following diagnostic screening. They also directed patients to additional external support.

Are maternity and gynaecology services responsive?

Requires improvement

We rated responsive as requires improvement because:

At the previous inspection in January 2015, we rated responsive as require improvement mainly due to staffing and capacity issues, multiple closures of the maternity unit, long waiting period for patients, outlier patients on the gynaecology ward and lack of transitional care facilities on the maternity ward. Following this inspection we have maintained this rating following this inspection because;

- Bed occupancy on the gynaecology ward was above 100% in January 2017 and February 2017. It was 98.66% in December 2016.
- Gynaecology beds were used on a daily basis, including weekends, for patients with other medical, surgical or orthopaedic conditions. This resulted in access and flow issues and some cancellations of procedure. These patients often remained longer on the gynaecology ward than expected, therefore, effecting capacity of beds for gynaecology patients. This was a concern highlighted in the last CQC inspection.
- We observed elective surgery patients being telephoned by staff and their procedures cancelled on the same day it was due.
- We observed examples of patients telephoning the maternity service to be told of significant delays to their expected admission.
- Staff informed us of delayed doctor reviews for patients due to the workload capacity within the unit. This could often lead to delays in treatment or discharge home.
- Full transitional care facilities were not available on the maternity ward, which meant babies who required treatment such as phototherapy, or intravenous antibiotics were transferred to the neonatal unit. This was not in line with best practice as it meant the mother and babies were separated. This was a concern highlighted in the last CQC inspection.
- The design of the some of the waiting areas in the antenatal clinic meant that gynaecology and maternity patients could wait together in the same area, which was not in the best interest for their emotional needs.
- We observed privacy and dignity concerns in both the obstetric theatre and gynaecology wards, which did not meet the individual patient's needs.
- Due to bed demands, staff informed us that sometimes antenatal and postnatal patients shared the same rooms on the maternity ward.
- Staff informed us of delays of patients on the induction of labour bay due to staffing issues and increased workload on the labour ward.
- Patients complained about staff not answering the telephone on the Early Pregnancy Unit (EPAU) when they tried to phone the unit from home.
- The maternity service did not audit delays in transfer from the antenatal ward, triage or induction bay to labour ward.
- The maternity service did not audit waiting times in the antenatal assessment day unit (ANDU).

- There was no dedicated triage area in the maternity service.
- Information notice board was displayed in staff and public areas. However, data collected on some of the public facing boards were difficult to understand as information was represented by coloured dots rather than written information.

However

- In May 2016, the service introduced n Alongside Midwifery Led unit (AMU) beside the labour ward to promote midwifery led care and promote "normality" in labour. A dedicated band seven midwife managed this service.
- Maternity services ran specialist clinics to provide care for individual needs and concerns and facilitated workshops for couple with specific worries such as fear in childbirth and previous poor obstetric history.
- From December 2016 and 8 March 2017, there were no maternity unit closures.
- Leaflets were available in different languages on the trust intranet system. The gynaecology wards also had resources in braille and large font.
- Staff were aware how to arrange interpreter services.
- Midwifery staff were trained to provide complimentary therapies to patients and facilitated workshops for aromatherapy, hypnotherapy and acupuncture.
- Smoking cessation advice and carbon monoxide monitoring being offered to patients in the antenatal clinic.
- The maternity service was recently successful in achieving a large financial award. The service planned to develop the training and development programme.
- The maternity labour ward had a large private dedicated bereavement room for patients to delivery in and for partners to stay overnight. This was decorated in a sensitive homely way.
- Antenatal booking appointments in antenatal clinic were offered in the evening to accommodate patients who were at work or busy during the day.
- Twenty-two midwives had completed the Newborn and Infant Physical Examination(NIPE) programme. This offered parents of newborn babies the opportunity to have their child examined shortly after delivery.
- Community midwives also offered appointments at GP practice close to the patients home.
- EPAU staff at the Warrington site tried to arrange procedures for Halton patients at the Halton site for patient ease and convenience.
- Medical termination of pregnancy (TOP) service was available at Warrington for baby abnormalities. Patients that requested a TOP for 'social' reasons were signposted to independent health providers locally.
- Patients with dementia were identified using the "Forget Me Not" flower symbol on the electronic patient information system.
- Gynaecology service provided a "rapid access" clinic for patients with cancer.
- Gynaecological cancer services achieved the national two-week wait for all patients where gynaecological cancer was suspected. The service also met the 31-day national standard. However, the 62-day national target was not achieved.
- Written information was readily available in a variety of languages. This was also an improvement from the last CQC inspection.

Service planning and delivery to meet the needs of local people

- We observed smoking cessation advice and carbon monoxide monitoring being offered to patients in the antenatal clinic (ANC). Staff were aware how to refer patients to the local stop smoking service for further advice and treatment.
- Antenatal booking appointments in antenatal clinic were offered in the evening to accommodate patients who were at work or busy during the day. Community midwives also offered appointments at GP practice close to the patient's home.
- Gynaecology services included many nurse led clinics and consultant clinics such as, colposcopy clinics, histoscopy clinics, and pre-operative clinics.

Maternity and gynaecology

- Patients from the Halton area, could access gynaecology day surgery at the Halton hospital site.
- Community midwives told us about providing care in various geographical areas to help patient's access services easily.
- Full transitional care facilities were not available on the wards, which meant babies who required treatment such as phototherapy, or intravenous antibiotics were transferred to the neonatal unit. This was not in line with best practice as it meant the mother and babies were separated.
- However, since the inspection, the trust had provided evidence, which suggested improvements to enable mothers to care for their babies, who needed extra care, with support from staff. This needed to be embedded into practice and audited to access the impact.

Access and flow

- Bed occupancy, including beds used for escalation for other speciality patients; on the gynaecology ward for December 2016 was 98.66%. January 2017 was 110.48% and February 2017 was 109.52%.
- Bed occupancy levels for maternity were generally lower than the England average, with the trust having 59.2% occupancy, compared to the England average of 61.1%.
- Between March 2015 and December 2016 the maternity unit closed on seven occasions. There were no further closures up to the 8 March 2017. The last time it closed was June 2016. Lengths of closures were between 4 hours and 14 hours. On three occasions, the length of closure was not recorded. The trust informed us that the main reason for the closures was the lack of available beds. No patients delivered in other trusts during the periods of closure.
- There was a hospital divert policy in place. This was within the midwifery escalation policy.
- Information provided by trust about outpatients waiting times was difficult to understand. Data was collected from April to March but the year was not stated. For this period overall obstetric waiting times was recorded as 11%, gynaecology 14.49% and midwifery 6.80%. However, these figures were not explained or represented against a trust or national target.
- Gynaecology 18 weeksreferral to treatment(RTT)trust target was met between April 2016 and January 2017.
- Between April 2016 and December 2016, gynaecological cancer services achieved the national two-week wait seven of the nine months, for all patients where gynaecological cancer was suspected. The service also met the 31-day wait from diagnosis to first treatment for all months. The 62-day national target was not achieved five of the nine months however; November and December 2016 achieved 100%. The trust reported that they were in the process of fully implementing Somerset Cancer register by the end of March 2017 to help improve the 62-day target. Staff also told us that the 62-day target was due to lack of radiographer support and a risk mitigation plan was in place.
- Data provided by the trust relating to delayed discharges showed that between August 2016 and January 2017, 165 patients experienced delay discharge. The trust stated that the delays were attributable to both the NHS and Social Care. Reasons included non-completion of risk assessments, funding, care home placements and community equipment and adaptions.
- We requested any audits, outcomes and action plans of delays in transfer from the antenatal ward, triage or induction bay to labour ward. The trust informed us that there are no audits performed to monitor this. This did not assure us that the trust were monitoring assess and flow and delays in transfers to the labour ward, therefore unable to implement any changes to improve the patient experience and monitor safety of patient and baby
- We requested the patient waiting times audits for triage. The trust provided us with an audit of the patient journey through ANDU from October 2015. This did not assure us that the trust were regularly monitoring assess and flow and waiting times in order to implement any changes to improve the patient experience and monitor safety of patient and baby.
- Between July 2015 and December 2016, there were 294 attendances for gynaecology at Warrington and 1, 581 gynaecology attendances at Halton, for the same period.

Maternity and gynaecology

- From April 2016 to March 2017, 584 gynaecology day surgery cases went undertaken at the Halton Day Case Unit. We were informed that 600 cases were projected for full 12-month period ending 31 March 17.
- The gynaecology ward included two six bedded bays and two cubicles for gynaecology and breast surgery patients. There was also an additional bay for day attenders, however; due to bed pressures in the hospital, this additional bay was being utilised as an escalation bay.
- The gynaecology ward was used for medical and surgical patients on a regular basis. There were five medical outliers and four surgical outliers on one day of the inspection. Staff told us that this was usual. Staff said this affected their ability to accommodate gynaecology patients and operations could be cancelled as a result. However, information provided by the trust showed that over the last 12 months, there were only five patient outliers on the gynaecology ward.
- We also observed a patient fasting for over 36 hours in the gynaecology ward while waiting for a sensitive procedure. The patient was upset and anxious due to the nature of her condition. Staff informed us that this was due to the busy workload and the medical team being too busy. This was highlighted to the CQC inspection Lead and highlighted to senior management as a concern during our inspection.
- For elective surgery, patients were contacted by phone to update about the availability of beds. At the time of inspection, two patients were admitted in the morning, however; the three patients expected in the afternoon were cancelled and rearranged.
- There was some uncertainly among midwifery staff regarding where the designated triage area was situated. The antenatal day unit (ANDU) acted as a triage for some patients with any pregnancy related issues, including abdominal pain, vaginal bleeding, close and regular blood pressure monitoring and rupture of membranes (sac of water that surrounds the baby in the womb). Staff reported that the unit could become very busy with patients waiting for long periods. There was a senior house officer (SHO) assigned to work on the unit every day. Registrar and consultant cover was available until 7pm. This did not provide a timely response to patients who had presented with concerns. This was also a concern raised at the last CQC inspection.
- A triage service was also available on the labour ward. Having two types of triage areas did not assure us that all patients knew where to phone into or attend when seeking advice and review.
- A junior doctor was responsible for the antenatal clinic and ANDU, with the second on call doctor (the registrar) who was responsible for the labour ward. This meant any patients who needed to see a doctor had to wait for one to become available. Staff said when the unit was due to close at 5pm they could have patients still waiting to see a doctor. This meant there were delays in patients being admitted to the labour ward or being discharged from this unit. This was also a concern raised at the last CQC inspection.
- Due to the workload and staffing level on the labour ward, we observed examples of advice given to patients via the telephone which highlighted an access and flow sue. A patient rang at 8pm with a history of reduced baby movements and was told by staff to come into the ward at 21:30pm, a patient rang at 3:40pm and was told to come in at 7pm, a patient rang at 6:10pm and wad informed to come in at 8pm. This did not assure us that patient concerns safety was actioned immediately.
- Some midwives informed us that due to lack of access to medical staff on the post-natal ward, patients were not always reviewed or discharged home in a timely way. This was also a concern raised at the last CQC inspection.
- Maternity staff informed us that they currently did not actively promote 6-hour discharges from hospital but this would commence on AMU in the future.
- Twenty-two midwives had completed the Newborn and Infant Physical Examination(NIPE) programme. This offered parents of newborn babies the opportunity to have their child examined shortly after delivery and helps with discharges from the postnatal ward in a timely way. Four more midwives were currently undertaking the training.

Meeting people's individual needs

Maternity and gynaecology

- We observed a patient undergoing a sensitive medically enhanced emotive procedure, sharing a six-bedded room on the gynaecology ward during our inspection. This did not assure us that privacy and dignity was maintained.
- We observed a patient fasting for over 36 hours in the gynaecology ward while she waited for an emergency sensitive procedure. This was highlighted to the CQC inspection Lead and highlighted to senior management as a concern during our inspection.
- The Early Pregnancy Assessment Unit (EPAU) was only open during weekdays, although patients were given open access to the gynaecology ward out of hours. We were given examples from patients about the difficulty in ringing the EPAU and having to choose an alternative department to be seen in due to their health and anxiety concerns.
- Clinics were accessible for patients with reduced mobility, however; there was no raised seating seen.
- Staff told us that there was no hearing loop in gynaecology, however; staff could contact a local deaf centre to access signing services if needed.
- There was no system in place to identify gynaecology patients with a learning disability, although, once identified patients were able to visit the wards prior to surgery and be accompanied by carers during their stay.
- There was a counselling room, in the EPAU, however; it was very plain. The ward sister explained that she would like to change the décor of the room. In addition, change one of the side rooms to be suitable for patients requiring sensitive surroundings.
- There was no 'one stop clinic' for colposcopy and hysteroscopy. Patients attended a consultation and scan appointment, via a rapid access system. The trust provided a diagnostic service; any treatment needed took place at a neighbouring NHS trust.
- There was a designated bereavement suite, which included a separate delivery room, for parents who had lost a baby. This included a large homely designed room away from the main ward with facilities for parents to remain with their baby should they wish. It was a sensitive environment and the decoration had been chosen and provided by a bereaved parents' charity.
- The community midwives ran parent education classes. A four week programme was based on the national "Pregnancy Birth and Beyond" programme. Venues were in the community setting and hospital. Day and evening classes were available to accommodate all parents. A programme included the health visitor attending, basic newborn resuscitation awareness training and a tour of the maternity unit.
- The consultant midwife cared for and supported patients who would like to try for a normal vaginal birth following a previous caesarean section in the past.
- The maternity service was involved with the "Bosom Buddy" volunteer's programme that provided extra support to breast feeding mothers. They worked voluntarily within the trust and in the Children's Centres in the community.
- Patients in the Halton area were able to access day case surgery services at the Halton hospital but needed to meet criteria of the American Society of Anaesthesiologists (ASA) guidelines. In addition, the day-case ward was only open Monday to Friday from 7:30am until 7:30pm. The day case unit closed during quieter times in the year, such as Christmas and summer holidays.
- Medical termination of pregnancy (TOP) service was available at Warrington for baby abnormalities. Patients that requested a TOP for 'social' reasons were signposted to independent health providers locally. This service involved MDT from the baby medicine consultants, bereavement midwife, paediatricians.
- Patients admitted for TOP that were more than 18 weeks pregnant, were cared for in a dedicated Butterfly Room on labour ward. Patients that were less than 18 weeks pregnant were cared for on the gynaecology wards. However, staff informed us that there was not enough space on the gynaecology wards to provide privacy to patients, especially those experiencing a miscarriage or TOP. A single side room was not always available which could lead to a delay in procedures.
- The trust had a "Fetal Remains" policy that included a flowchart for handling and storing remains, post mortem consent form, specific roles and responsibilities for staff such as the mortuary, ward staff, bereavement team, chaplaincy and crematorium.

Maternity and gynaecology

- Staff informed us that they followed the fetal remains trust policy when caring for patients who had lost a baby. The policy included duties and responsibilities of staff and departments, sources and references and associated documents.
- For non–English speaking patients, the trust accessed an interpreter service to provide face to face or telephone interpretation as well as a translation service.
- There was a range of information leaflets available that were all in English. Staff told us that leaflets, in languages other than English, could be accessed through the trust electronic systems. This included information in either larger font or Braille for visually impaired patients.
- Gynaecology patients with dementia were identified using the "Forget Me Not" flower symbol on the electronic patient information system.
- We observed a hospital chaplain visiting a patient on the ward providing support to a patient.
- There was a prayer room close to the gynaecology and maternity departments at Warrington. This included washing facilities for Muslim patients and visitors.
- There were a number of noticeboards, on the gynaecology ward including palliative care, student board, fire information, staff information and 'how are we doing?'
- Equipment in colposcopy was suitable for bariatric patients. Patients with reduced mobility could be seen in the main scan area where hoisting was possible if needed.
- Patients who attended EPAU or patients with hyperemesis (excessive nausea and vomiting in pregnancy) were given open access to the gynaecology ward. Some initially presented at Halton Hospital. Patients could be transferred to Warrington if needed for further care and treatment.
- For the EPAU, any patient that experienced a miscarriage was referred to the bereavement midwife for support and counselling.
- On the gynaecology and maternity wards, the daily safety briefing record included any patients with specific needs and required additional support.

Learning from complaints and concerns

- All complaints were reviewed by the patient experience manager who liaised with the ward managers and matrons depending on the seriousness level of the concern. A multidisciplinary 72-hour rapid review was carried out to deter the cause for complaint and implement further view and an action plan if required. A lead member of staff was appointed to oversee the complaint and a timeline was established by the governance lead.
- Complaints from complaints were discussed at the divisional integrated governance group where recommendations, education were discussed and lessons learnt disseminated to staff via newsletters, email, multi-disciplinary meetings and safety brief meetings.
- Staff informed us that if a single learning point message came from a complaint a "Quality Headline" memo were sent to staff.
- Between January 2016 and December 2016 there were 10 complaints about maternity and gynaecology. The trust took an average of 134 days to investigate and close complaints, this was in line with their complaints policy, which states complaints should be closed within six months . There were four complaints open, for an average of 203 days, which is not in line with the trust's timeframe. Staff told us that there had been about six complaints in the past 12 months with a timely response for all these complaints.
- There was information displayed, throughout the gynaecology department to inform patients how to make a complaint via the Patient Advice and Liaison Service (PALS) system.

Are maternity and gynaecology services well-led?

Requires improvement

We rated well-led as requires improvement because:

At the previous inspection in January 2015, we rated well led as requires improvement mainly due to the division

between medical and midwifery staff, lack of a team approach to improve the service, reactive approach from leadership and a risk averse culture among staff. We have maintained this rating following this inspection because:

- Through the trust's Clinical Business Unit (CBU), Women's and Children's Health was one of four specialities that was within the "Surgery and Women's and Children's Health" structure. Surgery and Women's and Children's Health was managed by the Chief of Service, Associate Director of Operations and Associate Director of Nursing.
- Women's and Children's Health consisted of breast surgery, maternity, obstetrics and gynaecology and paediatrics and neonatology.
- Women's and Children's Health management structure consisted of a Clinical Director, CBU Manager, Paediatrics matron, Midwife Matron, Head of Midwifery and Speciality Lead.
- The Clinical Business Unit (CBU) team was reviewing the lack of a specific maternity dashboard to collect activity data and benchmark outcomes to implement changes. However, we were not assured that the current data collection system was adequate to review the quality of care, monitor services or support improvements.
- The risk register had seven maternity, obstetrics and gynaecology risks listed. Five risks remained static, one risk had increased in severity and only one risk had reduced in severity. This did not assure us that controls were working and that action to mitigate risk was effective.
- Senior staff were aware and concerned about the annual reduction in the birth rate at the trust. However, we were informed about plans to increase this rate.
- Not all staff were aware of the vision and strategy for the future of the maternity service; however, they were aware of the short terms plans to develop the service.
- The ward managers and band seven midwives said they did not always have the time to carry out their managerial roles as they were often providing hands on care to patients and were not supernumery on the duty rota.
- Staff informed us there was open culture throughout the service however, we were given examples were staff had spoken up and raised concerns and there was little evidence to suggest the concerns were taken seriously and managed well.
- Staff reported that it was not always possible to attend necessary meetings due to clinical and staffing demands, therefore difficult to relate information back to their staff.
- Staff informed us that the trust executive team did not visit the maternity ward areas frequently.

However:

- Medical and midwifery staff informed us that the risk averse and reactive culture that was present at the last CQC inspection had improved but there was room for further improvements.
- The service had recently relaunched the Maternity Services Liaison Committee (MSLC) with a newly appointed chair.
- We observed and staff informed us that the working relationship and communication between medical staff and midwifery staff had improved since the last CQC inspection.
- Midwifery staff told us that they could articulate their opinions and views and work within a more team focused approach. There was evidence of shared education, shared practice and shared learning.
- Maternity staff told us it was a happier place to work and the culture had improved.
- Midwives informed us that a recently appointed HoM was visible, proactive and they now felt they had a representative "voice" up to the executive board. She was well respected by all the staff and staff felt that maternity would now be high on the trusts agenda.
- Information was disseminated regularly through daily emails and a closed Facebook page, which included video information.
- For TOP procedures, national legislation was followed in the completion of the HSA1 form.

- The maternity service had been award a large sum of money from the Maternity Safety Training Catalogue – Health Education England. The plans were to develop the training and education programme.
- The Midwifery service won the RCM 2017 "Team of the Year" during our inspection. The acupuncture midwife was also "highly recommended" at these national awards.
- The trust chief executive officer (CEO) was a panel member on the National Maternity Review (NHS England majorreviewof maternityservices as part of the NHS Five Year Forward View).

Vision and strategy for this service

- The Clinical Business Unit (CBU) had seven main objectives set out for 2016 to 2107, which included the trust mission, vision and core values. The objectives were set out under the CQC core values of safe, effective, caring, responsive and well led. Measurements for objectives included monthly governance dashboard, up to date risk register with appropriate risk classifications and shared lessons learned by cascading the information to all specialties.
- There was a Midwifery Strategy 2017-2021 Making Births Better, with clear priorities to deliver good quality care. The strategy was based on evidence and recommendations in the Intrapartum Care Guideline for Women with uncomplicated pregnancies (NICE 2014) and Better Births: A five Year Forward View for Maternity Care (NHS England 2016), staff feedback from the focus groups and workshops and the Maternity Service Liaison Committee (MSLC) meetings. Senior staff were keen for midwives to be the integral component of this strategy.
- An updated Women and Children's Strategy, 2016 - 2018, was also in place. This included plans that would be easily adapted to fit any around the new regional strategy within the new care models for the future. The strategy included objective and action plans, some already in progress.
- We were also provided with a midwifery strategy for 2015-2018. This was a list of expectations, duties and responsibilities of all midwives employed by the trust.
- The vision for the AMU was to establish a culture where normality is valued and part of mainstream service delivery. This included increasing Maternal choice in place of birth, awareness of Midwife led care in the AMU, increase the number of births on the AMU and providing safe and effective care, ensuring all transfers are clinically indicated, timely and appropriate.
- Even though midwives were keen and enthusiastic about the appointment of the new Head of Midwifery (HoM) and the establishment of the AMU, there was a lack of clarity for clinical staff about the future of the maternity service. Staff informed us that they were keen to establish midwifery led care and the "normal birth" care model however; they were not sure how this would fit into the plans across the region and worried about the financial and environmental constraints within the trust.

Governance, risk management and quality measurement

- Since the implementation of the new electronic patient system computer system in November 2015, Women's and Children's Health had been unable to collect maternity statistics and data for reports required by local, regional and national organisations such as Public Health England, UK National Screening Committee, Department of Health and Clinical Commissioning Group. There was no facility enabled on the new electronic patient IT system to generate these reports. The inability to monitor quality of care and provide assurance reports to local, regional and national bodies was on the risk register.
- However, since the inspection, the trust have provided evidence which suggested they had made improvements to collect maternity data.
- CBU senior staff informed us that they recognised the need for a detailed robust data collection system and that senior staff had been reviewing the issue since May 2016.
- During our inspection, we were shown a draft regional maternity dashboard from February 2017, where full implementation was to discussed at the next CBU women's health governance board meeting on the 16 March 2017.
- Once agreement was given by the trust to implement the new regional maternity dashboard, CBU staff informed us that they would continue to use their old

data collecting system as well as slowly introducing the new system, until the Failure Mode Effective Assessment (FMEA) tool was completed. This was to provide assurance that the new data collection system was effective and could be used to change practice.

- At the time of our inspection, the data collection midwife collated data from the Birth Register book on labour ward on a monthly basis, by hand. This covered only some elements of labour and delivery outcomes and did not cover all the data collection needed; therefore, this was only a partial control measure. We were also informed that data collected in this way was very reliant of completion of all clinical data by the clinical midwives, which proved challenging at times. Therefore, we were not assured that the current data collection system was adequate, sufficient and robust to review the quality of care, monitor services or support improvements.
- A Strategic Clinical Network North West Coast Maternity trial dashboard had been in circulation across the area, however, CBU staff informed us that the trust decided not to use it until the format finalised. Staff informed us that they were behind other regional trusts in the local network, as they could not join the pilot schedule for the new reginal dashboard, as the trust did not have the data to input onto the system due to the implementation of the new electronic patient IT system.
- The risk management lead midwife carried out risk assessment audits and led on the progress of action plans from these audits. The results from these audits were feedback to team leaders, governance lead, governance board, and the practice development midwife for training needs analysis.
- All maternity risks were managed and monitored by the clinical governance lead and reviewed at the monthly women's health governance meetings.
- These meetings were well attended however; we reviewed minutes from the October, November and December 2016 meetings and observed that the head of midwife (HoM) and bereavement midwife had only attended one of these meeting. The safeguarding and audit midwives had not attended any of these meetings. No other midwifery representation was evident.
- All new significant and high risks were approved through the directorate processes before being placed on the risk register.
- The trust provided a risk register for the period up to 9 March 2017. There were seven maternity, obstetrics and gynaecology risks listed.
- Six risks were rated as "high". This included poor data quality compliance due to the trust wide issues with the new electronic patient IT system. This was identified on the risk register in January 2016 and the initial risk score was eight. After the last review in January 2017, this had increased to a rating of 12. A risk mitigation action plan was in progress. However, due to the increase in rating, the action plan did not assure us that actions to mitigate risk were adequate.
- One risk identified in October 2015 involved CTG machines. The risk rating of nine was static since first being identified. Another risk identified in June 2016 regarding non-compliance with NICE guidelines for mental health also had a static rating score of nine. Both risks had action plans in place. However, the static ratings did not assure us that actions to mitigate risk were adequate.
- Two other risks were identified in December 2016 and one in January 2017. All were identified as high risk but again all had static rating scores after review.
- There was one risk identified in December 2016 for the non-compliance of cancer waiting times. This was initially rated as "extreme" with a risk score of 20. Following review and a risk mitigation action plan, the risk had reduced to "high" with a rating score of nine. This provided some assurance that the action plan was having a positive effect to mitigate risk.
- Minutes from the Patient Safety and Clinical Effectiveness Sub Committee meetings provided from the trust included discussions and actions for topics such as serious incident review updates, lessons learnt from incidents updates, safety alerts, high-level briefing and risk register. The minutes documented leads for any actions and review dates**.** Attendees included the trust executive board and senior heads of services. We reviewed five different meeting minutes and observed that direct midwifery representation only occurred in two of these meetings.

- Monthly Colposcopy MDT meetings took place. The agenda included comments from information documents submitted to Women's Health Risk group and operational issues. Minutes and action plans were documented with a named lead.
- Monthly Guideline Review meetings took place to approve new guidelines and discuss current guideline. This provided assurance that guidelines were reviewed regularly according to evidence based practice.
- For TOP procedures, national legislation was followed in the completion of the HSA1 form.

Leadership of service

- Through the trust's Clinical Business Unit (CBU), Women's and Children's Health was one of four specialities that was within the "Surgery and Women's and Children's Health" structure. Surgery and Women's and Children's Health was managed by the Chief of Service, Associate Director of Operations and Associate Director of Nursing.
- Women's and Children's Health consisted of breast surgery, maternity, obstetrics and gynaecology and paediatrics and neonatology.
- Women's and Children's Health management structure consisted of a Clinical Director, CBU Manager, Paediatrics matron, Midwife Matron, Head of Midwifery and Speciality Lead.
- Some staff felt this new CBU structure was positive and said it would help to improve the focus on quality for maternity services and strengthen the structure, leadership and management of the service. However, other staff told us that maternity and gynaecology was "overshadowed by surgery".
- There were clear local management structures in place that identified lines of accountability.
- There were clearly defined and visible local leadership in place in all gynaecology and maternity areas.
- Staff felt generally well supported by their local managers who were visible, approachable and willing to discuss any concerns.
- The consultant midwife was the clinical lead for low risk care within the trust and provided guidance, leadership and professional direction of the service.
- The ward managers and band seven midwives said they did not always have the time to carry out their managerial roles as they were often providing hands on care to patients and were not supernumery on the duty rota. This affected their ability to leave the clinical areas to attend management and MDT meetings.
- Maternity staff informed us that there was poor visibility of the executive board in the clinical areas. However, they did feel that the new HoM had a "voice" at board level and they felt confident the HoM would represent the service in a proactive and positive way. This was an improvement from the last CQC inspection, where staff felt management worked in a reactive way.
- However, some senior midwifery, nursing and medical staff informed us that the trust board still had a reactive approach and went above and beyond protecting staff and patients following some incidents by changing and stopping practice to avoid similar issues reoccurring.
- Senior staff also felt that there was an over amount of standard operating procedures (SOPs) and guidelines for standard practice, which inhibited staff from carrying out routine basic clinical procedures. Examples were given of maternity staff not carrying out blood sugar tests for babies or testing babies for jaundice. However, these are standard procedures covered under the NMC code of practice and midwifery training.

Culture within the service

- Most staff we spoke with felt supported by their departmental managers. They felt supported to learn and develop professionally through their annual appraisals.
- Most staff felt there was an open culture and told us they were supported across departments and all staff we spoke to liked working at the hospitals.
- However, we were given three examples from different staff about concerns being raised but nothing happening as a result. There was a perception from some staff that if concerns were raised higher than their immediate manager, nothing would happen. This has led to some frustration with the staff and a feeling that escalating concerns was sometimes pointless. A similar concern was raised at the last CQC inspection.

- Senior staff informed us that there was a working party set up to support the "It's OK to Question" project. This was to provide support staff, especially more junior staff, when productively and professionally questioning challenging clinical decisions by other members of staff.
- Most staff were very positive and spoke enthusiastically about their own departments, with good teamwork and many having worked at both hospitals for several years. Midwives told us that two years ago they "walked with their heads down" but now "walk with their heads held high".
- The head of midwifery had an open door policy and matrons visited all areas daily to address concerns and issues.
- The working relationship between medical staff and midwives had improved since our last CQC inspection. Both professions told us that they now worked closely together into a productive and supportive way.

Equalities and Diversity – including Workforce Race Equality Standard (to be used by exception only – main section is in the Provider report)

- Information provided from the trust showed that 44% of the doctors in the women's health department were of white ethnic origin and 56% were from black, Asian, minority ethnic (BAME) group. We found that in the healthcare assistant (HCA) group of staff there were 95% white HCAs and 5% from the BAME group. There were 93% midwives from a white background and 7% from the BAME group. There were 94% white staff nurses and 6% from the BAME group. This indicated that apart from the medical doctors, there was a sufficient difference in both groups.

Public engagement

- The service had recently relaunched the Maternity Services Liaison Committee (MSLC) with a newly appointed chair. This forum enables maternity service users, providers and commissioners of maternity services to come together to design services that meet the needs of local patients, parents and families.
- The gynaecology department participated in the NHS Friends and Family Test (FFT) and information about how patients and those close to them could provide feedback was displayed in corridors.

Staff engagement

- Ward managers had an 'open-door policy' and actively encouraged staff to discuss any concerns.
- Staff told us that staff engagement and communication was mainly through team meetings, memos, newsletters or by emails.
- The HoM sent staff regular updates via her closed social networking blog page. Staff spoke very positively about this form of communication.
- All staff received a Friday email message from the Chief Executive.
- Senior staff told us that it was not always possible to attend management and divisional meetings, therefore difficult to relate information back to their staff.
- Junior midwives told us they would like to be invited to managerial and senior meetings to gain a greater understanding of what was discussed and the rationale behind decisions made. This would also make them feel more part of the wider team. Currently, some junior staff told us that only the senior staff were invited to such meetings and they were never asked to deputise if senior staff were unable to attend.

Innovation, improvement and sustainability

- We were informed that the current traditional way of working for the community midwifery team was about to change. Community midwives were soon to rotate into the AMU to increase continuity of care and increase hospital and homebirth rates.
- The women and children's health clinical business unit had a business plan set out for 2017 to 2018. Highlighted were concerns about senior clinical and nursing staff retiring, which is a nationally recognised problem.
- The CBU was committed to supporting new initiatives and delivering national standards in conjunction with a number of new papers and guidance such as National Maternity Review 2016.
- There was some uncertainty among staff about the future of the maternity service especially within the local Vanguard (leading the way in new developments or

ideas) New Care Model programme within the region. Staff were aware of the plans within the unit for changes but there was some uncertainty and insecurity about future plans within the wider geographical area.

- The maternity service had been award a very large sum of money from the Maternity Safety Training Catalogue – Health Education England. The plans for the funding included: PROMPT (Practical Obstetric Multi Professional Training), AIMS training, RCOG labour ward leads, RCM leadership training, CTG masterclass training, human factors training, breech birth training, conferences and midwifery led environment.
- The Health Education England funding was also going towards two initiatives: "Whose Shoes?" This is a values-led, bespoke approach to change management, in the form of an engaging board game. The scenarios have been co-produced using the real voices of people using maternity services, clinicians, policy makers, commissioners, independent providers and others associated with pregnancy, childbirth and early parenthood.
- The second initiative is purchasing the Baby Buddy app. This app will guide parents through pregnancy and the first six months of their baby's life. It has been designed to help and support health and wellbeing and is available 24 hours a day.
- During our inspection, the midwifery service won the RCM Team of the Year 2016 for Excellence in Maternity Care. The acupuncture midwife was also "highly recommended" at these national awards.
- Other awards achieved within the service included: Maternity Service – Health Service Journal (HSJ) Finalist 2016 for Patient Safety - Learning and Improvement.
- The trust chief executive officer (CEO) was a panel member on the National Maternity Review (NHS England major reviewof maternity services as part of the NHS Five Year Forward View).
- Gynaecology Innovations included a dedicated fertility clinic, Urogynaecologist lead on all complex vaginal gynaecology surgery, specialist nurse colposcopists, and a gynaecology rapid access clinic.

Services for children and young people

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

Information about the service

Warrington and Halton Hospitals NHS Foundation Trust provides a range of paediatric and neonatal services. Neonatal services are located on the first floor and paediatric services are located on the ground floor of the main hospital building in Warrington. In addition, some paediatric outpatient appointments are offered at Halton General Hospital.

The neonatal unit has 18 cots and provides intensive care, high dependency care and special care for newborn babies. The children's unit consists of 37 beds, which include a 10 bedded cubicle area incorporating one high dependency bed, a seven bed paediatric day surgery area a six bedded assessment area and a 14 bedded bay area. A dedicated paediatric outpatient clinic is located next to the children's unit and a paediatric accident and emergency area is situated next to the main accident and emergency department. A paediatric acute response team (PART) deliver care in conjunction with a local community provider at a Health and Wellbeing centre in Warrington town centre.

Hospital episode statistics data (HES) showed there were 5435 children and young people seen between 1 December 2015 and 30 November 2016. Of these 93.1% were emergency admissions, 5.4% were day case admissions and 1.5% were elective admissions.

We visited Warrington and Halton Hospitals between the 7 and 10 March 2017 and performed an unannounced visit on the 23 March 2017. We inspected a range of paediatric services including the children's unit, the neonatal unit, surgical theatres and the paediatric outpatients department and we visited the Paediatric Acute Response Team (PART) at Bath Street Health and Wellbeing Centre.

We spoke with 16 patients and/or carers, observed care and treatment and inspected 17 sets of records and 16 prescription charts. We also spoke with 48 staff of different grades including nurses, doctors, consultants, ward managers, specialist nurses, housekeepers and administrative staff. We received comments from people who contacted us to tell us about their experiences and we reviewed performance information about the trust.

Services for children and young people

Summary of findings

We rated services for children and young people as Good because:

- Staff could demonstrate the process to report incidents and received feedback both individually and in staff meetings. Lessons learnt were shared in staff meetings and through the Safety Brief and trust wide email.
- The wards and clinical areas were visibly clean. Staff were aware of and adhered to current infection prevention and control guidelines such as the 'bare below the elbow' policy. Personal protective equipment such as aprons and gloves were readily available throughout the neonatal and children's unit.
- Staff were aware of their safeguarding roles and responsibilities and knew how to raise matters of concern appropriately.
- All staff groups exceeded the trust target for compliance with mandatory safeguarding training.
- Age dependant pain assessment tools were in use in the children's unit and analgesia and topical anaesthetics were available to children who required them.
- Between October 2015 and September 2016, the trust performed better than the England average for the percentage of patients aged 1-17 years who had multiple emergency admissions for asthma.
- 18 staff out of 33 on the children's unit had completed the high dependency course.
- In the neonatal unit 28 out of 34 eligible staff were Qualified in Speciality (QIS). This is a standard level of knowledge and skills for nurses within neonatal care.
- Staff described the principles of Gillick competency used to assess whether a child had the maturity to make their own decisions.
- Parents told us they felt involved in the decisions regarding their child's care and confident about leaving their baby in the neonatal unit.
- A CAMHS worker was present in the paediatric emergency department between 5pm and 11pm seven days per week to ensure timely assessment of children and young people.

However,

- Cleaning checklists were observed but at the time of the inspection, these were not consistently completed within all departments.
- Safety testing for equipment was in place however, we noted that a number of items in the paediatric outpatient clinic were out of date for example a urinalysis machine that had been due for review in April 2015 and two ophthalmoscopes due in January 2016 and February 2016.
- Six staff within the children's unit had completed Advanced Paediatric Life Support (APLS) training however, managers told us there was not always a nurse on duty with APLS.
- Staffing within the children's unit did not follow Royal College of Nursing (RCN) standards (August 2013) and neonatal nurse staffing did not meet standards of staffing recommended by the British Association of Perinatal Medicine (BAPM).

Services for children and young people

Are services for children and young people safe?

Good

We rated safe as 'Good' because:

- Staff could demonstrate the process to report incidents and received feedback both individually and in staff meetings. Lessons learnt were shared in staff meetings and through the Safety Brief and trust wide email.
- Joint obstetric and neonatal mortality and morbidity meetings were held monthly. Mortality reviews for paediatric deaths were completed by the paediatric team in conjunction with the safeguarding team and key messages and learning points were fed back to staff.
- The wards and clinical areas were visibly clean. Staff were aware of and adhered to current infection prevention and control guidelines such as the 'bare below the elbow' policy. Personal protective equipment such as aprons and gloves were readily available throughout the neonatal and children's unit.
- Hand hygiene audits completed between 01 October and 31 December 2016 showed the neonatal unit achieved 100% compliance in all areas, results on the children's ward B11 ranged from 89% to 100%.
- Emergency resuscitation equipment was in place in the children's unit and neonatal unit and records indicated this was consistently checked.
- All medicines in the neonatal and children's unit were found to be in date and stored securely in a locked cupboard as appropriate, and in line with legislation. Controlled drugs were stored securely and accurate records maintained in accordance with trust policy.
- Staff were aware of their safeguarding roles and responsibilities and knew how to raise matters of concern appropriately.
- All staff groups exceeded the trust target for compliance with mandatory safeguarding training. Newborn Life Support training was completed by staff in the neonatal unit, 88% of staff had received this training and there was always at least one staff member with NLS on every shift.

However:

- The children's unit and neonatal unit had controlled access however, even with a raised handle, access could be obtained to the dirty utility room in paediatric outpatient clinic despite being designated a staff only area.
- Safety testing for equipment was in place however, we noted that a number of items in the paediatric outpatient clinic were out of date for example a urinalysis machine that had been due for review in April 2015 and two ophthalmoscopes due in January 2016 and February 2016.
- There was no dedicated paediatric pharmacist for the children's unit which is not in line with accepted best practice. Since the CQC visit the team has submitted a business case that approved and trust has confirm that a specialist paediatric pharmacist has been appointed.
- Six staff within the children's unit had completed Advanced Paediatric Life Support (APLS) training however, managers told us there was not always a nurse on duty with APLS.
- Staffing within the children's unit did not follow Royal College of Nursing (RCN) standards (August 2013) and neonatal nurse staffing did not meet standards of staffing recommended by the British Association of Perinatal Medicine (BAPM).

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- All staff groups exceeded the trust target for compliance with mandatory safeguarding training. Newborn Life Support training was completed by staff in the neonatal unit, 88% of staff had received this training and there was always at least one staff member with NLS on every shift.

Incidents

- Incidents were reported using an electronic reporting system. Staff could demonstrate the process and received feedback both individually and in staff meetings.
- Lessons learnt were shared in staff meetings and through the Safety Brief and trust wide email. Staff could describe examples of changes in practice following incidents such as a change in the brand of topical anaesthetic cream used and the introduction of timers to monitor length of application.
- There were no never events or serious incidents reported by the trust within children's services between January 2016 and December 2016. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- Between January 2016 and December 2016 520 incidents were recorded by children's services. Of these, 517 were reported as low or no harm. This showed the trust were actively reporting and recording incidents to ensure the quality of the service was maintained. Of the incidents classified as low or no harm 33 related to the management and administration of medicines and 54 related to staffing. We reviewed details relating to four incidents, all documented the outcome of the incident and highlighted actions to improve service delivery.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Some staff we spoke to were unfamiliar with the term 'Duty of Candour' however all could describe the principle and the circumstances in which it was used.
- Joint obstetric and neonatal mortality and morbidity meetings were held monthly. These are meetings to review deaths and adverse incidents to enable lessons to be learnt and highlight areas for improvement. Mortality reviews for paediatric deaths were completed by the paediatric team in conjunction with the safeguarding team and key messages and learning points were fedback to staff.
- Managers told us all child deaths were reviewed by a designated lead paediatrician from the Child Death Overview Panel (CDOP).

Cleanliness, infection control and hygiene

- The wards and clinical areas were visibly clean. Staff were aware of and adhered to current infection prevention and control guidelines such as the 'bare below the elbow' policy. Personal protective equipment such as aprons and gloves were readily available throughout the neonatal and children's unit.
- Hand washing facilities, including hand gel were readily available in prominent positions in each clinical area for the use of staff, visitors and patients.
- There were arrangements in place for the handling, storage and disposal of clinical waste, including sharps.
- Hand hygiene audits completed between 01/10/2016 and 31/12/2016 showed the neonatal unit achieved 100% compliance in all areas, results on the children's ward B11 ranged from 88.9% to 100%.

- Cleaning checklists were observed however these were not consistently completed within all departments. This was highlighted to trust staff at the time of our inspection, who took action to address this concern. The trust have submitted additional information to support these changes. A schedule was in place for cleaning and changing curtains within clinical areas.
- Stickers were placed on equipment to inform staff at a glance that equipment had been cleaned and we saw evidence of this being used in the children's unit and the neonatal unit.
- In the CQC children's survey 2014 the trust scored the same as other trusts for the question "How clean do you think the hospital room or ward was that your child was in?".
- Parents in the children's unit told us they observed staff washing their hands before delivering care and parents in the neonatal unit told us they were provided with information regarding infection control.

Environment and equipment

- The children's unit was decorated with an underwater theme. Pictures of fish and underwater scenes were also positioned on the main corridor and were designed as a distraction for children on the way to theatre.
- The entrance to the neonatal unit had a photographic display of previous patients with their birthweight, entitled "Look at us now". This indicated how the children had grown and developed since discharge from the unit and demonstrated positive outcomes for current and future parents.
- The children's unit and neonatal unit had controlled access however, even with a raised handle, access could be obtained to the dirty utility room in paediatric outpatient clinic despite being designated a staff only area. This meant visitors to the department including patients and siblings, could access a potentially dangerous area containing medical equipment and used for testing clinical specimens. Following the inspection the trust provided evidence that an additional high level lock had been fitted.
- Bay two in the neonatal unit was designated for 10 special care cots. Four cots did not have wall mounted oxygen and suction, however portable oxygen and suction was available. This was added to the neonatal unit risk register following our inspection.
- Emergency resuscitation equipment was in place in the children's unit and neonatal unit and records indicated this was consistently checked.
- Supplementary emergency equipment and a transfer bag used when accompanying sedated children for Magnetic Resonance Imaging (MRI) was observed in paediatric outpatient clinic however, records indicated between 3/1/17 and the time of our inspection this equipment had not had daily checks on a number of occasions. This was brought to the attention of staff during our inspection.
- Safety testing for equipment was in place however we noted that a number of items in the paediatric outpatient clinic were out of date for example a urinalysis machine that had been due for review in April 2015 and two ophthalmoscopes due in January 2016 and February 2016. This was brought to the attention of staff during our inspection.
- We reviewed equipment again in paediatric outpatient clinic during our unannounced visit and observed some of the non-compliant items of equipment had been tested since our announced visit to the trust.
- The recording of the temperature of the fridge on the neonatal unit used for the storage of breastmilk was not consistently completed. Between 1/1/17 and the time of our inspection temperature recordings were missed on 27 occasions. This had also been noted in an infection control audit completed by the trust in January 2017.
- A Suicide Prevention Policy was in place, which detailed how the paediatric environment should be risk assessed prior to the admission of a child or young person with mental health issues.
- In the CQC children's survey 2014 the trust scored the same as other trusts for the question "Did the ward where your child stayed have appropriate equipment or adaptations for your child?".

Medicines

- All medicines in the neonatal and children's unit were found to be in date and stored securely in a locked cupboard as appropriate, and in line with legislation.
- Controlled drugs were stored securely and accurate records maintained in accordance with trust policy. Controlled drugs that had expired were included in twice daily checks but separated from stock that was in date until removed by pharmacy, however staff advised that this could take several weeks.
- Medicines fridges were secured however daily fridge temperatures were not consistently recorded. The temperature of a medicine fridge should be monitored daily to ensure the contents are stored under conditions to ensure quality and effectiveness is maintained.
- There was no dedicated paediatric pharmacist for the children's unit which is not in line with accepted best practice however pharmacy support was available from a pharmacist within the clinical business unit. Lack of paediatric pharmacy support had been recorded on the departmental risk register since July 2015 and an action plan was in place to mitigate risk. The British Association of Perinatal Medicine (BAPM) details the requirements for pharmacy support to neonatal services in their service standards for hospitals providing neonatal care.
- Prior to our unannounced inspection a Standard Operating Procedure for pharmacy visits to paediatrics had been developed and daily pharmacy visits had commenced. A business case was also drafted to identify pharmacy support going forward..
- The trust employed a medicines safety nurse who monitored drug errors as part of their role. Records we reviewed confirmed that following a drug error the practice of the individual would be reviewed and support provided to reflect on the incident.
- We reviewed 16 prescription charts during our inspection. Of those reviewed, all had the weight and age or date of birth of the child, 15 were legible, signed and dated and 14 had allergies documented.
- A stock of take home medicines were stored on the ward to give to patients discharged outside of the pharmacy's opening hours. Processes were in place to ensure the safe issue of medicines at the point of a patients discharge.
- In the paediatric outpatients department doctors prescribed medicines for patients to take home on an outpatient prescription form, medication was then dispensed by pharmacy.
- Nurses in the paediatric acute response team (PART) used Patient Group Directives (PGDs) to dispense medication such as paracetamol. A patient group direction allows some registered health professionals (such as nurses) to give specified medicines (such as painkillers) to a pre-defined group of patients without them having to see a doctor.

Records

- The trust were in the process of moving to a paperless system. Patient records on the children's unit consisted of paper records at the bedside including observation and prescription charts while demographic information and medical and nursing records were electronic. All paper records were in use on the neonatal unit.
- Documentation audits were completed weekly in the children's unit and results were presented monthly as part of the Quality Report. This included audit of observation charts, name bands, discharge paperwork and presence of up to date care plans.
- Results between October 2016 and December 2016 showed 100% for completion of observation charts, presence of name bands and care plans however completion of discharge paperwork ranged from 62.6% in October 2016 to 70% in December 2016.
- We reviewed 17 sets of records across the neonatal and children's unit, which were generally completed to a good standard. All had a diagnosis and management plan documented, 16 of the 17 had all entries signed and dated and all had evidence of a daily ward round including review with senior clinicians.
- Any child where there was social or child protection need had a separate information sharing form in their records to inform staff at a glance. We observed a form completed appropriately in a patients records.

Safeguarding

- Safeguarding policies and procedures were in place across the trust and these were available electronically

for staff to refer to. The Safeguarding Children Policy included information regarding child sexual exploitation (CSE), female genital mutilation (FGM), domestic violence and the counter-terrorism strategy Prevent.

- In discussion with us, it was clear that staff were aware of their roles and responsibilities and knew how to raise matters of concern appropriately.
- Staff we spoke with were aware of the safeguarding team and how to access support and advice.
- Safeguarding training formed part of the trusts mandatory training programme and the trust target was 85%. Compliance rates for nursing staff within the children's unit at the time of our inspection were 99% for Safeguarding Adults Level 1 and 97% for Safeguarding Adults Level 2, 100% for Safeguarding Children Level 1 and 2 and 95% for Safeguarding Children Level 3.
- Compliance rates for neonatal nursing staff at the time of our inspection were 100% for Safeguarding Adults Level 1 and 97% for Safeguarding Adults Level 2, 100% for Safeguarding Children Level 1 and 2 and 90% for Safeguarding Children Level 3.
- Compliance rates for medical and dental staff within services for children and young people were 100% in all modules.
- The trust safeguarding team structure included a lead doctor and lead nurse for safeguarding children, supported by a specialist nurse and a named midwife.
- A pathway was in place in the paediatric outpatients department for children who were not brought for appointments and formed part of the Safeguarding Children Policy.
- An audit of the trust wide use of the Did Not Attend (DNA) pathway reported in September 2016 that the trust was non-compliant with the safeguarding children DNA process. An action plan in response to the findings included a review of the DNA process within the safeguarding children policy, circulation of information regarding neglect and the impact of DNAs and repeat of the audit annually.
- A paediatric liaison health visitor visited the children's unit daily and details of primary care professionals were obtained as part of the admission process. This ensured communication with community health professionals who were involved with the child, enabled information regarding current safeguarding concerns to be shared and ensured continuity of care between hospital and community.
- Following the inspection and at the factual accuracy stage the trust provided evidence that the Safeguarding Children Supervision policy was ratified and went live in May 2017. Midwives and paediatric nurses who case hold patients have all been allocated a supervisor and are expected to attend supervision ever six to eight weeks. All identified safeguarding children supervisors will also be provided with one-to-one supervision from the Named Nurse Safeguarding Children.

Mandatory training

- Staff received training in areas such as fire safety, infection control, information governance and resuscitation. Training was delivered online as well as face to face.
- Managers and staff we spoke to told us that nursing staff were allocated mandatory training sessions and this was incorporated into the off duty rota.
- The trust target for mandatory training was 85%. Compliance rates for nursing staff within the children's unit at the time of our inspection ranged from 92% for resuscitation to 100% for Health and Safety.
- Compliance rates for neonatal nursing staff ranged from 75% to 98% with compliance rates for Infection Control and Information Governance falling below the trust target.
- Compliance rates for mandatory training for medical and dental staff within services for children and young people ranged from 60% to 90% with Fire Safety, Health and Safety and Infection Control falling below the trust target.

Assessing and responding to patient risk

- The trust used Paediatric Early Warning Scores (PEWS) which is a tool is designed to identify children who are at risk of deterioration. (PEWS) were used to monitor the condition of a child on the children's unit and Newborn Early Warning Scores (NEWS) on the neonatal unit.

Records we reviewed showed that patient observations were recorded in all cases and action taken on triggering PEWS/NEWS scores occurred in five out of seven cases were it was appropriate.

- Monthly audit of Paediatric Early Warning Scores [PEWS] was completed on the children's unit as part of the Quality Report and results for October 2016 to December 2016 showed 100% compliance.
- The Royal College of Nursing document Defining-staffing levels for children and young people's services identifies as a core standard to be applied in services providing health care for children and young people at least one nurse per shift in each clinical area (ward/department) to be trained in APLS/EPLS depending on the service need.
- Six staff within the children's unit had completed Advanced Paediatric Life Support (APLS) training however, managers told us there was not always a nurse on duty with APLS. Risk was mitigated as all paediatric staff had completed Paediatric Immediate Life Support (PILS) training and support was provided by onsite medical staff. Between 1 January 2017 and 28 February 2017 48 shifts out of 118 had an APLS trained nurse on duty. Following the inspection the trust provided evidence that the number of APLS trained staff had increased to 11 and the remaining 12 staff are to complete training by December 2107.
- Newborn Life Support training was completed by staff in the neonatal unit, 88% of staff had received this training and there was always at least one staff member with NLS on every shift.
- Guidelines were in place for the management of paediatric sepsis and staff told us they had received information sessions when these were introduced.
- Transfers of infants between hospitals was completed by the Cheshire and Merseyside Neonatal Network Transport service.
- Children and young people who required child and adolescent mental health services (CAMHS) were reviewed in the paediatric emergency department by a CAMHS worker who was present between 5pm and 11pm seven days a week. If admission to the children's unit was required a risk assessment was completed.

Nursing staffing

- The expected and actual staffing levels were displayed within the neonatal and children's unit. This informed patients and visitors of the current staffing levels.
- At the time of our inspection staff from the children's unit nursing establishment covered the paediatric accident and emergency department however a review of paediatric urgent care was in progress.
- Staffing within the children's unit did not follow Royal College of Nursing (RCN) standards (August 2013) which recommends a staff ratio of 1:3 for children under two years of age and 1:4 for children above 2 years of age. The minimum staffing ratio adhered to was 1:5 within the children's unit. Staff and managers told us this was maintained with the use of bank or agency staff if required and rotas we reviewed supported this.
- Managers told us staff and beds were also flexed between the ward and assessment area to allow for redeployment of staff according to patient need.
- A staffing review had been completed in September 2016 which identified the need for additional staff due to service pressures and an increase in the acuity of patients being cared for on the children's unit. Recruitment had taken place and was continuing during our inspection. Following the inspection the trust provided evidence to show a paediatric acuity tool had been introduced to monitor staffing levels.
- The average fill rate for registered nurses in the children's wards for January 2017 and February 2017 for the day shift was 94.4% and 106.9% respectively and 86.8% and 125.7% for night shifts.
- The average fill rate for care staff in the children's wards for January 2017 and February 2017 for day shift was 93.2% and 96.4% respectively and 100% for night shifts.
- The average fill rate for registered nurses and care staff in paediatric emergency department was 100% for both January 2017 and February 2017 day and night.
- Between January 2016 and December 2016 five incidents were recorded relating to staffing on the children's unit. An escalation policy was in place to maintain safe staffing and a flowchart was displayed in a prominent position in the unit.
- Staffing within the neonatal unit did not meet standards of staffing recommended by the British Association of

Perinatal Medicine (BAPM). We reviewed staff rotas on the neonatal unit between 1 January 2017 and 9 March 2017 and found that BAPM standards were met on 86 shifts from 136, a rate of 61.8%.

- Between January 2016 and December 2016, 48 incidents were recorded relating to staffing on the neonatal unit. In the six months prior to our inspection the neonatal unit reduced cot capacity on 22 occasions due to staffing levels.
- A similar review of nurse staffing was conducted in the neonatal unit in September 2016 which identified an increase in staff was required to be compliant with BAPM standards.
- Managers told us that bank staff were used to cover for staff shortages in the neonatal unit and that shifts were mainly covered by existing staff members who were familiar with the unit.
- Following the inspection a further paper was prepared relating to neonatal staffing and an acuity tool introduced to monitor levels of BAPM compliance.
- We observed a nursing handover, which provided name, age, diagnosis, observations, medications and treatment plan of patients on the ward. Social information was also provided such as if parents were resident or if there was any ongoing social care involvement.

Medical staffing

- Consultant paediatric and neonatal cover was provided 24 hours per day. In December 2016, the proportion of consultant staff working at the trust was lower than the England average as was the proportion of junior staff, however a further consultant had come into post prior to our inspection.
- In December 2016 the trust reported a vacancy rate of 15.9% and a turnover rate of 18.2% in children's services.
- The trust had nine whole time equivalent consultants (WTE), of whom seven took part in 'paediatrician of the week' rota. At our last inspection British Association of Perinatal Medicine recommendations for Local Neonatal Unit out-of-hours Tier 1 medical cover was not adhered to. We reviewed medical rotas between January 2017 and March 2017 and while the rota was covered, there was little extra capacity should there be any additional demand on the service.
- Medical staffing was recorded on the risk register and the trust had employed Advanced Paediatric Nurse Practitioners (APNP) in the paediatric emergency department and the neonatal to support the medical rota. A further APNP post was being recruited to for the neonatal unit at the time of our inspection.
- Paediatric consultants who took part in a "Consultant of the week" rota were present in the hospital during times of peak activity and available on call at other times. This ensured senior clinical decision could be made in a timely manner.
- We attended a clinical handover on the children's unit. This was attended by the consultant of the week and all junior doctors and was observed to be efficient and thorough.

Major incident awareness and training

- The trust had a business continuity plan for the Women's and Children's Health Clinical Business Unit which listed key risks that could affect the delivery of services.
- Staff were aware of the major incident policy and described how information was sent by email from the Communications department during a recent episode of bad weather.
- The trust set a target of 85% for completion of major incident training. Compliance for major incident training courses between January 2016 and December 2016 was 57 registered nurses and midwives against a target of 62, 14 healthcare assistants against a target of 16 and five medical staff against a target of nine.
- Managers told us a separate winter management plan was no longer in place in the children's unit as demand was high throughout the whole year however the paediatric team sat on the Winter Planning groups in the autumn.

Are services for children and young people effective?

Services for children and young people

Good

We rated effective as Good because:

- The service used National Institute for Health and Care Excellence (NICE) guidelines to determine care and treatment provided and records we reviewed confirmed there were a number of evidence-based pathways in place.
- Paediatric Early Warning Score (PEWS) audits were completed monthly as part of a Quality Report and between October 2016 and December 2016 compliance was 100%.
- Age dependant pain assessment tools were in use in the children's unit and analgesia and topical anaesthetics were available to children who required them. In the CQC children's survey 2014 the trust performed better than others for the question 'Do you think the hospital staff did everything they could to help ease your child's pain?'.
- The National Paediatric Diabetes Audit 2014/15 showed that Warrington hospital performed better than the England average for the number of individuals who had controlled diabetes.
- Between October 2015 and September 2016 the trust performed better than the England average for the percentage of patients aged 1-17 years who had multiple emergency admissions for asthma.
- Staff identified their learning needs through the trusts appraisal process and the trust target was 85%. Trust data showed that at the time of our inspection 95% of nursing staff on the children's unit had received an appraisal, 88% of nursing staff on the neonatal unit and 100% of medical staff.
- Eighteen staff out of 33 on the children's unit had completed the high dependency course This meant there was at least one nurse on each shift to care for high dependency patients.
- In the neonatal unit 28 out of 34 eligible staff were Qualified in Speciality (QIS). This is a standard level of knowledge and skills for nurses within neonatal care.
- Meetings were held with social care and community professionals as required, for example in cases involving safeguarding or for patients who required discharge planning such as infants receiving oxygen.
- The paediatrician on call was available on a designated telephone number three hours per day for GP's who required advice.
- Staff described the principles of Gillick competency used to assess whether a child had the maturity to make their own decisions and how support would be obtained from specialist colleagues and the safeguarding team when dealing with parents who may lack capacity.

Evidence-based care and treatment

- The service used National Institute for Health and Care Excellence (NICE) guidelines to determine care and treatment provided for example for neonatal jaundice and intravenous fluid therapy in children and young people in hospital.
- There were a number of evidence-based pathways in place for conditions such sepsis and asthma and the Paediatric Acute Response Team (PART) used pathways for conditions such as bronchiolitis and diarrhoea and vomiting.
- The neonatal unit had achieved Level 3 Baby Friendly accreditation. The Baby Friendly Initiative supports breastfeeding and parent infant relationships and to achieve accreditation the provider is required to demonstrate they have met a set of evidence based standards.
- Policies and procedures were in place and could be accessed via the trust's intranet and staff we spoke with were aware of how to access them.
- Paediatric Early Warning Score audits were completed monthly as part of a Quality Report and between October 2016 and December 2016 compliance was 100%.
- A Children's Health Audit Programme was in place and included topics such as Neonatal Cooling Therapy, Croup and an annual meningitis audit.

Pain relief

- The children's unit used age dependant pain assessment tools. For younger children a faces pain rating scale was used and for older children pain was assessed using a number scoring system.
- The neonatal unit used visual observation to assess pain and anticipatory prescribing of sucrose prior to procedures taking place.
- Analgesia and topical anaesthetics were available to children who required them in the children's unit.
- The monthly quality report included pain assessment as part of the record keeping audit. Between October 2016 and December 2016 the percentage of records showing a documented pain assessment ranged from 74.9% to 90%.
- Managers told us the Pain Specialist Nurse would complete ward rounds with the surgical team on the children's unit and we observed a discussion with a child and parent during a pre-operative appointment that included a discussion regarding pain relief during the procedure.
- Patients we spoke with told us that pain relief was given "whenever I needed it", the staff "always come to ask if I need any pain relief" and "I can always ask for more if I need it".
- In the CQC national children's survey 2014 out of 137 acute NHS trusts, the trust performed better than others for the question 'Do you think the hospital staff did everything they could to help ease your child's pain?'.

Nutrition and hydration

- A range of menus were available on the children's unit. Patients told us there were "plenty of options", there was "quite a lot of fruit and a wide choice" and the food "was better than school".
- Staff told us that feeding advice on the neonatal unit was consultant led however, the dietician would come to the unit if there were any specific requirements.
- Infants on the neonatal unit were weighed three times per week and fluid balance was monitored.
- A designated breast milk fridge was kept on the neonatal unit and mother's were encouraged to express breastmilk.
- Breastfeeding training was part of the trust's mandatory training programme for staff within the neonatal unit to ensure advice given was consistent and evidence-based and junior doctors received information regarding breastfeeding during their induction.
- A private room was available to mothers on the neonatal unit if they wished to express and a referral could be made to a breastfeeding co-ordinator for additional support if required.
- Breakfast was offered to all parents and all meals were offered to mothers who were breastfeeding.

Patient outcomes

- The trust provided data for the National Neonatal Audit Project. The latest published report was 2016 using 2015 data and showed there was a documented consultation with 89% of parents and/or carers within 24 hours of admission; this ensures that parents have a timely explanation of their baby's condition and treatment. Thirty-six per cent of eligible babies were discharged feeding only mother's milk and 20% taking some mother's milk. Results also showed 100% of eligible children were screened for Retinopathy of Prematurity (ROP). ROP is an eye condition that can affect babies born weighing under 1501g or 32 weeks gestation.
- An action plan was developed to address areas of improvement such as improving awareness of the benefits of breastfeeding by use of posters and restarting the lunch provision for breastfeeding mothers on the neonatal unit however, no review date was documented.
- The National Paediatric Diabetes Audit 2014/15 showed that Warrington hospital performed better than the England average for the number of individuals who had controlled diabetes.
- Between September 2015 and August 2016 there was a lower percentage of children aged under one year readmitted following an emergency admission compared to the England average.
- The speciality of Trauma and Orthopaedics had a readmission rate of 3.2% compared to the England average of 1.1% for patients aged between one and

seventeen years. We discussed this with managers who advised that patients admitted with a trauma injury were often sent home overnight and would return the next day for treatment, for example surgery.

- Between October 2015 and September 2016 the trust performed better than the England average for the percentage of patients aged 1-17 years who had multiple emergency admissions for asthma.

Competent staff

- Staff identified their learning needs through the trusts appraisal process and the trust target was 85%. Trust data showed that at the time of our inspection 95% of nursing staff on the children's unit had received an appraisal, 88% of nursing staff on the neonatal unit and 100% of medical staff.
- Induction processes were in place for new staff and students. Preceptorship was in place for newly qualified staff and included demonstration of competencies with equipment.
- Competency assessments were in place for healthcare assistants and student nurses for procedures such as the application of topical local anaesthetic and recording of patient observations such as heart rate and respiratory rate.
- Band 5 staff nurses on the children's unit had an identified band 6 buddy who they could approach with any concerns however staff told us this was not restrictive and they could approach any senior member of staff if needed.
- Junior medical staff reported Consultants were helpful and supportive.
- In the event of a drug error an appointment would be arranged with the medicines safety nurse to review practice and reflect on the incident.
- Eighteen staff out of a total of 33 on the children's unit had completed the high dependency course.
- In the neonatal unit 28 out of 34 eligible staff were Qualified in Speciality (QIS). This is a standard level of knowledge and skills for nurses within neonatal care.

Multidisciplinary working

- Good multidisciplinary (MDT) working was noted in areas we visited. Clinical staff told us there were good working relationships between medical and nursing staff.
- Records we reviewed indicated multi-disciplinary (MDT) working as appropriate however, there was no dedicated paediatric pharmacist or daily pharmacy support provided to the children's unit.
- A child and adolescent mental health (CAMHS) worker was present in the paediatric emergency department between 5pm and 11pm seven days a week. If children and young people presented outside of this time they were usually seen the next day. Staff told us that the CAMHS workers telephoned the unit daily to enquire if any inpatients required a review.
- Paediatric physiotherapy support commissioned by a local community trust was provided for children with Cystic Fibrosis and adult physiotherapists with special interest in paediatrics delivered care for children with other respiratory conditions or who were under the speciality of trauma and orthopaedics.
- Records we reviewed confirmed that meetings were held with social care and community professionals as required. For example in cases involving safeguarding or for patients who required discharge planning such as infants receiving oxygen.
- Two play specialists were available within the children and young people's service, one based on the children's unit and one in the paediatric emergency department. Play specialists worked a shift system and worked with children and young people to prepare them for theatre.
- Paediatric Health Visitor liaison informed community professionals when a baby was admitted to the neonatal unit and when children and young people had attended the accident and emergency department.
- Health Visitors were advised by telephone when a baby was discharged from the neonatal unit and summary letters were sent electronically to a patients' GP following discharge from children's services.
- Specialist nurses were in post to support young people transitioning to adult services and joint clinics took place for young people with respiratory conditions such

as Cystic Fibrosis, Epilepsy and Diabetes from 14 years of age. Children with complex needs transitioned to adult services on an individual basis in conjunction with parent's preferences.

- The Paediatric Acute Response Team (PART) team were co-located with the GP out of hour's service and described examples where multi-disciplinary working had prevented the need for attendance at hospital.
- In the CQC national children's survey 2014 out of 137 acute NHS trusts, the trust scored the same as others for the question, ' Did the members of staff caring for your child work well together?'.

Seven-day services

- Seven-day services were provided on the children's unit including the assessment unit as well as the neonatal unit, X-ray and A& E. The PART service was available six days a week however, appointments in the paediatric outpatient department were only scheduled Monday to Friday.
- Child and adolescent mental health services (CAMHS) were available seven days per week between 5pm and 11pm in the paediatric emergency department and children referred to CAMHS were usually seen the next day if admitted outside of these hours.
- The two play specialists for the children's unit worked a shift system that covered seven days.
- Consultant on-call cover was provided out of hours. The consultant of the week was present in the hospital during times of peak activity and available on call at other times.

Access to information

- Policies and procedures were kept on the trusts intranet and staff we spoke with confirmed they were familiar with how to access them.
- Parent Health Child Health Records (PHCR) were completed by staff in the neonatal unit at parent's request.
- Care Summaries were sent to GP's following discharge from the children's unit to ensure continuity of care in the community and a copy was provided to parents.
- Discharge summaries were provided to GPs when babies were discharged from the neonatal unit.
- The paediatrician on call was available on a designated telephone number three hours per day for GP's who required advice.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust's Consent to Examination, Treatment or Autopsy Policy included specific information regarding obtaining consent to treat young children. Guidance was also included for children who understood fully what was involved in the proposed procedure (Gillick or Fraser competent) and were able to give valid consent for treatment.
- Staff could describe the principles of Gillick competency used to assess whether a child had the maturity to make their own decisions and how decisions were made with the involvement of parents.
- Staff described how they worked on the principle of verbal consent for some procedures such as taking observations of temperature and pulse.
- We observed a discussion about obtaining written consent for a Looked After child going to theatre, during a pre-admission appointment.
- Staff described how support would be obtained from specialist colleagues and the safeguarding team when dealing with parents who may lack capacity.
- Data from the trust showed that between January 2014 and December 2016 89% of medical staff and 95% of nursing staff in the children and young people's service had completed Mental Capacity Act training.

Are services for children and young people caring?

Good

We rated caring as Good because:

- Care was provided by committed, compassionate staff who were enthusiastic about their role.
- Staff were observed treating patients and their relatives with kindness and respect both in person and on the telephone.

- Staff described how they had supported a family from abroad who experienced a sudden illness and bereavement. Staff provided practical, emotional, spiritual and psychological care for the family who were alone a great distance away from home and went over and above what could be normally expected to facilitate the family's return home as easily as possible.
- Parents told us they felt involved in the decisions regarding their child's care and one parent stated they felt able to 'say what I want' and another stated they could 'disagree too'.
- Parents encouraged to stay with their child on the children's unit and fold out beds were available at each bedside however, newly delivered mothers were provided with a regular bed.
- Parents felt confident about leaving their baby in the neonatal unit, one parent said the baby was "definitely in safe hands when I am not around".
- Children scheduled for surgery would be cared for by the same nursing staff during their pre-operative outpatient appointment, inpatient admission for surgery and recovery period to ensure they had a familiar face and continuity of care.
- Cold cots were available in the neonatal unit to enable bereaved parents to spend time with their infant after they had passed away and a bereavement midwife was in post to support families who had lost a child in the neonatal or children's unit.

Compassionate care

- Care was provided by committed, compassionate staff who were enthusiastic about their role.
- The children's unit presented as a calm environment during our inspection and call bells were observed to be answered in a timely fashion.
- Staff were observed treating patients and their relatives with kindness and respect both in person and on the telephone. We observed a staff member speaking with a parent in a polite and helpful manner.
- Results of the CQC national children's survey 2014 showed that out of 137 acute NHS trusts, the trust performed better than others for the question 'Do you feel your child was well looked after by the hospital staff?'.
- Parents told us that staff 'had been fantastic every time I come', that nurses had been reassuring and supportive, that staff were easy to talk to and 'they don't just look after the babies, they look after the parents'.
- Staff described how they had supported a family from abroad who experienced a sudden illness and bereavement. Staff provided practical, emotional, spiritual and psychological care for the family who were alone a great distance away from home and went over and above what could be normally expected to facilitate the family's return home as easily as possible.
- Results of the NHS Friends and Family Test for the children's unit 1 December to 31 December 2016 showed that from 24 reviews in this period 21 respondents were "likely" or "extremely likely" to recommend the service.
- Friends and Family data was not collected on the neonatal unit, however there was a suggestions box on the unit for parents to leave comments or ideas and parents could submit feedback on a neonatal social media page.

Understanding and involvement of patients and those close to them

- Parents told us they felt involved in the decisions regarding their child's care and staff are happy to answer any questions. One parent commented they felt able to 'say what I want' and another stated they could 'disagree too'.
- Information booklets were provided for parents on admission to the children's unit and the neonatal unit and included details of visiting times, parent's facilities and car parking.
- Patients discharged from the neonatal unit were given an information pack and blanket.
- Parents were encouraged to stay with their child on the children's unit and fold out beds were available at each bedside however, newly delivered mothers were provided with a regular bed.

Emotional support

- Parents felt confident about leaving their baby in the children's unit and neonatal unit, one parent told us their baby was 'definitely in safe hands when I am not around'.

Services for children and young people

- Children scheduled for surgery would be cared for by the same nursing staff during their pre-operative outpatient appointment, inpatient admission for surgery and recovery period to ensure they had a familiar face and continuity of care.
- A play specialist supported children to prepare for theatre. Play specialists and healthcare assistants used distraction therapy to help children cope with painful or difficult procedures.
- Parents were provided with the contact number for the neonatal unit on admission this allowed them to telephone for advice following discharge if they had any problems.
- Children and young people with complex needs and long term conditions had open access to the children's unit. This meant that parents or carers could contact the children's unit at any time if they had concerns regarding their child's health.
- Psychological support was available for children with diabetes and long term conditions. Counselling was available following referral to child and adolescent mental health services (CAMHS).
- Cold cots were available in the neonatal unit to enable bereaved parents to spend time with their infant after they had passed away.
- A bereavement midwife was in post to support families whose child passed away in the neonatal unit or children's unit.
- Bereavement support and counselling for parents and siblings was accessed locally in a tertiary centre.

Are services for children and young people responsive?

Good

We rated responsive as Good because:

- The environment on the children's unit including paediatric outpatients and the paediatric emergency department was colourful and child friendly and a separate adolescent waiting area was available in the paediatric outpatient department.
- Parents were encouraged to stay with their child on the children's unit and facilities were available to support this.
- Facilities to stay were available for parents with infants in the neonatal unit if the baby was unwell or parent's lived a distance from the hospital. The rooms could also be used by parents to gain confidence caring for their baby prior to discharge.
- Breakfast and drinks were provided for all parents on both the neonatal and children's unit and lunch and dinner was provided for breastfeeding mothers.
- Open visiting was available to parents with infants on the neonatal and children's units and support was available with parking charges when children had been on the units for more than a week.
- Specialist nurses were in post in a range of specialities including Epilepsy and Diabetes and provided support to young people transitioning to adult services.
- A CAMHS worker was present in the paediatric emergency department between 5pm and 11pm seven days per week to ensure timely assessment of children and young people.
- Young people between the ages of 16 and 18 years who required admission to hospital were offered the choice of a bed on an adult or paediatric ward.
- The Paediatric Acute Response Team (PART) worked with a local community trust to reduce the need for children and their families to attend hospital.
- The children's community respiratory team (CREST) provided a service to support parents and avoid admission to hospital if possible.
- Data from the trust showed at the time of our inspection the 90.5% of patients referred to paediatric services were seen within the 18 week standard.
- The consultant of the week triaged all referrals to ensure children and young people were seen appropriately, this could be in outpatient clinic, the paediatric assessment unit or by the PART team.

- Parents we spoke with told us they felt able to raise concerns or complain if necessary. Staff were aware of the complaints process and complaints were discussed with staff at monthly ward meetings and through the safety brief.

However,

- Adult areas were children were seen with the exception of ophthalmic clinic, lacked any child friendly decoration or activities.
- There was a separate paediatric section in the theatre recovery area however, this was not child friendly and had no decoration to distinguish it from other recovery areas.
- Two play specialists were available within the children and young people's service however seven out of nine parents asked, were unaware of a play therapist within the ward environment.

Service planning and delivery to meet the needs of local people

- The environment on the children's unit including paediatric outpatients and the paediatric emergency department was colourful and child friendly and a separate adolescent waiting area was available in the paediatric outpatient department. However, adult areas were children were seen with the exception of ophthalmic clinic, lacked any child friendly decoration or activities.
- The children's unit was decorated with an underwater theme and this continued on the 'walk to theatre' with a corresponding activity book which was used as a distraction.
- A play room and an adolescent recreation room were available however staff told us the adolescent room was not used and had become a meeting area. During our inspection we noted surplus equipment placed in this room.
- Every bed in the children's unit had an overhead television which was free to use until 7.30pm and a games console and range of DVDs were available.
- Children attending for day case surgery could be accompanied by their parents into the anaesthetic room. There was a separate paediatric section in the recovery area however, this was not child friendly and had no decoration to distinguish it from other recovery areas.
- Parents were encouraged to stay with their child on the children's unit. A sitting area was available with a refrigerator and tea and coffee making facilities away from the patients' bedside but within the unit. Parents were able to make hot drinks that could be taken on to the ward in lidded cups.
- The environment in the neonatal unit was welcoming and had designated 'breastfeeding corners' with screens. A private room was also available next to the unit for mothers who wished to express breast milk in a more private environment.
- Parent's facilities for the neonatal unit were situated in a 'flat' just outside the unit. This contained two bedrooms, shower facilities and a kitchen and lounge area with a refrigerator, microwave oven and tea and coffee making facilities.
- Facilities to stay were available for parents with infants in the neonatal unit if the baby was unwell or parent's lived a distance from the hospital. The rooms could also be used by parents to gain confidence caring for their baby prior to discharge.
- Breakfast and drinks were provided for all parents on both the neonatal and children's unit and lunch and dinner was provided for breastfeeding mothers.
- Open visiting was available to parents with infants on the neonatal and children's units and support was available with parking charges when children had been on the units for more than a week.
- Parents we spoke with in paediatric outpatients told us finding a parking space was difficult when attending for appointments however, based on the clinical requirements, individual parking arrangements could be made.

Meeting people's individual needs

- A national charity for premature and sick babies provided leaflets in a variety of languages to the neonatal unit.

- Interpreting services could be arranged to support families whose first language was not English and staff confirmed they knew how to access these however, we did not see this in use during our inspection.
- Records we reviewed confirmed that a pre-operative assessment was completed by nurses who would care for the child and family during their admission to ensure continuity of care.
- Two play specialists were available within the children and young people's service however seven out of nine parents asked were unaware of a play therapist within the ward environment.
- Staff told us children were prioritised in x-ray and diagnostic scanning areas and on adult theatre lists.
- Paediatric outpatient appointments for children with complex needs were arranged on the same day to prevent patients attending on more than one occasion.
- Specialist nurses were in post in a range of specialities including Epilepsy and Diabetes and provided support to young people transitioning to adult services.
- A CAMHS worker was present in the paediatric emergency department between 5pm and 11pm seven days per week to ensure timely assessment of children and young people. Children and young people presenting at other times were assessed within 24 hours and if admission to the children's unit was required a Suicide Prevention Policy was in place to promote patient safety.
- All parents with a child admitted to the neonatal unit less than 34 weeks gestation received an 'Emily's Star' box. This included toiletries for mother and baby as well as items such as nappies, a vest and a muslin cloth.
- Following discharge from the neonatal unit infants who met the criteria were visited by the neonatal community nurse specialist. Eligibility criteria included infants born less than 2.3kg or below 36 weeks gestation or any family that may require additional support.
- Leaflets were available for parents on the children's unit covering a variety of topics including minor head injuries and fever.
- Young people between the ages of 16 and 18 years who required admission to hospital were offered the choice of a bed on an adult or paediatric ward.
- Managers told us children and young people approaching end of life were cared for at home by a local community trust, in a hospice or a tertiary centre.

Access and flow

- Admission to the children's unit was either via A & E, GP or Paediatric Acute Response Team (PART) referral to the assessment unit however patients with known conditions had direct ward access with a patient passport.
- The PART service was located in a health and wellbeing centre in Warrington town centre and was a joint service with a local community trust. Services provided included wound checks, intravenous antibiotic administration and review of jaundice in infants. Referral could be initiated by a range of community professionals as well as hospital staff and reduced the need for children and their families to attend hospital.
- Between January 2016 and December 2016, 1,535 children and young people were referred to the PART service. In this period 2,968 face to face contacts took place and 1,446 telephone contacts.
- The children's community respiratory team (CREST) provided a service to support parents and avoid admission to hospital if possible. The service saw children and young people with non-acute respiratory wheeze or asthma and provided an individualised asthma care pathway, supported inhaler technique and provided education for parents.
- At the time of our inspection a paediatric eczema and dermatology service (PED) was commencing. This was a partnership between a local GP with a special interest and a dermatology specialist nurse from the hospital.
- The observation and assessment unit was open seven days a week between 7am and 8.30pm Patients who required care after this time were transferred to an inpatient bed.
- Babies admitted to the neonatal unit that required intensive care for longer than 48 hours were transferred to a specialist unit.
- Pre-operative assessments were completed on the ward and day surgery took place four days per week.
- Data from the trust showed at the time of our inspection the 90.5% of patients referred to paediatric services

were seen within the 18 week standard. This varied according to speciality with trauma and orthopaedics achieving 83.6% and general medicine, cardiology, respiratory medicine and rheumatology achieving 100%.

- Bed occupancy rates on the neonatal unit for 2016 were 66.9%. This was broken down to 33.5% for intensive care, 34% for high dependency care and 83.4% for special care. Following external advice a recommendation had been made to reduce cot capacity with a planned completion date of 30 April 2017.
- Between January 2016 and December 2016 bed occupancy rates on the children's unit were 5.7% for the paediatric assessment unit, 63.2% for the paediatric bays and 64.5% for paediatric cubicles.
- The consultant of the week triaged all referrals to ensure children and young people were seen appropriately, this could be in outpatient clinic, the paediatric assessment unit or by the PART team.
- There were no rapid access clinics however children and young people who required an immediate review were seen on the children's unit the following day.
- Children and young people who attended for medical outpatient appointments were seen in the paediatric outpatient department. Appointments for other specialities such as general surgery or ophthalmology were held in general adult clinics.
- Between January 2016 and December 2016 6,220 paediatric medical outpatient attendances were recorded at the Warrington site and 567 attendances at the Halton site.
- Between September 2016 and December 2016 nine paediatric outpatient clinics cancelled were within 6 weeks.
- Between January and December 2016 there were 14,814 attendances at the accident and emergency department by patients aged 0-18 years, 55.5% of which were discharged without follow up. Of those patients admitted, 33% were patients under 1 year of age.
- When calculating length of stay a one day admission would be over midnight. Between January 2016 and December 2016 of the 3675 emergency admissions of children and young people to the hospital, 50% were less than a day.
- Children and young people referred to child and adolescent mental health services (CAMHS) were seen the next day if not reviewed by the CAMHS worker who was present in the paediatric emergency department between 5pm and 11pm seven days a week.

Learning from complaints and concerns

- Parents we spoke with told us they felt able to raise concerns or complain if necessary.
- Information leaflets were available within the areas we visited advising patients and families about the Patient Advice and Liaison Service (PALS) if they wished to make a complaint.
- Staff were aware of the complaints process. Staff told us they would try and resolve issues immediately and if this was unsuccessful would direct the patient and family to the ward manager or Matron and PALS.
- Between January and December 2016 12 complaints were received relating to paediatrics. The three main themes identified were regarding treatment, care and staff attitude.
- Following a review of complaints learning points were identified for both individual staff members and teams.
- Complaints were discussed with staff at monthly ward meetings and through the safety brief and staff could describe changes in practice following a complaint.

Are services for children and young people well-led?

Good

We rated well-led as Good because:

- Staff we spoke to were aware of the trusts vision and paediatric strategy and could describe plans to develop services.
- The development of community services such as the Paediatric Acute Response Team (PART) and the

children's community respiratory team (CREST) in collaboration with a local community trust was part of the trusts paediatric strategy to develop outreach services.

- Quality and performance were monitored through divisional dashboards and the Child Health Governance Group reviewed risks, incidents and complaints and new clinical guidance.
- Corporate and divisional risk registers were in place, managers knew the risks and mitigating actions within their departments.
- Monthly team meetings took place on the children's unit to ensure staff received information and feedback regarding incidents and complaints and were kept informed of developments within the trust.
- Staff reported effective team working and felt they were able to raise concerns or ideas for service improvement.
- The PART team had been shortlisted in the Primary Care category of The BMJ Awards 2017.

However,

- There were seven risks on the divisional risk register relating to paediatrics and neonatology at the time of our inspection. All had action plans to mitigate risk and review dates however three risks had been on the risk register for more than two years.

Vision and strategy for this service

- The children and young people's service was active with the Merseyside & Cheshire Women's and Children's Vanguard. This aims to develop a network of services across the region to improve quality and ensure future service delivery.
- Staff we spoke to were aware of the trusts vision and paediatric strategy and could describe plans to develop services.
- The development of community services such as the Paediatric Acute Response Team (PART) and the children's community respiratory team (CREST) in collaboration with a local community trust was part of the trusts paediatric strategy to develop outreach services. Staff were proud of the services and the impact on patients.

Governance, risk management and quality measurement

- Quality and performance were monitored through divisional dashboards and included patient access to investigations and treatment, patient experience including complaints, workforce recruitment and attendance at essential training.
- The Child Health Governance Group met monthly and was attended by senior staff including the divisional governance lead, consultants, matron and ward managers. This forum was used to review risks, incidents and complaints and discuss the introduction of new clinical guidance. Meeting minutes could be accessed by all staff on the trust intranet.
- Quality reports for the paediatric unit were submitted monthly and detailed activity at ward level such as compliance with controlled drug and resuscitation equipment checks as well as audits of documentation and paediatric early warning scores.
- We observed corporate and divisional risk registers in place, managers knew the risks and mitigating actions within their departments.
- There were seven risks on the divisional risk register relating to paediatrics and neonatology at the time of our inspection. All had action plans to mitigate risk and review dates however three risks had been on the risk register for more than two years.
- There was a named executive at board level who led on services for children and young people.

Leadership of service

- Services for children and young people were led by a matron supported by a band 7 manager within the children's unit and the neonatal unit.
- Nursing staff told us managers were visible and approachable.
- Doctors told us that consultants were supportive and helpful.
- Monthly team meetings took place on the children's unit to ensure staff received information and feedback regarding incidents and complaints and were kept informed of developments within the trust.

- There were no regular team meetings on the neonatal unit however a safety brief was circulated daily to provide essential information such as lessons learned from incidents.
- Staff we spoke with told us that the clinical business manager and members of the trust board were visible.

Culture within the service

- Staff we spoke with were passionate about their work and were committed to providing high quality care.
- There was an open and honest culture in the service. Staff we spoke to were candid about the challenges they faced within the service and were proud of what worked well.
- Staff told us morale could vary however they felt colleagues were very supportive of each other.
- Staff reported effective team working and felt they were able to raise concerns or ideas for service improvement.
- Managers spoke highly of the hard work and commitment shown by their staff.

Public engagement

- The views of patients were actively sought within the children's unit using the NHS Friends and Family Test.
- Parents on the neonatal unit could submit comments or ideas via a suggestion box on the unit and feedback could be submitted on a neonatal social media page.
- We observed noticeboards on the corridor approaching the main ward area on the children's unit which provided examples of comments received from parents and suggestions for improvements such as the frequency drinks were offered.
- Managers told us parental engagement took place with a core group of parents whose children had complex needs.
- Children's eye clinic obtained feedback from patients regarding the reception and waiting area, contact with staff and overall experience.

Staff engagement

- Results of the 2016 NHS Staff Survey showed the trust scored better than the national average for acute trusts for support from immediate managers and recognition and value of staff by managers and the organisation. However the trust scored worse than the national average for acute trusts for staff recommendation of the organisation as a place to work or receive treatment.
- Physical and psychological support services were available to staff and staff we spoke with were aware of how to access them.
- Team meetings took place monthly in the children's ward and weekly trust wide emails were sent by the communications team to inform staff about events and news within the trust.

Innovation, improvement and sustainability

- The trust was working with local partners to develop a fully integrated community paediatric pathway. This included the existing PART and CREST teams and also the development of a paediatric eczema and dermatology service (PED) which had commenced prior to our inspection.
- The trust was working with a local specialist children's trust to increase the number of paediatric surgical patients treated at Warrington hospital.
- Recruitment was in progress for a second Advanced Paediatric Nurse Practitioner (APNP) to work in the neonatal unit.
- Thee children's unit was fundraising to develop an outside play area next to the inpatient playroom.
- The PART team had been shortlisted in the Primary Care category of The BMJ Awards 2017.

End of life care

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

Information about the service

End of life care services were part of the hospital acute care division. Warrington Hospital's specialist palliative care team offered a service; from Monday to Friday with core hours of 8.30am to 4.30pm. The team covered both Warrington Hospital and Halton General Hospital and covered Bank Holidays.

Patients with palliative/end of life needs were accommodated on the general wards in the hospital. The trust provided a consultant led hospital specialist palliative care (HSPC) team. The HSPC team is a resource available to all clinical areas within the hospital providing specialist palliative care, advice and support for adult inpatients that are affected by cancer and other life limiting illnesses. The HSPC team provides an advisory and supportive service whilst the medical and nursing management of the patient remains the responsibility of the ward teams.

We visited nine wards where end of life care was being provided at the time of our inspection. We also visited the chapel/multi-faith room, the hospital mortuary, viewing room and the bereavement offices.

During the inspection, we spoke with two patients and their relatives on the wards. We spoke with 36 staff across a range of staff including: nurses, doctors, consultants, ward managers, anatomical pathology technicians and members of the senior management team. Additionally we spoke with members of the hospital palliative care team, including the clinical lead and matron for palliative care

We observed care and treatment and we looked at 33 paper care records and 32 electronic records. We looked at appropriate policies and procedures related to end of life care.

End of life care

Summary of findings

We inspected Warrington and Halton hospital in 2015 and gave end of life services an overall rating of good. Following this inspection we have maintained the overall rating because:

- There were systems for reporting actual and near-miss incidents across the hospital which meant the service was able to monitor any risks and learn from incidents to improve the quality of service delivery.
- There were sufficient numbers of trained clinical, nursing and support staff with an appropriate skill mix to ensure that patients receiving end of life care were well cared for in all the settings we visited.
- Medicines were prescribed, stored and administered safely. Access to medicines for people needing continuous pain relief was available to ensure patient's pain was managed.
- The HSPC team had received mandatory training such as safety and safeguarding in order to maintain the safety of patients.
- To meet patients' needs the HSPC team had developed a training programme for specialist palliative care across the trust with end of life link nurses for each ward to support, advise and educate other ward staff in relation to end of life care.
- The HSPC team was adequately staffed, well trained and received regular appraisals.
- A care management approach "amber care bundle" was in place when doctors were uncertain whether a patient may recover and were concerned that they may only have a few months left to live. This is an approach to care management used in hospitals when doctors are uncertain whether a patient may recover and are concerned that they may only have a few months left to live. The trust had appointed a designated member of staff who worked within the palliative care team to facilitate implementation across the trust.
- The trust participated in the "End of life care Audit: Dying in Hospital 2016", which replaced the NCDAH. The audit results showed an improvement in end of life care at the trust. Out of 17 clinical and organisational indicators the trust had performed either better than or in line with national average in the majority of the indicators. The trust performed better than the England average for three of the five clinically related indicators. The trust scored particularly well for having documented evidence that the needs of person(s) important to the patient were asked about, scoring 73% compared to the score of 56%.
- All the feedback we received was overwhelmingly positive showed a committed and passionate workforce relating to the provision of end of life care in the trust.
- We found several examples of staff on the wards and the mortuary consistently providing a service to patients at the end of their lives that went beyond what could reasonably be expected of them and they regarded that as their everyday job.
- Services were planned and delivered to meet the needs of local people. There were systems in place to support patients with particular needs.
- The trust worked with other services that provided end of life care in the Warrington area to carry out a joint self-assessment identifying areas for development to promote excellence in end of life care.
- The trust had fully implemented an individual end of life care plan of care (IPOC) when patients were identified as approaching end of life. This was a stand-alone document which had been based on the principles and essential elements of excellent end of life care as outlined in the "One chance to get it right."
- The trust had a clear mission and vision statement. This was to provide high quality, safe healthcare "We are Warrington and Halton hospital and together we will work as one". Staff we spoke to were able to describe the vision and strategy and they felt that they were part of the trust.

End of life care

- Since our last inspection the hospital specialists palliative care team (HSPCT) had reviewed the strategy for end of life care and had undertaken a self-assessment structured around the six national ambitions for palliative and end of life care.
- We reviewed the trust self-assessment and action plan for ensuring the implementation of the "Ambitions for Palliative and End of Life Care" to improve the provision of better care for patients at end of life. Actions included the development of more leaflets for relatives to improve communication and active engagement in regional audits to ensure the HSPCT is complying with best local and national best practice.

However:

- At our last inspection we found there was no access to specialist palliative care medical support out of hours. At this inspection we found this was still the case with no access to out of hour's specialist palliative care medical support. Senior managers told us that they had improved access to support and advice through the hospital intranet and the lack of specialist palliative medical support had been identified on the trust risk register.
- The trust had commissioned an external audit of the use of the DNACPR policy as well as its own internal audit. Results showed there were a number of occasions, where documentation in relation to DNACPR forms has not been in line with Trust Policy. Engaging in difficult conversations with patients, family or carers was not always fully recorded within the case notes. Patient's wishes were not appropriately discussed and recorded, and as a result, they are not treated appropriately We reviewed the action plan which had been put in place to ensure the staff training and monitoring of the DNACPR policy was strengthened.to ensure that the DNACPR's are completed accurately with the medical rationale for not attempting resuscitation and discussions with patients and family being recorded appropriately. The lack of a clear mental capacity assessment meant that the service could not be clear how much the patient understood the care they were receiving and it may not have access to reasonable adjustments such as access to specialist support.
- We found that patients at the end of their lives could not always be assured of a single room to ensure privacy.

End of life care

Are end of life care services safe?

Good

At the previous inspection in January 2015 we rated safe as good. Following this inspection we have maintained the overall rating because:

- There were systems for reporting actual and near miss incidents across the hospital. Staff were able to explain the process of using an electronic reporting system and describe the types of incidents that would be reported. This meant that the service was able to monitor any risks and learn from incidents to improve the quality of service delivery.
- Medicines were prescribed, stored and administered safely.
- We looked at 33 paper care records and 32 electronic patient's care and treatment records and found they were accurate and clinical notes were completed to a good standard in order to inform care and treatment.
- Patients were transferred to an end of life care plan if their condition required this so they could receive appropriate and timely care. The plan enabled staff to identify care requirements through risk assessment of the patients' needs such as symptom and pain relief, skin care, hydration and care of those people close to the patient.
- There were sufficient numbers of trained clinical, nursing and support staff with an appropriate skill mix to ensure that patients receiving end of life care were well cared for.
- Data provided by the trust showed that the hospital Specialist palliative care (HSPC) team completion of mandatory training, including safeguarding training was above the trust target of 85%.

However:

- Staff were aware of their responsibilities in relation to duty of candour (DoC) and the need to be open and honest with patients or their representatives. We requested and did not see any examples of evidence that the systems were in place to capture DoC within the End of Life (EOL) service.
- Some medical staff told us they had not had training on how to complete the individual plan of care documentation which may impact on the ability of the service to provide appropriate management of end of life care.

Incidents

- There were systems for reporting actual and near miss incidents across the hospital using an electronic incident reporting system. Staff were able to explain the process of using an electronic reporting system and describe the types of incidents that would be reported. This meant that the service was able to monitor any risks and learn from incidents to improve the quality of service delivery.
- Incidents reported relating to EOL care were very low compared with the rest of the trust. The senior management team reviewed any incidents related to EOL across the trust to ensure that any actions required were carried out.
- Staff were encouraged and supported to report any issues in relation to patient care or any adverse incidents that occurred. We reviewed minutes of team meetings and saw evidence of learning and reflection.
- Staff we spoke with described action that had been put in place immediately after an incident in the mortuary to improve checking patient identification. The service was carrying out a root cause analysis to implement any further learning across the mortuary service to improve patient care.
- Staff were aware of their responsibilities in relation to duty of candour and the need to be open and honest with patients or their representatives. The DOC is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain "notifiable safety incidents and provide reasonable support to that person. However, we requested and did not see any examples of evidence that the systems were in place to capture DOC within the EOL service.

Equipment

- We saw that the Trust had actioned the recommendations from Medicines Healthcare Products Regulatory Agency (MHRA) safety alert with regards to

equipment (syringe drivers) used for pain relief. We saw that syringe drivers were maintained in order to make sure they correctly worked and assisted in managing patients

- We were told by mortuary staff and records showed, that the mortuary equipment; such as fridges and trolleys were serviced within the manufacturer's recommendations.
- The mortuary access was kept secure to prevent inadvertent or inappropriate admission to the area.
- The security personnel used a covered body trolley to transport deceased patients from the ward to the mortuary in order to maintain their privacy and dignity. The trolley was cleaned between use.

Medicines

- There was clear, accessible guidance for staff regarding the prescribing of medicines to be given via a syringe driver or as the patients required including the use of booklets and specially printed mouse mats freely available on the ward for staff to access. Policies and procedures were also accessible to staff on the hospital intranet and staff were aware of the procedures to follow.
- We looked at six records for medicines (prescription charts) and saw that patients were receiving their medicines safely and according to their needs.
- Medicines, including those requiring cool storage, were stored safely and at the correct temperature. We saw controlled drugs were stored and managed safely.
- Anticipatory end of life medicines were prescribed appropriately. The EOL team told us that requests for end of life medicines for patients going home on rapid discharge could be provided with a quick turnaround. Which we observed during our unannounced inspection when staff were arranging a rapid discharge for a patient. A number of members of the HSPC team were trained to be non-medical prescribers with extended prescription rights. Their role was to provide advice, training and support to clinicians and nursing staff where needed. The team confirmed the plans to increase the number of non-medical prescribers in the team.

Records

- The HSPC team utilised the trust electronic patient records, which were accurate and completed to a professional standard. Information relating to tests and investigations was also stored on the electronic system. In total we reviewed 32 electronic records and 33 paper records and 12 individual plans of care. We found they were accurate and clinical notes were completed to a good standard in order to inform care and treatment.
- Following the introduction of electronic patient record system some records were held in paper format. The use of these may impact on the consistency of accessing relevant patient data and results.
- On the wards we found a hybrid approach to documentation with nursing notes kept by the bed side as well as other nursing notes on the electronic system. For people identified at end of life the trust had introduced a paper version of an individualised plan of care in response to the removal of the original Liverpool care pathway for end of life care. Patients would receive an individual plan of care when there was anticipation that the patient may die within hours or days. We found that wards were using the new individual care plan and there was evidence that the HSPC team reviewed the notes in a timely manner. Staff told us and records confirmed that there was clear documentation and completion of the plans which were signed and dated by the reviewing professionals which showed the care plans for the patients was reviewed and updated to meet their needs.
- Staff we spoke with confirmed that the HSPC team were accessible as and when required to provide support and guidance on the documentation. However some medical staff told us the documentation was easy to use but they had not had formal training on how to complete the documentation. We were shown plans that were in place for further rollout of training on the document.
- Effective systems were in place in the mortuary to ensure that people were correctly admitted and safely stored. Release forms were signed before a deceased person was released to the undertaker.

Safeguarding

End of life care

- Trust-wide policies and procedures were in place, which were accessible to staff electronically for safeguarding vulnerable adults and children to give them skills and knowledge to support and manage vulnerable patients.
- Staff we spoke with were aware of the process for referring a safeguarding concern, advice and support was accessible 24 hours a day, seven days per week should staff require support.
- Safeguarding training formed part of the trust's mandatory training programme. At our last inspection we found 67% of the HSPC team had completed the relevant safeguarding training. At this inspection we found 100% of the HSPC team had completed their safeguarding mandatory training and had the skills and knowledge to support vulnerable patients.
- HSPC staff we spoke with were knowledgeable about their role and responsibilities regarding the safeguarding of vulnerable adults. Additionally, they were aware of the process for reporting safeguarding concerns. Staff told us they felt confident to raise concerns and make safeguarding referrals, and felt well supported to do this.

Mandatory training

- At our last inspection we found staff did have access to training but had not met the trust standard for completing the mandatory training due to pressure of work. At this inspection we found 100% of staff had completed their mandatory training. Staff received annual mandatory training, which included key topics such as infection control, information governance, equality and diversity, fire safety, health and safety, safeguarding children and vulnerable adults, manual handling and conflict resolution. Mandatory training was delivered on a rolling programme and monitored on a monthly basis.
- Basic life support (BLS) training was provided by the trust as part of mandatory training. Data provided by the trust showed that 100 % of staff across end of life services had completed the training at the time of the inspection. Staff were able to support patients who may require immediate resuscitation.

Assessing and responding to patient risk

- The trust used the National Early Warning Score (NEWS) to recognise if a patients' condition was deteriorating. The NEWS score is a simple scoring system in which a score is allocated. It uses six physiological parameters to form the basis of the scoring system, these include, respiratory rate, oxygen saturation, temperature, systolic blood pressure, pulse rate and level of consciousness. Records showed that this was used appropriately on the wards.
- A care management approach "amber care bundle" was in place when doctors were uncertain whether a patient may recover and were concerned that they may only have a few months left to live. Patients would be transferred to an individual plan of care when they were identified as approaching end of life and there was recognition the patient was expected to die within hours or days. The plan enabled staff to identify care requirements through risk assessment of the patients' needs and provide appropriate care to meet their individual needs such as symptom and pain relief, skin care, hydration, and care of those close to the patient. Care was based on ensuring the person remained as comfortable as possible at all times.
- Anticipatory care plans were put in place to ensure that all staff were aware of the best ways to manage symptoms relating confirmed the team responded promptly when needs. We observed the team providing reassurance to a member of staff on how they were managing an individual patient's needs.

Nursing staffing

- At our last inspection we found the increase in referral rates year on year presented a challenge for the service and the provider should ensure that the specialist palliative care team has the appropriate staffing levels and skill mix to meet the demands on the service. At this inspection we found that a full skill mix review had been undertaken of the HSPC team and managers confirmed the service had now filled all vacant posts to assist in providing care to safely meet patient's needs.
- The HSPC team consisted of one clinical matron post, three whole time equivalent clinical nurse specialists and part time administrative support. Senior managers told us that the matrons role had included clinical work which they believed had limited their ability to take an

active management role. They had reviewed this and supported the matron to have a stronger management presence in order to have an overview of the safe care and treatment of patient.

- Providing end of life care was the responsibility of all staff and was not restricted to the HSPC team. The role of the HSPC team was to provide specialist support to all staff in order to achieve the best care and support for patients to ensure that patients at the end of life received sufficient care and treatment.
- The trust had at least one end of life link nurse per ward. The link nurses were part of the ward team whose role included working with the specialist staff to provide consistent safe care and treatment whose role included raising awareness of end of life processes and cascading education to the rest of the nursing team to provide consistent safe care and treatment
- Nursing handovers took place at the start of each shift on all the medical wards. Staffing for the shift was discussed as well as any high-risk patients or patients at end of life to ensure the appropriate staffing levels were in place. Handovers were detailed and staff on duty were familiar with the needs of patients in their care.
- The HSPC team also held a comprehensive handover meeting each morning to ensure staff were aware of risks and prioritise patients requiring urgent reviews to ensure timely care and treatment. We observed the handover and found that staff liaised closely with ward staff and the community.
- The HSPC team also provided telephone support and face to face reviews for the sister hospital patients when required.

Medical staffing

- The Association for Palliative Medicine of Great Britain and Ireland, and the National Council for Palliative care guidance states there should be a minimum of one whole time equivalent (WTE) consultant per 250 beds. This trust had 649 beds this equates to a minimum of three WTE consultants. The trust employed 0.6 WTE consultants. This was mitigated by the additional input of ward medical staff with additional training and support given by the lead consultant.
- For patients with palliative/end of life needs, medical support was provided on the general wards in the hospital. Medical nursing management of the patient remained the responsibility of the ward teams.
- Junior and trainee doctors told us they knew where to get support for information and management of palliative care and symptom control in order to provide safe care and treatment to patients in their care.

Major incident awareness and training

- There was a robust policy in place of action to take if the hospital was involved in a major incident. The policy listed the key risks that could affect the provision of care and treatment.
- The mortuary staff were able to describe how to initiate escalation plans for increased capacity in the event of a major incident involving mass casualties by utilising facilities at the sister hospital site.
- Staff we spoke with were able to describe the actions they would take in the event of a fire and received training in fire and health and safety.

Are end of life care services effective?

Good

At the previous inspection in January 2015 we rated effective as good. Following this inspection we have maintained the overall rating because:

- The palliative care team based the care it provided on the National Institute for Health and Care Excellence (NICE) Quality Standard for End of Life Care for Adults (2013). They also followed the National Institute for Health and Care Excellence (NICE), care of dying adults in the last day's life published in December 2015. The Trust had previously contributed to the National Care of the Dying Audit (NCDAH).
- The trust participated in the "End of life care Audit: Dying in Hospital 2016", which replaced the NCDAH. The recent audit results showed an improvement in end of life care at the trust. Out of 17 clinical and organisational indicators the trust had performed either better than or in line with national average in the majority of the indicators. The trust performed better than the England

average for three of the five clinically related indicators. The trust scored particularly well for having documented evidence that the needs of the person(s) important to the patient were asked about, scoring 73% compared to the national result of 56%.

- Patient's level of pain was reviewed often for effectiveness and changes were made as appropriate to meet the needs of individual patients. Pain relief was available for patients as they needed it. Anticipatory prescribing took place to ensure that patients' pain and other symptoms were managed in a timely manner.
- The trust had a comprehensive education and training programme in end of life care and a formal programme of study days which was co-ordinated by the HSPC team. Training in end of life care was provided within the hospital and collaboratively with other providers in the area.
- There was a weekly integrated MDT meeting with video conferencing across Warrington hospital, the local hospice and community services .Patients whose location of care was changing or who had complex needs were discussed at this meeting.
- There was also a weekly discussion with the palliative medicine consultant at another local hospice and patients transferring care settings were discussed at this meeting.
- Access to medicines and infusion pumps (syringe drivers) for people needing continuous pain relief was available to ensure patient's pain was managed. Syringe pumps were maintained and used in accordance with professional recommendations.

However:

- At our last inspection we found there was no access to specialist palliative care medical support out of hours. At this inspection, we found that this was still the case Senior managers told us that they had improved access to support and advice through the hospital intranet and the lack of specialist palliative medical support had been identified on the trust risk register.
- The trust had commissioned an external audit of the use of the Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) policy as well as its own internal audit. Results showed there were a number of occasions, where documentation in relation to DNACPR forms has not been in line with Trust Policy. Engaging in difficult conversations with patients, family or carers is not always fully recorded within the case notes. Patient's wishes were not appropriately discussed and recorded, and as a result they are not treated appropriately. We reviewed the action plan which had been put in place to ensure the staff training and monitoring of the policy was strengthened to ensure that the DNACPR's are completed accurately with the medical rationale for not attempting resuscitation and discussions with patients and family being recorded appropriately.

Evidence-based care and treatment

- The trust had introduced in line with national guidance an individual plan of care and support for patients who had been identified as at end of life to replace the previous Liverpool care pathway. At our last inspection this had been introduced a few weeks prior to the inspection. The newly developed individual plans were in the process of being reviewed and evaluated in order to make sure that they met patient's needs. At this inspection we found that this process had been fully implemented across the trust.
- The palliative care team based the care it provided on the National Institute for Health and Care Excellence (NICE) Quality Standard for End of Life Care for Adults (2013). They also followed the National Institute for Health and Care Excellence (NICE), care of dying adults in the last days of life document published in December 2015. The trust had previously contributed to the National Care of the Dying Audit (NCDA). Following the previous audit results the trust had put in place an action plan to address the issues raised. We also saw evidence of and reviewed the end of life service programme in place in order to identify and address any short falls in clinical practice for end of life care.
- Policies and procedures were accessible on the trust intranet and staff were aware of how to access them.
- At our last inspection we found the palliative care team had reviewed the Department of Health's National End of Life Strategy recommendations, which identified the need to introduce the "amber care bundle". At this inspection we found that the use of amber care bundles had now been embedded across the trust.

Pain relief

End of life care

- Patient's level of pain was reviewed often for effectiveness and changes were made as appropriate to meet the needs of individual patients. Pain relief was available for patients as they needed it. Anticipatory prescribing took place to ensure that patients' pain and other symptoms were managed in a timely manner.
- The HSPC team provided advice and guidance with regards to pain management. Staff told us and records showed they were able to access clear guidance on the prescribing of medicines to be given 'as required' (PRN) for symptoms that may occur at end of life, such as pain and nausea. This meant that patients had timely access to the most appropriate pain and symptom relief.
- Access to continuous pain relief for patients who needed this was readily available. There were systems in place for checks to be carried out in relation to the use of syringe drivers. The use of syringe drivers for managing patients' pain was supported by the Hospital Specialist Palliative Care team (HSPC). The HSPC was available to support staff on a daily basis including weekends. Staff reported no issues in obtaining syringe drivers for individual patients as needed.
- The National End of Life Care Audit: Dying in hospital March 2016 showed the clinical protocols for the prescription of PRN medicines for the five key symptoms which may develop at the end of life were adhered to at a better rate (68%) than the national average (65%) for England.

Nutrition and hydration

- Patients were screened using the malnutrition universal screening tool (MUST) to identify any nutritionally risk. Staff were aware of patients who required additional support with eating and drinking. Patients who required support and assistance with eating and drinking were discreetly identified using a coloured jug system and supported by staff accordingly.
- The ward staff supported patients to eat and drink normally for as long as possible. Patients had access to drinks and food suitable to their needs. This was identified and monitored through their individual plans of care.
- Staff told us and records showed us they were able to support people's religious and cultural needs regarding meals and dietary requirements such as helping to observe fasting or food prepared accruing to cultural beliefs.
- All wards had access to specialist advice from dieticians if required. Records we reviewed showed evidence of appropriate discussion with dieticians.
- The National End of Life Care Audit: Dying in hospital March 2016 showed that the clinical protocols for the review of the patient's nutritional requirements and review of the patients hydration requirements were achieved at a better rate (83%) than the national averages (60% and 61%) for England. This included the monitoring and use of prescribed supplements and additional nutritional support.

Patient outcomes

- In the period April 2015 and March 2016, 731 referrals were made to the Specialist Hospital Palliative care team (HSPC), of these referrals 475 were cancer related and 256 were non cancer related. This was a similar breakdown to the previous year. The trust had 221 deaths in the same period.
- The trust participated in the "End of life care Audit: Dying in Hospital 2016", which replaced the NCDAH. The recent audit results showed an improvement in end of life care at the trust. Out of 17 clinical and organisational indicators the trust had performed either better than or in line with national average in the majority of the indicators. The trust performed better than the England average for three of the five clinically related indicators. The trust scored particularly well for having documented evidence that the needs of the person(s) important to the patient were asked about, scoring 73% compared to the national result of 56%. It also scored better than the national average "multi-disciplinary recognition that the patient is dying".
- The trust answered yes to three of the eight organisational indicators. However we found the trust had answered no to question 8C compared to 71% of trusts nationally which answered yes. This question asked whether formal in house training was provided covering communication skills for care in the last hours or days of life for registered nursing staff. At the time of

our inspection we found that the trust had already responded to the audit resulted and had appointed a palliative care educator to improve access to staff training in palliative care.

- The trust had developed an action plan in response to the end of life care audit to address the issues raised. Key actions included the development of formal in house training for both nursing and medical staff which had been implemented.
- The service had completed the End of Life Care Quality Assessment Tool self-assessment. The latest assessment showed that the trust was compliant in 80% of the key areas with the rest partially compliant. The service had identified actions to achieve full compliance within set timescales; progress against the timescales was regularly monitored.
- The HSPC team aimed to see at least 90 % of patients within 24 hours. Data showed that the team exceeded this in the last three months prior to our inspection achieving 95% of patients seen within 24 hours.
- From September 2016 to February 2017 all patients had a plan of care or advice from the HSPC.
- Referrals to the HSPC team from the hospital were received either electronically, by telephone, bleep, or via face to face contact with staff on the ward. Following referral the patients' needs were assessed and advice would be discussed with the clinical staff responsible for the patients care. All patients were discussed in detail at the HSPC handover to ensure that the patient's management was as effective as possible and any relevant communication required with team members was in a timely manner.

Competent staff

- Newly appointed staff had an induction including end of life care and their competency was assessed before working unsupervised. Agency and locum staff also had inductions before starting work.
- A full Preceptorship programme was offed to all newly registered nurses.
- The trust had a comprehensive education and training programme in end of life care and a formal programme of study days which was co-ordinated by the HSPC team. Training in end of life care was provided within the hospital and collaboratively with other providers in the area.
- All staff had access to e-learning modules on palliative and end of life care and the trust extranet also included supporting information for out of hour's teams. Opportunities for days with the team were in place for student nurses and medical students also spend time with the team on a regular basis. Doctors reported they were well supported by the HSPC team with reviews and advice on prescribing during the working day seven days a week.
- Communication skills had been initiated in January 2017 as part of consultant mandatory training; this was also provided to senior nursing staff.
- Ad hoc 1:1 or group sessions on the wards were also offered to staff about the Amber care bundle, individual plan of care or any individual palliative care learning needs.
- Training in end of life care was provided within the hospital and collaboratively with other providers in the area.
- Records showed that "symptom control" training was provided at least twice per year to both the Medical and Surgical trainee doctors during their rotations through the specialities. Presentations were also given during the "grand round" clinical meetings.
- The HSPC team were well qualified and attended relevant course to extend and update their skills and knowledge including advance communication training.
- Trust data showed 100%of the HSPC team had completed their annual appraisals during
- the year.
- There was no formal process for clinical supervision but staff felt they could access support from any member of the team.
- Team meetings were held monthly and provide updates on audits and opportunities for reflection and learning.

End of life care

- A robust palliative care link nurse programme was in place with training provided on subjects related to palliative and end of life care which could then be cascaded to other staff on the wards.
- Staff confirmed that they had received training regarding the implementation of the Amber care bundle and individualised end of life care plans.
- We were shown copies of "Palliative Matters" a quarterly newsletter circulated electronically through the communications department to all staff. The newsletter provided information for staff and included updates on topics such as the individual plan of care. The HSPCT team attend and contribute to the local economy Integrated Clinical Network meetings and education and training Meetings. There are frequently cross setting education events and documentation around end of life care is consistent across the Warrington geographical area regardless of care setting.
- As part of the inspection we requested information on the numbers of staff trained in the use of syringe drivers. The trust informed us that at present there was no formal process to provide the information on a trust wide basis. We were told and shown a self-declaration nursing staff completed each year regarding their compact to use identified clinical equipment such as syringe drivers but we were not assured how well the system was being monitored. The lack of clear information may affect the provider's availability to ensure that all staff are trained appropriately to provide appropriate pain relief through the use of syringe drivers.

Multidisciplinary working

- Patients received comprehensive support from a multidisciplinary team (MDT), which included specialist palliative care nurses and a consultant. The records we reviewed showed that patients regularly had input into their care from other health professionals, including the pain team.
- Although the trust did not employ dedicated end of life therapists the multidisciplinary team worked well together to coordinate and plan care for patients at the end of their lives. The team included occupational therapy, physiotherapy, chaplaincy support and members of the discharge planning team.
- The HSPC team worked closely with the pain team to ensure that people at end of life had appropriate pain management.
- The hospital held regular multidisciplinary team (MDT) meetings to review patients at both Warrington and Halton hospital as required.There was a weekly integrated MDT meeting attended by the HSPC team, allied health professionals, discharge planning team and chaplaincy. The palliative care consultant from the local hospice attended MDT meetings via a videoconferencing facility. New patients, patients whose location of care was changing, or who had complex needs, were discussed at this meeting. Outcomes and attendance at the MDT meetings were recorded electronically on the trust's patient record system.
- For patients already known to community specialist services in both Warrington and Halton, teams would routinely liaise with their professional counterparts. This was an informal arrangement, strengthened by the close working relationships between Warrington and Halton hospital, local community specialist palliative care teams and the local hospices. All of the partners were active members of the local Cheshire and Mersey Palliative Care Network.
- There was a weekly integrated MDT meeting with video conferencing across Warrington hospital, the local hospice and community services. Patients whose location of care was changing or who had complex needs were discussed at this meeting.
- There was also a weekly discussion with the palliative medicine consultant at another local hospice and patients transferring care settings were discussed at this meeting.
- Staff working in the trust emergency admission areas were encouraged to refer patients to the SPCT at the point of admission if requiring specialist input.
- There was work on-going within the community to create ceiling of care documents to be shared with the hospital teams if admission is necessary.
- The hospital team attended and contributed to the Halton and Warrington Integrated Clinical Network Meetings and Education and Training Meetings. We saw

evidence of frequent cross setting education events and documentation around end of life care to ensure consistency in approach across the Warrington geographical area regardless of care setting.

Seven-day services

- At our last inspection we found there was no access to specialist palliative care medical support out of hours. At this inspection we found this was still the case with no access to out of hour's specialist palliative care medical support. Senior managers told us that they had improved access to support and advice through the hospital intranet and the lack of specialist palliative medical support had been identified on the trust risk register.
- We reviewed the register and found no active plans to provide a full seven day consultant service to enhance the care and treatment of patients who are at the end of life. Senior clinical staff told us they had carried out a review of potential requests for out of hour's support which were found to be very low. They also continued to up - skill members of the hospital specialist palliative care team (HSPC) to provide further specialist advice at weekends. Staff felt they managed the situation with good will from the consultant to provide support for a few very complex urgent cases.
- Out-of-hours medical cover was provided to patients on the wards by junior and middle grade doctors as well as on-site and on-call consultant cover.
- The HSPC nurses worked on a rota basis seven days per week, in order to make sure that their support was available at weekends as well. The HSPC team provided a specialist on site service.
- Microbiology, imaging (e.g. x-rays), physiotherapy and pharmacy support was available on-call outside of normal working hours and at weekends.

Access to information

- As part of the inspection process, although data was provided it was acknowledged by senior managers that there had been a gap in data collection in the twelve month period prior to our inspection. The matron had inputted all the data retrospectively however the lack of timely access to live data may impact on the ability of the service in monitoring the quality and efficiency of service delivery.
- All staff had access to the information they needed to deliver effective care and treatment to patients in a timely manner including x-ray results.
- There was a clear process in place to communicate with community staff and ensure that records were available for patients on discharge. Copies of discharge letters were forwarded to relevant persons involved in the patient's care, and copies of the letter were held electronically on the trust's patient records system..
- Records confirmed that letters were sent to a patient's GP on discharge and if any changes in medication had been made to pain relief then this would be faxed through to the individuals' GP.
- Any care plans and DNACPR forms moved across with the patient to ensure that information was shared appropriately.
- The trust was working with its community partners and local hospices to develop an Electronic Palliative Care Co-ordinating System (EPACCS) records system to enable sharing of records to improve continuity of care and communication with people involved in the care of patients receiving end of life care.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Data showed 100% of the HSPC team had completed their Mental Capacity Act (MCA) training. However at December 2016, 67% of medical staff and 78% of nursing staff had completed their Mental Capacity Act (MCA) training. The lack of appropriate training meant that staff may not understand the implication of the act on patient care such as considering capacity, consent and deprivation of liberty. Staff we spoke with understood the legal requirements of the Mental Capacity Act 2005 and Deprivation of Liberties Safeguards (DoLS) in order to protect patients appropriately.
- We found staff were clear about how they sought informed verbal or written consent before providing care and treatment.
- If a patient was assessed as lacking the capacity to make specific decisions staff made recorded decisions

about care and treatment in the best interests of the patient. Patients' representatives and other healthcare professionals were consulted with in determining the best interest of the patient.

- There was a trust-wide safeguarding team that provided support and guidance for staff for mental capacity assessments, best interest meetings and DoLS applications.
- The trust had signed up to the NHS North of England North West Unified Do Not Attempt Cardio Pulmonary resuscitation form (DNACPR) policy. The policy covered all aspects of consent; including responsibilities for the consent process, mental capacity guidance and documentation for gaining consent. Medical staff we spoke with were able to describe the procedures for DNACPR and the decisions that were made by a senior clinician.
- Staff used the same DNACPR form as their community partners in order to improve communication between the patient, families and health professionals. The purpose of a DNACPR decision is to provide immediate guidance to those present (mostly healthcare professionals) on the best action to take (or not take) should the person suffer cardiac arrest.
- We reviewed 17 DNACPR forms and found they were mostly stored correctly and completed appropriately with the relevant signatures in place in line with the trust guidance. However we found that out of 17 records six had not recorded the completion of a mental capacity assessment. It was not possible to identify if the assessment had not been completed or not recorded. The lack of a clear mental capacity assessment meant that the service could not be clear how much the patient understood the care they were receiving and it may not have access to reasonable adjustments such as access to specialist support. Despite this when best interest decisions were recorded, we found them to be appropriately documented.
- The trust had commissioned an external audit of the use of the DNACPR policy as well as its own internal audit. Results showed there were a number of occasions, where documentation in relation to DNACPR forms has not been in line with Trust Policy. Engaging in difficult conversations with patients, family or carers is not always fully recorded within the case notes. Patient's wishes were not appropriately discussed and recorded, and as a result, they are not treated appropriately We reviewed the action plan which had been put in place to ensure the staff training and monitoring of the DNACPR policy was strengthened.to ensure that the DNACPR's are completed accurately with the medical rationale for not attempting resuscitation and discussions with patients and family being recorded appropriately.

Are end of life care services caring?

Good

At the previous inspection in January 2015 we rated caring as good. Following this inspection we have rated caring as good because:

- All the feedback we received was overwhelmingly positive showed a committed and passionate workforce relating to the provision of end of life care in the trust.
- The specialist palliative care team (HPCT) had worked to ensure that all ward staff recognised that it was everyone's responsibility to provide compassionate, high quality end of life care.
- We found several examples of staff on the wards and the mortuary consistently providing a service to patients at the end of their lives that went beyond what could reasonably be expected of them and they regarded that as their everyday job. This was recognised by the trust in presenting an award to the mortuary service for their work out of normal working hours with a number of bereaved families. Members of the trust had been invited to a funeral by a family for whom they had provided especially attentive care.
- The HSPCT spent time building a rapport with patients and their families. They were knowledgeable about patients' background, wishes, spiritual and cultural beliefs.
- Staff had raised funds for end of life patients to provide extra items to support patients and relatives at end of life on the wards. This showed a strong commitment to providing the best end of life care.

However:

End of life care

- Some themes from relative feedback related to wards staff being busy and not always being able to spend sufficient time with relatives to talk through their concerns.

Compassionate care

- We spoke to four patients and their relatives during the inspection and observed interactions between staff, patients and their loved ones. We also reviewed feedback to the trust in the form of thank you letters and cards as well as feedback from the relative survey. All the feedback we received was overwhelmingly positive and showed a committed and passionate workforce relating to the provision of end of life care in the trust. One person said "the doctor was very kind considerate and clear" another told us "the doctor was so gentle and kind. "
- We found numerous examples of staff providing caring, compassionate and individualised care. We found staff to be caring and understood the need for sensitive communication with patients who were approaching the end of life. . Documentation showed that staff were able to identify individual spiritual and religious needs, which were followed through both at end of life care and in the care of the deceased person.
- Patients and relatives told us conversations were held regularly where they were updated on their progress or condition.
- Staff were positive about the hospital specialist palliative care team (HSPC) team and felt supported by them to deliver compassionate end of life care on the wards. Patients were treated with respect, and dignity on the wards. We found staff understood the need for sensitive communication with patients who were approaching the end of life.
- We saw examples of privacy and dignity signs used on a side room where end of life care was being delivered in order to respect and protect the person's privacy. Staff knocked on the patients' doors before entering and introduced themselves to the patient and their relatives.
- We observed the HSPC team following up new patients referrals on the wards. The HSPC staff spent time with the patients and their families, discussing the patients' preferred place of care. A patients' family expressed an interest in the local hospice and this information was provided promptly by the HSPCT nurse with a full explanation of the differences between the hospital and the hospice.
- Ward staff demonstrated flexibility and kindness in meeting people's wishes, consistently going above and beyond to accommodate requests. Staff had arranged for a visit for members of a local football team to visit a patient on the ward. Other examples included: arranging several weddings, accommodated a married couple to spend their last hours together and enabled a pet dog to visit a patient after a full risk assessment.
- We were told and observed that when a patient was identified as end of life their relatives would receive free parking to support relatives at a difficult time.
- Staff attended the wards quickly when notified a patient had died and required moving to the mortuary. The manager of the service reported the care standard from everyone within the trust in relation to end of life care was excellent. If there were any issues they would be escalated and dealt with promptly.
- The mortuary team had won a trust award for excellence. One of the mortuary technicians had also been nominated for a trust award for excellence relating to the care and support given to a family that lost a child. the family invited the mortuary technician to the child's funeral, which the staff member felt was a "privilege".
- The mortuary had links with the butterfly suite on the labour ward and would facilitate the movement of babies from the mortuary to the butterfly suite for their families to spend time there.
- Mortuary staff reported deceased bodies were properly prepared on the wards with a high regard to dignity and respect and transported to the mortuary in a timely manner.
- Staff had raised funds for end of life patients to provide extra items to support patients and relatives at end of life on the wards. and had a strong commitment to providing the best end of life care. One example was the purchase of a discreet chiffon bag to carry jewellery belonging to recently deceased patients when returned to a family in a sensitive manner.

End of life care

- We visited the bereavement office as part of the inspection and the staff demonstrated a caring attitude to deceased patients and their relatives. Staff told us they were very aware of "what is valuable" to relatives such as a treasured photo which they took pride in keeping safe for relatives.

Understanding and involvement of patients and those close to them

- The end of life service had a clear process for seeking feedback from patients and families. There was a local Specialist Palliative Care Bereavement Questionnaire. Results were collected monthly and fed through to both business unit meetings and individual team meetings. The overwhelming majority of responses were positive about the care provided for patients at end of life. However some themes related to wards staff being busy and not always being able to spend sufficient time with relatives to talk through their concerns. Another theme was the number of different staff relatives had to meet which had an impact on communication and people having to "retell their story."
- Patients who were at end of life were identified by experienced clinicians. Referrals were made to the HSPC to support the care of the patient and their families. All staff we spoke with were positive about the support provided by the HSPC team. End of life patients were supported on all wards.
- The trust "Individual end of life plan of care" incorporated the principle of care that the needs of families and others identified important to the dying person are actively explored, respected and met as far as possible. This was clearly documented in the care plans we reviewed. Staff told us the new end of life care plan had helped them to start those conversations and ensured that detailed discussions were held with patients and families and that these conversations were recorded in a sensitive way.
- Hospital staff demonstrated a clear empathy for people who were at end of life. Side rooms were available for patients if they wished and relatives were encouraged and guided to help provide care for example, mouth care. We observed that nurses explained the reasons for care they provided.
- Staff spoke to patients who were not conscious and their loved ones in a kind and caring manner and explained what they were going to do and why, giving the family the opportunity to ask questions.
- Patients and relatives we spoke with reported they had been involved in making decisions about their care and their wishes had been taken into account. One person told us "I feel well informed and glad my relative is being so well cared for". Feedback from another relative stated "the plan was to move my relative but I was glad they stayed on the same ward with familiar faces."
- Patients and families were involved in the assessment and planning for their end of life care. Information with regard to support services, e.g. community specialist palliative care teams, hospice inpatient and day therapy units, local support groups, and the local information centre were offered to patients and reinforced with written information leaflets.
- The electronic discharge summary had been updated to allow information about the use of the "AMBER" care bundle in the hospital to be reflected in the summary so that healthcare professionals were aware of the discussions had with patients during the acute admission. There was work on-going within the community to create ceiling of care documents to be shared with the hospital teams if admission was necessary.
- We saw that on all wards there were end of life notice boards with literature available for relatives of those patients at the end of their life that helped to address fears and explain what was going to happen – for example, changes to breathing and what relatives could do whilst sitting with a relative.
- Staff told us they could provide leaflets in different languages or other formats, such as braille, if requested. However we did not see we did not see many examples of information leaflets for people whose first language was not English or for people who were visually impaired. This did not assure us people had access to information in a format they could understand.
- The trust had developed plans to involve families at an earlier stage for difficult conversations following the results of a DNACPR audit. We found that within the

DNACPR policy was a copy of information booklet for patients and carers explaining the process of obtaining a Do Not resuscitate order and the roles and responsibilities of staff and their duties within the policy.

- Following the death of a patient, families were offered advice, guidance and support through the process. The service provided a resource pack with guidance for bereaved relatives on procedures such as registering a death and arranging a funeral.
- The mortuary had flexible out of hours viewing times and could arrange for deceased patients to be released quickly if required.

Emotional support

- There was a functional multi-faith room which staff, patients or families could access for prayer and spiritual support.
- The palliative care team, the chaplaincy, clinical staff across the trust, the bereavement service and mortuary staff provided emotional support to patients and those close to them.
- We observed staff talking to patients and relatives in a comforting and reassuring way. Staff were supportive to patients and those close to them, and offered emotional support to provide comfort and reassurance. When relatives became tearful, staff were kind and offered support.
- Out of 12 bereavement questionnaire forms between September and October 2016 ten people reported they felt supported in dealing with their feelings surrounding the death of their relative and had been given the opportunity to talk with any doctors involved in their relatives care. All of the respondents reported they had been able to spend time with their loved one after they had died which they found very positive and supportive.
- Staff were supportive towards patients and those close to them, and offered emotional support to provide comfort and reassurance. Patients and relatives were signposted to counselling services throughout their journey.
- There was a single viewing room where relatives were able to spend time with their deceased relative.
- Chaplaincy support was available 24 hours a day through an on-call system. There was access to spiritual support for other faiths, which was coordinated through the chaplaincy. There were appropriate provisions of care for the deceased and their families that met their personal or religious wishes.
- There was a single viewing room where relatives were able to spend time with their deceased relative.
- Staff had access to psychological support through occupational health, managers told us and records showed that sessions had been held for particularly complex cases to offer staff the opportunity to talk through the case and receive peer support.

Are end of life care services responsive?

Good

At the previous inspection in January 2015 we rated responsive as good. Following this inspection we have maintained the overall rating because:

- Services were planned and delivered to meet the needs of local people. There were systems in place to support patients with particular needs.
- There were good examples of collaboration with local community providers to produce joint protocols for example joint prescribing guidelines and cross boundary documentation.
- The trust worked with other services that provided end of life care in the Warrington area to carry out a joint self-assessment identifying areas for development to promote excellence in end of life care.
- There was routine engagement with staff from the neighbouring provider, such as the local hospice and community trust to improve continuity of care.
- The trust had fully implemented an individual end of life care plan of care (IPOC) when patients were identified as approaching end of life. This was a stand-alone document which had been based on the principles and essential elements of excellent end of life care as outlined in the “One chance to get it right.”
- At our last inspection found that there was limited access to single rooms and dedicated relatives rooms on some of the wards where sensitive conversations could be conducted in private. At this inspection we

found the end of life service had carried out regular audits of side room availability and the latest results showed 80% of patients had access to a side room which was a significant improvement.

- The rapid discharge pathway was available to enable patients to be discharged from the acute hospital to home in the last hours/days of life. Rapid response for discharge to the preferred place of care was coordinated by the palliative care team. There were very close operational links with the HSPC team and the discharge planning co-ordinators who were employed by another local community trust.
- At a local service level we found very few complaints related to end of life care. Managers told us that they would be involved in any complaint relating to end of life care anywhere in the trust.

However:

- There was no rapid discharge home to die policy in place at the time of our inspection.
- There was limited access to dedicated relatives accommodation throughout the trust although some wards had provided a recliner for relatives to sleep in next to their relatives.

Service planning and delivery to meet the needs of local people

- Services were planned and delivered to meet the needs of local people. There were systems in place to support patients with particular needs.
- There were good examples of collaboration with local community providers to produce joint protocols for example joint prescribing guidelines and cross boundary documentation.
- The trust worked with other services that provided end of life care in the Warrington area to carry out a joint self-assessment identifying areas for development to promote excellence in end of life care.
- There was routine engagement with staff from the neighbouring provider, such as the local hospice and community trust to improve continuity of care.
- Bi monthly end of life steering group meetings were held with to drive service delivery across the trust and Warrington area.
- The trust was committed to working towards improved end of life care in the local region and was part of the Cheshire and Merseyside palliative and end of life network audit group. This group was made up of different health care professionals and included representatives from hospitals, the community and hospice settings to use audit projects to develop standards and guidelines to support specialist palliative care professionals.
- The HSPC service was widely embedded in all clinical areas across the trust and had been involved in planning and delivering end of life services. All staff we spoke with were very positive about the support and advice received from the hospital specialist palliative care team.

Meeting people's individual needs

- The trust had fully implemented an individual end of life care plan of care (IPOC) when patients were identified as approaching end of life. Care was based on meeting individual needs such as symptom relief, and care of those close to the patient. This was a stand-alone document which had been based on the principles and essential elements of excellent end of life care as outlined in the "One chance to get it right". This put patients and their family's needs at the centre of clinical care and practice. The decision to use the IPOC was made by senior members of the multidisciplinary teams involved in caring for the patient and the decision had been communicated with the patient (if appropriate) and the patient's family/carer.
- Once a patient was placed on an Individual plan of care (IPOC), their family could stay with them overnight and visit at any time. There were no separate accommodation for relatives staying at the hospital but they were offered chairs they could sleep in.
- Conversations with patients and families around supporting care with an IPOC were further supported with the provision of the leaflet 'what happens when someone dies'.
- At the initial assessment visit every patient was given information about their specialist palliative care key worker and information about the specialist palliative care team (including how to contact them).

End of life care

- The end of life service reviewed patients daily and their contact details were placed in the patient's records in order for staff to contact the team if a patient's condition deteriorated and they required advice from the HSPC team. At each handover the HSPC nurses checked the patient understanding of their condition and any significant issues that needed to be communicated. From observing the handover the team demonstrated they understood the needs and wishes of the patients and their loved ones. Staff we spoke with on the wards were also able to demonstrate they understood the individual needs of patients receiving end of life care on their wards.
- Documentation showed that staff were able to identify individual spiritual and religious needs, which were followed through both at end of life care and in the care of the deceased person.
- Translation services were available for people whose first language was not English. 24 hour access to face to face, telephone and written translation.
- Information was available on the trust intranet for staff to access linked to the learning disabilities community. This document provided advice to staff on a range of issues, including reasonable adjustments, carer involvement, communication, consent and advocacy for people with learning disability to ensure that individual needs are met.
- We saw examples of privacy and dignity signs used on a side room where end of life care was being delivered in order to respect and protect the person's privacy. Patients at the end of their lives were discreetly identified with a purple butterfly symbol on the door of their room or in the ward bay.
- Patients with dementia were identified using the Forget Me Not flower symbol on the electronic patient information system. This was used throughout the trust to highlight to the staff that this person required extra time to communicate and adjustments to care may be required. The wards also used a "this is me" booklet to support communication between patients and staff. The booklet was completed by a close relative or loved one expressing the likes, dislikes and history of the patient.
- Staff we spoke with and records confirmed the action taken if there were issues related to the care of the deceased for transportation to the mortuary. Staff were clear about escalating issues to their manager for action.
- There was a functional multi faith room which staff, patients or families could access for prayer and spiritual support with washing facilities to support people to meet their religious observance.
- The mortuary had a quiet garden area for time relatives to visit if they needed to leave the building. The facilities for visiting and viewing loved ones were quiet and welcoming and provided a space for families to sit with comfortable furniture, before moving into the viewing room, which was well decorated, calm and quiet. The mortuary had a quiet garden area for time relatives to visit if they needed to leave the building.
- Information leaflets about services were readily available in all the areas we visited. Staff told us they could provide leaflets in different languages or other formats, such as braille, if requested. There was access to support for patients with hearing impairment for sign language support, advice and advocacy.
- Details of procedures for care before and after death were documented in order to ensure that all the spiritual and physical care was carried out to take into account their cultural and religious beliefs. We found several examples when the mortuary service had taken steps to support families to meet these needs. For example dressing a deceased patient in an outfit in line with their cultural beliefs.
- Feedback from families also showed that conversations had taken place to take into account any spiritual needs and they had been offered the appropriate service such as the chaplaincy.
- Patients property was well managed we saw evidence of a checklist being completed to ensure all patient property returned to their relatives.

Access and flow

- The hospital had an electronic referral process to the palliative care team which ensured that there was timely

referral to the service when required. Staff explained how they would refer a patient to the palliative care team and systems were in place for urgent referrals via a bleep system.

- Patients attending the Emergency Department requiring skills within the Specialist Palliative Care Team were referred via the normal hospital referral method.
- Data provided by the trust showed the service met its locally set target of assessing 95% of urgent referrals with 24 hours and non-urgent assessments within 48hrs.
- As part of the assessment process for all referred patients, staff told us that the patients preferred place of care /death was ascertained. If the patient's condition deteriorated and patient/family had chosen an alternative place of care other than hospital, the discharge planning team were alerted to the wishes of the patient and any necessary paperwork was completed as a matter of urgency.
- The trust collected data in line with the national minimum data set (MDS) for palliative care. For the period1 April 2016 – 1 March 2017 data showed that 678 patients had been seen by the HSPC team of which 347 end of life patients died in hospital.
- The data identified that 67 % of patients died in their preferred place of death. Senior managers confirmed that it was not always possible to achieve the identified? particularly if clinically, this was not possible such as difficulties with care at home and the patient changing their identified PPC.
- Data provided by the trust showed between April 2015 and March 2016, 731 referrals were made to the specialist palliative care team of these referral 475 were cancer related and 256 were non-cancer related. This breakdown was similar to the previous reporting year. We did not have access to the full data for the period April 2016 to March 2017 but managers told us the new referrals remained on average 16 per week.
- There was access to spiritual support through the chaplaincy on-call if a patient needed an urgent visit.A chaplain attends the palliative care multi-disciplinary team meetings. The chaplaincy team worked closely with other religious faiths to ensure all patients religious wishes were adhered. The service was accessible 24 hours, seven days a week.
- The trust acknowledged there was no “Rapid Discharge Home to Die Policy” in place at the time of our inspection. However we found very clear processes in place to manage discharge. The service had a rapid discharge pathway for discharge to a preferred place of care.
- The rapid discharge pathway was available to enable patients to be discharged from the acute hospital to home in the last hours/days of life. Rapid response for discharge to the preferred place of care was coordinated by the palliative care team. There were very close operational links with the HSPC team and the discharge planning co-ordinators who were employed by another local community trust. During our inspection we observed close liaison with community nurses, nursing/ care homes, social workers and continuing health care to facilitate a safe and timely discharge home to die on an individual case by case. The HSPC team liaised with community specialist palliative care teams and additional services in the appropriate area.
- The hospital has an agreement with the local ambulance Service for a rapid transfer, which included the transport of those patients who are returning home to die or being transferred to an appropriate community bed. The response time aimed to meet these requests within a 2 hour window from initiation.
- The bereavement service was very responsive and did not close for lunch in order to accommodate bereaved families so that they didn’t have to wait at such a difficult time. It also provided support for trainee doctors who did not have experience in end of life processes and procedures.

Learning from complaints and concerns

- At a local service level we found very few complaints related to end of life care. Managers told us that they would be involved in any complaint relating to end of life care anywhere in the trust.
- We reviewed one complaint regarding a relative’s perception of the involvement of the HSPC team with their relatives’ care. The HSPC had taken steps to improve communication with wards and families to clarify the role of the team and the provision of an additional specialist service to the patient in addition not the overall care/treatment they continue to receive on the wards.

End of life care

- Patients and relatives we spoke with knew how to raise concerns or make a complaint. We found there was information on wards to inform people of the complaint process and staff were able to describe process if a patient or their family wanted to raise a concern or a complaint.

Are end of life care services well-led?

Good

At the previous inspection in January 2015 we rated well led as good. Following this inspection we have maintained the overall rating because:

- The trust had a clear mission and vision statement. This was to provide high quality, safe healthcare. All staff we spoke with were able to describe the vision and strategy.
- Since our last inspection the hospital specialists palliative care team (HSPCT) had reviewed the strategy for end of life care and had undertaken a self-assessment structured around the six national ambitions for palliative and end of life care.
- We reviewed the trust self-assessment and action plan for ensuring the implementation of the "Ambitions for Palliative and End of Life Care" to improve the provision of better care for patients at end of life. Actions included the development of more leaflets for relatives to improve communication and active engagement in regional audits to ensure the HSPCT is complying with best local and national best practice.
- The hospital specialist palliative care team (HSPCT) had an annual work programme in collaboration with other community partners. There was a clear purpose linked to an end of life work plan.
- At our last inspection we found the new consultant had been in post for three weeks and there were no firm plans for nurse leadership succession planning. At this inspection we found the service had undertaken a skill mix review and strengthened its nurse clinical leadership. The HSPC team showed clear leadership and their leaders fully understood the complexities of providing high quality end of life care across the trust.
- There was routine engagement and collaboration with staff from the neighbouring provider, such as the local hospice and regular multidisciplinary team meetings.
- Staff received communications in a variety of ways such as newsletters, emails and briefing documents and regular staff and clinical meetings.

However:

- There were a few risks on the corporate and divisional risk register relating to end of life care at the time of our inspection. All had action plans to mitigate risk and review dates however the risk related to out of hours medical cover had been on the corporate risk register since our previous inspection. We discussed this with the lead clinician who identified that the trust continued to review the impact of the lack of cover but had put steps in place to increase access to advice for staff on the trust intranet and staff also had access to specialist nursing advice seven days a week.
- We found that at the time of our inspection there was a vacancy for a non-executive director with responsibility for End of Life Care. This role was being covered on a temporary basis by another non-executive and the new post holder was due to take up post in April 2017.
- The trust wide electronic record system had enabled the team to use electronic Multi-Disciplinary team (MDT) documentation from the outset improving communication within the teams. We found the integrated MDT and information sharing across the Warrington area to be innovative and included the use of video links to the hospice.
- The team had fully embraced the new electronic patient record and was planning to move the "individual plan of care" into an electronic format which would then be part of the strategy to share information with community services.

Leadership of service

- The Chief Nurse represented end of life care at an executive level. However we found that at the time of our inspection there was a vacancy for a non-executive director with responsibility for End of Life Care. This role was being covered on a temporary basis by another non-executive and the new post holder was due to take up post in April 2017.

End of life care

- At our last inspection we found the new consultant had been in post for three weeks and there were no firm plans for nurse leadership succession planning. At this inspection we found the service had undertaken a skill mix review and strengthened its nurse clinical leadership. The HSPC team showed clear leadership and their leaders fully understood the complexities of providing high quality end of life care across the trust.
- Senior managers told us there had been some capacity issues until recently. The managers were now able to focus on driving forward the service vision. The managers told us the trust had also undertaken a clinical business unit restructuring in last twelve months with end of life care reporting under specialist medicine in the acute care division. Senior staff told us this new arrangement was working well and they felt supported and had a clear structure for promoting end of life care.

Vision and strategy for this service

- The trust had a clear mission and vision statement. This was to provide high quality, safe healthcare. All staff that we spoke with were able to describe the vision and strategy.
- Since our last inspection the hospital specialists palliative care team (HSPC) had reviewed the strategy for end of life care and had undertaken a self-assessment structured around the six national ambitions for palliative and end of life care.
- The hospital specialist palliative care team (HSPC) had an annual work programme in collaboration with other community partners. There was a clear purpose linked to an end of life work plan including; supporting delivery of high quality care and support to patients and their carers under the care of the trust as inpatients and outpatients, providing leadership through education, audit and service development and maintaining links within the locality, regionally and nationally to ensure up to date guidelines and evidence based practice was utilised.

Governance, risk management and quality measurement

- The HSPC team annual work programme was reviewed bimonthly at the trust end of life care steering group to drive through improvements in end of life care such as the introduction of new clinical guidance. Meeting minutes could be accessed by all staff on the trust intranet.
- The results from the 2015 end of life audit were in the majority positive. We reviewed the end of life care team 2016 annual clinical audit report and associated quality improvement action plan put in place to further improve results in the next round of audits. We were assured the end of life service had clear processes in place and was proactive in reviewing the quality of service delivery and service improvement.
- There were systems in place to audit the quality of end of life services. Quality and performance were monitored through divisional dashboards and included patient experience including complaints, workforce recruitment and attendance at essential training. These were reviewed at both team and clinical meetings.
- Although we observed there was a rapid discharge pathway in place to ensure patients returned home to their preferred place of care, there was no supporting policy to ensure that this process was followed.
- The trust had reconfigured its reporting structure in 2015. Palliative care medicine now reported through the specialist medicine clinical business unit in the acute care division through to the board. Senior managers said they welcomed the new structure, and we saw evidence of reporting to relevant trust quality committees. We were told and records showed a palliative care assurance and action plan was submitted through the clinical business unit (Specialist Medicine) Quality Governance meeting as part of the revised governance processes. However we found that communication and performance reporting structures still needed to be strengthened to fully engage the end of life service both within the clinical business unit and across the whole trust.
- Corporate and divisional risk registers were in place, managers knew the risks and mitigating actions within their departments. However we found there was no specific risk register for end of life care.
- There were a few risks on the corporate and divisional risk register relating to end of life care at the time of our inspection. All had action plans to mitigate risk and review dates however the risk related to out of hours

medical cover had been on the corporate risk register since our previous inspection. We discussed this with the lead clinician who identified that the trust continued to review the impact of the lack of cover but had put steps in place to increase access to advice for staff on the trust intranet and staff also had access to specialist nursing advice seven days a week. The lack of timely response to risk may impact on the provider's ability to effectively monitor and deliver services.

- We reviewed the trust self-assessment and action plan for ensuring the implementation of the "Ambitions for Palliative and End of Life Care" to improve the provision of better care for patients at end of life. Actions included the development of more leaflets for relatives to improve communication and active engagement in regional audits to ensure the HSPC team is complying with best local and national best practice.

Culture within the service

- The HSPC team was well embedded in the trust and worked closely across the local clinical network to improve the quality and visibility of end of life services in the Warrington and Halton areas. We found a culture of continuous improvement throughout the service.
- The HSPC team and ward staff were passionate about the provision of end of life care in the trust. We observed and staff told us there was close collaboration between the HSPC team and ward staff. We found staff keen to improve services so that patients received the best care possible.
- Ward staff were overwhelmingly positive about the HSPC team and felt that they were now more visible since the last inspection but had continued to be both responsive and supportive to staff managing the needs of patients requiring end of life care.
- The HSPC staff reported they were well supported by their managers and felt able to raise any concerns if they needed to.
- We observed staff interaction with patients and their relatives and found them to be open and honest in their communication.

Public engagement

- The service was continually looking for ways to improve the care for patients and worked closely with the bereavement service. The bereavement team gave out questionnaires to bereaved relatives. Response rates were around 10%. Feedback from the questionnaires was reported to the End of Life Steering group on a bimonthly basis.
- The trust had a disability equality group to discuss the interpretation and communication needs of hearing impaired.
- Information about how the public could provide feedback was displayed in the departmental areas and feedback mechanisms for the public to engage with the trust were also on the internet site.
- The trust was a member of the Cheshire and Merseyside strategic clinical network which had set up an audit focus group to invite the public to have discussions on standards and guidelines on a number of clinical and non-clinical topics such as hydration and bereavement.

Staff engagement

- The HSPC team and ward staff were passionate about the provision of end of life care in the trust. We observed and staff told us there was close collaboration between the HSPC team and ward staff. Staff were keen to improve service is so that patients received the best care possible.
- There was routine engagement and collaboration with staff from the neighbouring provider, such as the local hospice and regular multidisciplinary team meetings.
- Staff received communications in a variety of ways such as newsletters, emails and briefing documents and regular staff and clinical meetings.
- Staff supported each other well and there were regular opportunities to share ideas and meet together.
- Results of the 2016 NHS Staff Survey showed the trust scored better than the national average for acute trusts for support from immediate managers and recognition and value of staff by managers and the organisation. However the trust scored worse than the national average for acute trusts for staff recommendation of the organisation as a place to work or receive treatment.
- Physical and psychological support services were available to staff and staff were aware of how to access these services.

End of life care

- Results of the 2016 NHS Staff Survey showed the trust scored better than the national average for acute trusts for support from immediate managers and recognition and value of staff by managers and the organisation. However the trust scored worse than the national average for acute trusts for staff recommendation of the organisation as a place to work or receive treatment and the percentage of staff reporting good communication between senior management and staff.

Innovation, improvement and sustainability

- Since our last inspection the HSPC team had appointed a clinical educator for palliative care to improve the education of staff across the trust in the management of end of life care as well as the use of amber care bundles.
- A programme of four days simulation training had been devised and was being delivered as part of a patient centred care approach.
- The trust wide electronic record system had enabled the team to use electronic Multi-Disciplinary team (MDT) documentation from the outset improving communication within the teams. We found the integrated MDT and information sharing across the Warrington area to be innovative and included the use of video links to the hospice.
- The team had fully embraced the new electronic patient record and was planning to move the “individual plan of care” into an electronic format which would then be part of the strategy to share information with community services.
- The End of life team had signed up to the national quality transform programme for improving end of life care in hospitals.
- The HSPC team described their initiative to develop a "Grab Bag" containing relevant medications and syringe driver to enhance the quality of service delivery in a timely manner.

Outpatients and diagnostic imaging

Safe	Requires improvement
Effective	Not sufficient evidence to rate
Caring	Good
Responsive	Good
Well-led	Requires improvement
Overall	Requires improvement

Information about the service

Warrington hospital served a population of approximately 200,000. The hospital was centrally located and the largest hospital in the trust. The trust provided outpatient clinics for all specialties and diagnostic (scanning) services at both Warrington and Halton so people could access their initial appointments close to home wherever possible. They also provided some outpatient services in the local community.

Between October 2015 and September 2016 there were 337,557 outpatient appointments at Warrington. The main outpatient clinic was centrally located on the ground floor of the hospital and consisted of six clinical areas each with small waiting areas that hosted 22 consultation rooms in total.

Some specialities had dedicated outpatient areas including ophthalmology, breast screening, physiotherapy, diabetes, gynaecology and obstetrics clinics. There was a separate children's outpatient clinic on the hospital site. Warrington & Halton hospitals main outpatient clinics hosted over 300 clinics per week, which included 65 ophthalmology and 51 trauma and orthopaedic clinics.

Diagnostic Imaging sat within the Diagnostic CBU in Acute Care Services along with Pathology and Cardio-Respiratory services. The Trust provided imaging in various modalities for both inpatients and outpatients, magnetic resonance imaging (MRI), computerised tomography (CT), x-ray/ Primary Imaging, Nuclear Medicine, DEXA, Ultrasound and Interventional Radiology. The Trust also led on the outpatient breast screening service across the Warrington, Halton, St Helen's and Knowsley area.

During the inspection at Warrington, we spoke to 107 staff, 54 patients and inspected 30 sets of patients paper healthcare records and 10 further electronic records. At Warrington we visited x-ray, CT, MRI, Interventional, A&E x-ray, nuclear medicine (NM), ultrasound (US), General outpatients, Ophthalmology, Maxillo-facial, Physiotherapy, Hydrotherapy, Urology, ECG/Physiology, Phlebotomy, Cardiac, Rheumatology, ENT, Colorectal, Fracture, Breast screening, Orthoptics and Medical Records.

Outpatients and diagnostic imaging

Summary of findings

We rated this service as requires improvement because:

- The CT waiting area was not suitably designed to keep people safe. The area was too small and lacked equipment that would be required in an emergency. The area lacked also privacy and dignity.
- We found three breaches of Health and Safety Executive guidance note PM77 'Equipment used in connection with medical exposure' Reg 36 where there was no record that the equipment had been tested and signed back into use following fault repairs in the CT department.
- Audit evidence showed poor compliance with the WHO (World Health Organisation) surgical safety checklist in interventional radiology
- We found six separate breaches of Ionising Radiation Regulations 99, regulation 32, which refers to routine quality assurance of equipment used in diagnostic imaging.
- There was a lack of available rooms for counselling patients in the breast screening clinic.
- There had been significant changes in the leadership team which had the left the staff feeling disconnected and ensure of the strategy and future vision of the service.

However:

- We saw evidence of good safe practice within the Outpatient department.
- There was evidence of excellent hand hygiene compliance and monitoring with regular audits undertaken across six outpatient locations.
- Clinical audits were performed in line with best practice and results frequently shared at a regional and national level.
- We saw evidence that staff from several disciplines work together to assess, plan and deliver care and treatment to patients including clinicians and allied health professionals.
- Cross-site culture was good and staff reported good collaborative working, staff were happy to move between hospital teams.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Requires improvement

We rated safe as requires improvement because:

- Serious incidents had undergone investigation and analysis and assurance measures put in place to prevent reoccurrence where possible.
- The CT waiting area was not suitably designed to keep people safe. The area was too small and lacked equipment that would be required in an emergency. The area also lacked privacy and dignity.
- We found six separate breaches of Ionising Radiation Regulations 99, regulation 32, which refers to routine quality assurance of equipment used in diagnostic imaging.
- We found three breaches of Health and Safety Executive guidance note PM77 'Equipment used in connection with medical exposure' Reg 36 where there was no record that the equipment had been tested and signed back into use following fault repairs in the CT department.
- We found two stock medicines that were out of date in the cupboard in interventional radiology, and an empty oxygen cylinder with the resuscitation trolley in ultrasound.
- Staff were compliant in mandatory training in all areas apart from medicines management and health and safety level 3.
- Audit evidence showed poor compliance with the WHO (World Health Organisation) surgical safety checklist in interventional radiology.

However:

- Staff understood their responsibilities to raise concerns and near misses and nurses, allied health professionals (AHP) and administration staff were able to give us examples.
- There was evidence of excellent hand hygiene compliance and monitoring with regular audits undertaken across six outpatient locations.
- The records team had worked hard to make a significant improvement to the availability of records since the last inspection. Records audits now demonstrated an average of 99.7% of records being in clinic when required. Investigations were undertaken on every missing record.
- We inspected a sample of 22 patients healthcare records in diagnostic imaging areas. All patients had been assessed for possible contraindications with contrast media in CT and all safety screening questions had been answered in MRI. Appropriate pregnancy assessments had been made in appropriate notes.
- The diagnostics department had an appointed radiation protection supervisor in each imaging modality.

Incidents

- The hospital provided an electronic system for recording incidents and staff of all grades were able to identify its use and how to access the system. Staff knew how to report incidents and gave us examples of what should be reported.
- Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. Between January 2016 and December 2016, the trust reported no incidents, which were classified as Never Events in outpatients or diagnostic imaging.
- In accordance with the Serious Incident Framework 2015, the trust reported one serious incident in diagnostics and two in outpatients between January 2016 and December 2016.
- One incident involved a delay in treatment due to a failure of the electronic appointments system. This was escalated and became part of a nationwide issue. The hospital undertook thorough investigations to ensure no further patients had been affected. An action plan was created and completed, which included new operating procedures, progress audit and a failsafe plan.
- In diagnostics, we were informed of four level 1 incidents that had been investigated in 2016. Three incidences related to missed diagnoses occurring in

previous years and a further incident relating to a patient fall during an x-ray. Each incident had undergone investigation, analysis, and conclusions made.

- Staff understood their responsibilities to raise concerns and near misses and nurses, allied health professionals (AHP) and administration staff were able to tell us what sort of incident should be reported and what the reporting process was.
- In outpatients, learning from incidents was shared at monthly team meetings, in staff emails and on staff communication notice boards in staff room areas We observed records of sign in sheets kept by local managers, which confirmed staff had read this information.
- The radiology department had recorded 118 minor, level two, incidents on the trust reporting system between 1 January and 31 December 2016. We were told that the radiology governance lead reviewed every incident report that staff added to the system and ensured the grading was appropriate. The lead told us that incidents were often downgraded following the assessment flowchart.
- Incident investigation was undertaken for major and severe harm (level three or above). As radiology had only one incident recorded there were potential missed opportunities to learn from errors recorded as minor. Learning had taken place in some cases where themes had been identified. We were shown evidence of procedural changes made because of some incidents.
- We saw evidence, and discussed with staff, the actions taken following a patients unintended exposure to radiation. The incident had been reported correctly and analysis and actions had been taken as a result. The trust had five incidents of unintended exposure since 2009.
- We spoke to staff who understood that duty of candour meant being open and honest with patients and family when things go wrong. Radiology provided us with an example when an apology had been given to a patient, which was timely and appropriate.

Cleanliness, infection control and hygiene

- The trust had a policy for infection prevention and control, which staff could access on the trust intranet. We observed staff following 'bare below the elbow' guidance and wearing personal protective equipment, such as gloves and aprons, when delivering care.
- All areas we visited in the outpatients and diagnostics department were visually clean. Patient areas and store-rooms were mainly clutter free. The cleaning records in some areas of outpatients had not been completed for two days at the time of the inspection but evidence of completed cleaning schedules were submitted after the inspection.
- Monthly cleanliness audits had been undertaken in Ophthalmology. Results for six months from Sept 2016 to Feb 2017 demonstrated overall scores between 82 and 93%. Comments and actions were planned each month to address issues and improve facilities.
- Staff were trained in hand hygiene techniques and weekly audit checks were performed to assess staff and the environment. Results were displayed on infection control notice boards in the clinics. The results of audits for six outpatient locations over a six month period showed an average of 99.5% compliance, which was evidence of good standards of hygiene.
- During the inspection, we saw staff using protective equipment, and hand washing before and after delivering care in several locations including computerised tomography (CT) and Interventional radiography.
- We saw personal protective equipment available for staff, where required, such as gloves and aprons. Examination couches were covered with clean paper and hand sanitizer and wash lotion were available at all sinks.
- A member of nursing staff told us when a patient attended with a known infection risk, such as Methicillin-resistant Staphylococcus aureus (MRSA), then the patient was given the last appointment of the day and the examination room used was deep cleaned following the appointment.
- In the hydrotherapy pool, regular water tests were performed so ensure there was no risk of infection to patients. Results demonstrated good cleanliness standards were maintained.

Outpatients and diagnostic imaging

- The diagnostic imaging department had a lead staff member responsible for infection prevention. Staff had additional training and was available to monitor systems and processes and advise team members.
- The nuclear medicine department was situated off the main radiology corridor and patients had access to the waiting area and directly into the scanning room. Staff however, had to enter the staff only areas via the departments sluice room. At the time of the inspection, the sluice macerator was broken and had been taped closed with yellow and black hazard tape. There was a large yellow, wheeled bin that had waste bags on top and in front of it, as the bin was full. Staff were expected to use this route to enter and exit their department daily.

Environment and equipment

- The computerised tomography (CT) department was located on the ground floor of the hospital and provided imaging for adults and children as inpatients from wards and accident and emergency department as well as outpatients, including prisoners from a nearby prison. There were two CT scanners in the department, which had a shared control/reporting room. The waiting area was directly off the main hospital corridor and provided seating for twelve. There were two individual toilets directly off the waiting area. When an inpatient on a trolley was brought to the department, the only available space was placing the bed in the waiting area against the wall and directly blocking access to one of the toilets. The patient was then lying directly in front of the fixed seating, less than one metre away, and in sight of the main corridor. This provided no privacy or dignity for the inpatient and created a risk to anyone using the toilet. One member of staff told us of an occasion when four inpatients on trolleys were in the department at the same time. The main hospital corridor had been utilised at this time.
- If a patient were to require emergency care, there was no room for staff to provide life support in that area. Inpatients were brought to the department by porters and we were told by a radiology lead that there was an expectation that clerical staff, responsible for booking patients into the department, would monitor the patient's condition and alert clinical staff if required. There was no call bell in the waiting area. Resuscitation equipment was kept on a trolley in one of the scanning rooms, which was not accessible if a scan was in progress. Portable oxygen was stored in the waiting area.
- We raised the issue with the radiology governance lead who told us the area had been risk assessed and placed on the trust risk register in May 2014. The risk was graded as high, 16, as a privacy and dignity issue. Since then a set of curtains were attached to the ceiling, in order to give a bedded patient some privacy, however it was realised that the patient could no longer be seen and there was a greater risk if the patient deteriorated so the curtain was not used. The risk had been downgraded on 28 Feb 2017 to a 12, and justification for that change was not provided. There had been an incident where a level 3 patient, who had already had two cardiac arrests, was brought to CT and had to wait in the waiting area for his scan. The patient had a further arrest in the CT scanning room. The incident was categorised as minor (level 2). We escalated our concerns during the inspection and received assurance from the trust senior management that action would be taken.
- As part of The Ionising Radiations Regulations 1999, regulation 32, a suitable quality assurance programme must be in place to ensure safe exposure to ionising radiation. We found several breaches of this regulation during the inspection.
- The Philips Brilliance CT scanner had no monthly quality assurance or air calibration checks performed between 3 April 2016 and 2 Jul 2016, but was still in use during this time.
- Radiation warning light checks, usually performed weekly, had 17 weeks between June 2016 and March 2017 when tests were not recorded as being performed.
- X-ray rooms 1 and 3 had no monthly test performed for three months between Jan 2016 and March 2017.
- The three image intensifiers had not been tested since November 2016 at the time of the inspection. Three monthly tests had not been done.
- The AMX 4 had been tested in Jan and Feb 2017, but there was no record for 2016.

Outpatients and diagnostic imaging

- There were 3 months quality assurance entries missing for both SCBU and A&E room 2 x ray equipment records since July 2016.
- Each imaging speciality had equipment fault reporting books with details recorded including fault, log number and action taken, the information was also recorded on the trust computer system. We inspected the fault records in computerised tomography (CT) and found there were three faults recorded where an equipment handover form was not present. The faults had occurred 15 Jan 2016, 24 Jan 2016 and 12 Oct 2015. This contravenes the Health and Safety Executive guidance note PM77 'Equipment used in connection with medical exposure' Reg 36. 'The regulation states that 'No radiation equipment or ancillary equipment should be accepted back into service until a competent employer representative (such as a senior radiographer or medical physicist) has reviewed the service report/summary to confirm that the equipment has been left in a state fit for use, and that no alterations have been carried out which may significantly affect patient doses or radiation safety'.
- We found an overfull confidential waste bag in the outpatients clinic, which was a manual handling risk.
- In treatment room one, we saw an unsafe trip hazard from computer wires trailing from a desk to the socket halfway up the wall approximately 1.5 metres away. This was escalated during the inspection.
- Resuscitation equipment was available in outpatient and diagnostic areas and staff knew where their nearest trolley was located. Daily checks were made on equipment and expiry of medicines. A logbook accompanied each trolley and these were found to be up to date. Daily defibrillator tests were done and oxygen cylinders were checked, dated and stored appropriately. We found an empty oxygen cylinder in ultrasound, which was immediately escalated.
- We found the policies and procedures relating to Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER) were appropriate and up to date. Documentation was available to staff via the hospital internet and up to date paper copies were also seen. We reviewed 'local rules' in seven locations which were all within review dates and appropriate.
- The radiology department had a long-term contract with a supplier of imaging equipment to service, maintain and replace equipment on a rolling programme. This included equipment in plain film x-ray, CT, magnetic resonance imaging (MRI), Ultrasound and Interventional radiology (IR).
- Biennial independent radiation protection surveys had been performed and reports contained recommendations that had been actioned where appropriate.
- Staff wore radiation monitoring badges and records of staff results were stored on the computer to assess exposure over time and regularly reviewed by the local radiation protection supervisor (RPS).
- There were maintenance contracts in place for radiology equipment. Staff in nuclear medicine told us that equipment was repaired quickly and caused minimum disruption to service.
- All visible electrical equipment was checked for evidence of portable appliance testing and any service due dates. Where stickers were not evident, on larger equipment in radiology for instance, staff assured us with up to date service documentation that ensured the equipment safety.
- We found all quality assurance records were up to date for testing of protective lead aprons and followed radiation protection guidance.
- We saw good use of handling equipment when a patient was transferred to the scanning tables in radiology locations.
- Sharps bins that were in use in clinical areas were not over full, secured to walls and were safe.

Medicines

- During our inspection, we looked at the safe and secure handling of medicines in a variety of clinic and outpatient settings. Medicines were kept locked in secure cupboards and the keys were held by a senior member of staff. We were told stock had recently been reviewed to meet the department's needs.
- Medicines requiring storage between two and eight degrees centigrade were kept in locked fridges. Temperatures were monitored daily to ensure the temperature remained within the recommended range.

Outpatients and diagnostic imaging

- The nurse in charge in outpatients was responsible for carrying medicine keys and a log of prescriptions issued that day, including patient specific information. The log was locked away each evening and we were told the process had been introduced to ensure prescription security. The manager had no recollection of the loss of this information or any issues with information governance.
- Medicines were prescribed and used correctly in interventional radiology, though we found two medicines that were out of date in the stock cupboard. Contrast media in CT was in date and we observed appropriate administration and storage.
- The nuclear medicine department administered patients doses in accordance with The Medicines (Administration of Radioactive Substances) Regulations 1978. Radioactive medicines were prescribed, administered, stored and disposed of appropriately.
- Anaphylaxis kits were available in the CT and MRI areas of radiology. The kits were made up of injections required should a patient have a contrast induced reaction.
- There were patient information leaflets relating to specific medicines and treatments available in outpatient areas including the breast screening waiting room. The leaflets included what the medicine does, how to take and possible side effects.
- Staff in some outpatient areas used patient group directions (PGD's) to administer medicine without a doctor, such as eye drops or contrast media. The procedures and staff competencies were inspected and complied with standards.
- At the last inspection, there were significant issues with incomplete patient records, with up to 25% of records missing at appointment. A system was introduced that ensured healthcare records were available in time for outpatient clinics. Continuous audits were undertaken to record the response.
- At the time of the inspection the medical records department recorded 99.7% availability of records. We inspected the audit records for a period of 3 months and found only 11 cases of missing records. Nine were located in time for the appointment and two were duplicated. An escalation process was in place and missing notes were reported to divisional management for investigation. Themes were discussed at outpatient steering group meetings.
- There were significant national issues with the electronic records system that had caused difficulties with follow up appointment letters. Patients across the country had either received multiple letters for one appointment or not received a letter at all. The trust had identified the problem and had addressed any potential concerns. There had been 200 patients that did not attend their appointment that had been subsequently contacted and offered appointments. At the time of the inspection there were 33 patients that still needed a follow up appointment.
- After the introduction of a new IT system in November 2015, appointment outcomes were recorded electronically by Consultant and Specialist Nursing staff on a bespoke system. This removed the risk of paper outcome forms being 'lost' in the system, which may have affected patient safety and referral to treatment recording. The process was audited daily to ensure any appointment without an outcome was followed up with the clinician. A daily check of outcomes against the bespoke system and Lorenzo was also performed to ensure all patients were accounted for.
- These issues were recorded on the risk register and the risk of harm due to the missed appointments was assessed. An investigation identified where improvements could be made and these were actioned.
- Case notes were kept in secure trolleys behind the main reception desk, out of public view.We saw patient record sheets in preparation for the day's clinic, with no letters attached or included. Admission front sheets were observed in one patient's record, with several letters to and from the GP, all filed in date order. These clearly confirmed the patient pathway
- We inspected a sample of eight sets of paper healthcare records and the electronic records of ten further patients in the outpatients department. Paper records included diagnostic results, specialist nurse letters and communication forms. These were dated and signed where appropriate, or recorded as dictated but not

signed. There was evidence of patient allergies recorded and clinic attendances in chronological order. Some patients with chronic conditions had several volumes of notes, which were numbered according to the IT system.

Safeguarding

- The trust had a policy for safeguarding adults and children, which informed staff who the named professionals were that could be contacted for advice. We found staff were aware of the policy and gave us examples of appropriate practice.
- We saw safeguarding information boards in staffing areas that covered issues including safeguarding patients with learning difficulties and female genital mutilation.
- The trust provided training in safeguarding adults and children. Outpatient and diagnostic staff were trained up to level 2 for both adults and children. Overall, the target of 85% in all levels with all staff groups was met. An appointments officer gave us an example of when she raised a safeguarding alert and said she felt confident and supported throughout the process. A consultant told us of an issue he had raised that uncovered a case of domestic abuse.
- Key staff in outpatients were trained to level three including phlebotomists, nurse specialists and physiotherapists. The safeguarding lead in ultrasound was trained to level 3 in child protection. The lead told us they actively monitored patients that failed to attend a first trimester appointment. However, dental nurses who directly cared for children were only trained to level 2.
- In radiology, we saw prompts and checklists for staff to ensure correct identification was made prior to patients receiving any diagnostic imaging. We observed patients receiving a full identification check and correct dose information being recorded in notes.
- We saw evidence of WHO (World Health Organisation) surgical safety checklists (which aims to decrease errors and increase communication in any theatre setting) used in interventional radiography when non-surgical procedures were performed.
- However, a compliance audit undertaken in August 2016 examined 40 patients records and found only 19 had completed checklists. With 'not appropriate' and 'missing records', the audit determined that there was 70% compliance. The audit stated that 100% is expected but did not have any recommendations, learning or action plans for improvement.
- The maxillofacial department had developed a patient pack that was based on the WHO checklist for patients undergoing orthodontic surgery. It contained full information for a patient pathway through the department from consent, pre and post procedure checks and sedation. The department only treated patients over 16 years old.

Mandatory training

- Comprehensive corporate and local inductions were in place at the hospital for all new starters. Staff were expected to undergo mandatory training within three months of commencing work.
- Mandatory training was delivered face to face and via an e-learning package on the hospital intranet. Learning included essential subjects such as health and safety, infection control and moving and handling.
- The trust target for annual attendance was 85%. Staff in outpatients and diagnostic imaging were compliant with this target in most topics, apart from medicines management where compliance ranged from 100% to 13% across staff groups with a total compliance as 61%. Health and safety level 3 also had only 77% compliance.

Assessing and responding to patient risk

- There were controlled area illuminated warning signs at the entrance to each diagnostic imaging area that conformed to radiation regulations and yellow radiation danger warning signs, however some quality assurance checks had not been done. Signs were evident in the waiting room and camera rooms informing patients to let staff know if they may be pregnant.
- We saw records of training for staff who were radiation protection supervisors (RPS). There was an RPS available in each clinical area where patients and staff were exposed to radiation who could advise on safety.
- We saw interactions with a patient prior to undergoing MRI imaging. The patient was advised what to expect, and safety precautions were undertaken appropriately.
- We checked the healthcare records of twelve patients undergoing CT diagnostic examinations and ten

patients attending MRI. All patients had been assessed for possible contraindications with contrast media in CT and all safety screening questions had been answered in MRI. Appropriate pregnancy assessments had been made.

- A policy was in place that had been developed locally to assess patients for risk of contrast induced acute kidney injury (AKI). The policy was developed based on NICE guidance.
- We asked staff how they would manage a patient whose condition deteriorated during their appointment. A receptionist and two radiographers and four healthcare assistants we spoke to were able to explain the procedure. Staff were confident in their response and knew how to act appropriately and where the nearest resuscitation trolley was stored. This included calling for assistance and pulling an emergency alarm.
- There were sufficient emergency call bells in radiology. We tested emergency call bells in two areas and both alarms were in working order. Staff responded quickly to the alarm.
- The resuscitation trolley in the CT department was kept in one of the two scanning rooms. Due to the potential radiation risk, this room was not accessible when in use. This presented a risk of delay to treating a patient outside of the room. We escalated this issue to the radiology governance lead.
- The physiotherapy department had a referral policy in place and assessment criteria prior to a patient commencing pool therapy. The policy ensured patients were not at risk in the pool. If a patient did collapse during hydrotherapy treatment, a procedure for emergency evacuation of the pool gave clear instructions to staff how to manage the situation.

Nursing staffing

- The hospital had undertaken an outpatient staffing review and nurse staffing in outpatients was predominantly health care assistants (HCA). Of the 36 whole time equivalents, there were 24 HCA's. At the time of the inspection the nurse manager had only been in post for seven weeks.
- Nursing staff worked between Halton and Warrington sites, covering and responding to change in staffing needs on a day-to-day basis as necessary. Rotas were planned ahead according to clinic demands and staff worked flexibly to cover this.
- There were 6.2 whole time equivalent (wte) band 5 nurses that worked across the two hospital sites in outpatients. At the time of the inspection, 2.6wte were on long-term sickness. This was managed with two temporary posts.
- The trust submitted data for planned versus actual staffing figures for one week in January and demonstrated 75% compliance with planned staff levels. Where there was shortfalls, numbers were usually increased with staff of other grades. the trust provided information to show that at the time of inspection the rate was 89% compliance.
- The current turnover rate of outpatient staff was 7.7% qualified staff and 5.4% unqualified. This number was unusual and did not raise any concerns. The trust has provided further information confirming that the original information submitted was not correct and the true figure was 0% for qualified and 2.7% unqualified staff.
- In December 2016, the radiology department had vacancies for both radiologists and radiographers, particularly band 6 grade. There was a shortfall of 25% radiographers in breast screening clinic equivalent to 6.5 whole time equivalent staff and 17% vacancy rate in ultrasound. This reflected current national shortages. The trust were managing to maintain services by over recruitment to lower grades and initiatives such as apprenticeships were being explored. The principal radiographer
- The trust also reported vacancies in histopathology and outpatient appointments staff. Pathology had recruited over establishment figures in microbiology, histopathology and haematology in order to manage higher-grade vacancies.
- Radiology had a low sickness/absence rate of 3.3%, which was less than other divisions in the trust. Radiology turnover rate was 10%.

Medical staffing

Outpatients and diagnostic imaging

- The trust had 10% vacancy rate for consultant radiologists (1.78 whole time equivalent (wte)) the service was managed with over-establishment with lower training grade medical staff.
- A local agreement was in place with seven neighbouring trusts to ensure out of hours scans were reported quickly. Warrington radiologists participated in an on-call rota currently working 1:10 shifts. There was a consultant presence at the hospital till 8pm on weekday evenings and weekend mornings till 1pm. Consultants were available to be called in to help with reporting or provide advice/support to the radiology trainees as required. All on-call scans reported by the trainees were checked by the on call consultant for the relevant site as soon as practicable and definitely within 24 hours. Imaging other than CT scans remained the responsibility of the consultant radiologist on call at each site. At Warrington this was a 1:15 on call rota currently.
- Medical staff were present in speciality clinics as necessary. Some clinics were run by consultants from other trusts, or patients were referred to attend other hospitals when a speciality was not offered such as dermatology.

Major incident awareness and training

- The trust had a major incident and business continuity plan. Staff were trained as part of their induction training and details of emergency planning procedures were available on the trust intranet. Senior nursing staff had good knowledge of emergency planning procedures.
- We saw the procedure in accident and emergency x-ray department and staff gave us an example of the procedure in action during a chemical incident at a local factory. Staff were confident that the process kept people safe.
- We asked clinic staff what they knew about the hospital's major incident policy. We were assured that staff knew how to access the policy and what role they took in the plans. The general continuity plan was that staff would be utilised at the acute site.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

We inspected but did not rate the effective domain. However, we found:

- We saw many examples of evidenced based care and treatment in outpatient and radiology. Clinical audits were performed in line with best practice and results frequently shared at a regional and national level. Results were monitored to ensure consistency and improvement. Good patient outcomes were evident as a result of assessments and evidence based treatments.
- Patient outcomes were a priority in clinical areas and frequent audits undertaken to monitor success. Ophthalmology, physiotherapy and urology gave us examples of investigations and quality improvements made.
- We saw evidence in healthcare records of staff from several disciplines working together to assess, plan and deliver care and treatment to patients including clinicians and allied health professionals. The trust hosted several clinics for patients from neighbouring hospitals and in breast screening a weekly multi-disciplinary team meeting was held by teleconference.
- All staff we spoke with had a good understanding of when consent would be sought, and were able to explain guidance from the Mental Capacity Act. We saw evidence that the consent process for patients was monitored and there was good compliance with legislation.

However:

- Interventional radiology was only available Monday to Friday between 9 and 5. Urgent patients had to be transferred to another hospital outside these hours.

Evidence-based care and treatment

- There was a multitude of clinical audits performed in line with best practice and results frequently shared at a regional and national level. Results were monitored to ensure consistency and improvement. Good patient outcomes were evident as a result of assessments and evidence based treatments.

Outpatients and diagnostic imaging

- An example of best practice was orthodontic mini-screw treatment offered in the orthodontic clinic as an alternative to jaw surgery.
- In urology, procedures that referenced National Institute for Health and Care Excellence (NICE) guidance had been devised to maintain staff competency using bladder scanner equipment.
- The ophthalmology department participated in a several patient experience audits and used results to improve patient outcomes. This included an amblyopia review, stroke service review and school vision screening. Standards and outcomes were measured against national standards.
- The radiology governance lead was responsible for ensuring all pathways and policies were regularly reviewed and updated in line with NICE and Royal College of Radiographers guidance. The documents we inspected conformed with current guidance.
- We saw evidence of posters of research work undertaken displayed in radiology. The work had assessed techniques against NICE guidelines including 'Paediatric elbows', 'lumber spine GP referrals' and Pelvic radiography'. The audits ensured continued quality and best practice.
- The diagnostic reference levels were monitored and assessed during the annual radiation protection advisor inspection. Any discrepancies were highlighted, discussed and actioned.

Pain relief

- The fracture clinic had a supply of the medical gas Entonox to provide patients with pain relief, if required, during examination and treatment. The gas was stored appropriately in a locked store room.
- No other pain medication was available for patients in the clinic. We were told that patients would be advised to take oral pain relieving medication at home prior to an appointment if it was deemed necessary, for example during a dressing change.

Patient outcomes

- We saw evidence in team meeting minutes that patient quality issues including waiting times were discussed and actions were included, where possible.
- The radiology department was involved in a number of clinical audits including nasogastric tube audit, and studies in pelvis orientation and chest x-ray referral times.
- The physiotherapy department routinely measured appropriate patients emotional and physical condition with a 'Back to Action' questionnaire. The back rehabilitation programme was audited every three years and measured against NICE guidance.
- The specific learning difficulties department undertook annual monitoring of patient outcomes in order to assess their achievement of goals, including the impact of orthotic intervention on progress and measure patient and school satisfaction. Results were positive and actions and recommendations made.
- Urology staff had audited the outcomes of patients with indwelling catheters that had been discharged from the hospital service as part of a quality improvement project. As a result of patient responses, a patient catheter passport was developed that was a transferable document between hospital and community services and provided patients with essential information. The passport contained a self-help guide, health and hygiene advice along with space for personalised information such as products and equipment types. Staff awareness and training was undertaken. Staff planned to re-audit patients when the passport had been embedded.
- Although there was no formal audit process in place, we were told that the dressing clinic has positive patient outcomes. Wounds healed well and there were no reportable infection incidents.
- The audiology department had received an award from the National Tinnitus Society for recognition of their work with tinnitus patients. This was also published in the hospital magazine.
- Warrington and Halton hospital trust does not currently have any services registered with the Improving Quality in Physiological Services (IQIPS) accreditation scheme.

Competent staff

- All trust staff were expected to have a regular annual personal development review in line with trust policy. The trust target was 85% and data for January 2017. Compliance ranged between 81% and 100% across the

outpatient and diagnostic divisions. However the registered nurses was reported as 40%. The review was an opportunity for staff and their line manager to discuss learning needs and opportunities. The trust have confirmed that the average compliance is now 97%.

- A nurse practitioner told us that she had been supported by the trust to further her education. The trust had funded both her degree and an MSc in advanced practice.
- Radiographers were registered with the Health and Care Professions Council (HCPC) and as such maintained professional competency and audited their practice. Staff at Warrington had close ties to a University in Liverpool including lecturing and educational supervisors.
- Staff participated in continued professional development in the department with regular learning sessions. A presentation was given to diagnostic staff to provide staff with awareness of complaints, risks and safe practice techniques.
- The hospital supported radiographers to undergo advanced practice training and there were seven staff trained to report diagnostic imaging results at the time of the inspection.
- Ultrasound staff held regular discrepancy and monthly audit meetings in order to learn and improve. Case studies were presented and discussions took place to share information and knowledge.
- The hospital had clinical specialist nurses in a variety of specialities including urology, ophthalmology and cardiology. The trust also employed a number of nurse prescribers.
- A member of the orthotic team was trained to undertake intravitreal injections. This enhanced the role of the AHP staff and also positively contributed to the ophthalmology team to manage the increasing number of patients diagnosed with AMD.

Multidisciplinary working

- We saw evidence of collaboration between staff in other hospital trusts in many areas of outpatients and diagnostics specialities. Ultrasound, Breast screening, physiotherapy and urology. Nurse practitioners were able to refer patients directly to allied health professionals services and physiotherapists could request diagnostic tests.
- An MDT co-ordinator team worked within the breast screening service. The screening service provided at Warrington covered patients from four geographical boroughs and Skype meetings were co-ordinated on a weekly basis. Meetings included consultants from other trusts along with breast care nurses, pathologists and radiographers.
- Service level agreements were in place with other local hospitals to provide services to Warrington patients when the trust were unable to provide a local service. Interventional radiology had an agreement for a hospital in Chester to provide care out of normal working hours when emergency treatment was required.
- Physiotherapy staff participated in clinical meetings across many services and divisions in the trust, including trauma and orthopaedics, stroke and respiratory which demonstrated delivery of coordinated care.
- The consultant rheumatologist told us he was the clinical lead for the Halton Physiotherapy Initiative for patients from the Halton and Widnes areas.
- A patient told us how impressed they were with communication between doctors. “they know why you’re here, have read your notes and know your full story”.

Seven-day services

- Most of the outpatient clinics were open Monday to Friday 8am till 5pm. Waiting time initiatives meant that some services provided late night or Saturday morning services.
- The ophthalmology department provided a regular Saturday morning clinic in order to meet demand.
- Diagnostic services were available seven days a week. Outpatient appointments were available for non-urgent plain film imaging six days per week. MRI appointments were available 12 hours per day at the weekend. CT scanning was performed 24 hours a day for inpatients

and at weekend for consultant lists. Ultrasound provided a regular Saturday morning and afternoon service. There were community based radiology services that supported ambulatory care pathways.

- Interventional radiology appointments were available at Warrington hospital between normal working hours. Urgent referrals outside of those hours were managed with a service level agreement with a neighbouring trust.

Access to information

- All staff had access to the most current policies and procedures via the trust intranet, which could be accessed at any computer terminal.
- We saw evidence in health care records of information being shared between specialities caring for an individual. Referrals to other professionals had taken place and responses received.
- All diagnostic images were reported in time for the patient's next appointment, which meant there were no delays in treatment decisions. This was achieved by trust radiologists, reporting radiographers and a local agreement with nearby trusts in the area.
- The trust used the Lorenzo electronic records and appointments system. Paper records were still made available in clinic but all clinical staff could securely access patients details from any terminal.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- All staff we spoke with had a good understanding of when consent would be sought, and were able to explain guidance from the Mental Capacity Act. We saw copy of the Best Interest Decision Record and given an example when this might be used.
- The trust reported that between January 2014 and December 2016 Mental Capacity Act (MCA) training had been completed by 75% of staff within the outpatient department. Following the inspection the trust have confirmed that this has improved to 96%.
- A consent audit was undertaken in September 2016, to assess compliance against seven criteria when administering cyclopentolate eye drops to children. The audit was a retrospective case note study repeated from 2015. From 100 healthcare records examined, compliance was 100% which had improved from 99% the previous year.
- We saw evidence of a two-stage consent audit undertaken for laparoscopic cholecystectomy. Records between April and December 2016 were examined and demonstrated a compliance rate of 98%, which met responsibilities within legislation.

Are outpatient and diagnostic imaging services caring?

Good

We rated caring as good because:

- We observed many patients receiving considerate, respectful care. Staff gave clear information and kept patients informed throughout their appointment.
- Patient satisfaction surveys had received feedback from a large number of patients in several clinical areas. The results were positive, with an average score of 4.87 out of 5 and nearly all patients stating they would recommend the service.
- Patients told us that their privacy and dignity was respected whilst they were receiving care. Staff communicated in ways which supported and reassured patients when attending appointments, we observed staff interacting with children in a relaxed and calming manner.
- The orthoptics department arranged fancy dress 'patch' parties for children who needed to wear an eye patch and needed support with compliance. This encouraged children and parents to meet and share their experiences. The parties received excellent feedback from parents.

However:

- We observed a patient in fracture clinic, in a room without the curtain pulled together, who appeared to be in some pain during a leg examination

Compassionate care

Outpatients and diagnostic imaging

- We observed eight patients receiving considerate, respectful care in outpatients and radiology. Staff gave clear information and kept the patients informed throughout the procedure. At sensitive times in the process, staff closed blinds in the observation room to protect the patient's dignity.
- We observed healthcare assistants interacting with patients with a sensitive and supportive attitude. Consent was sought prior to observations being undertaken and staff gave patients clear information about their appointment.
- We observed two children interacting with staff in orthodontics. The children appeared happy to be in the department and addressed the receptionist by name. Dental nurses then spoke directly to the children on entering the consultation room.
- We spoke to two healthcare assistants who ensured that the clinic was prepared and ready for patients each morning by starting work half an hour before the start of their shift.
- We observed a patient in fracture clinic, in a room without the curtain pulled together, who appeared to be in some pain during a leg examination.

Understanding and involvement of patients and those close to them

- We saw evidence of an audit undertaken in eye clinic where the opinions of 50 patients were assessed in April 2016 and compared results from 2013. The questionnaire included 17 questions about making an appointment, clinic experience- waiting times, courteousness and seeing the doctor- length of time, information provided etc. Results were positive and improvements were seen from the earlier survey. Recommendations and actions were made that reflected the results.
- The orthoptics and ENT departments undertaken a number of surveys with different patient groups to assess satisfaction and enable improvement. This included primary care groups, special educational needs and parents of children with amblyopia. Results were positive and considerations for improvements made.
- We saw a patient satisfaction survey undertaken between 1 October and 31 December that included feedback from 1053 patients. Patient shad attended audiology, orthodontics, ophthalmology and physiotherapy at both Warrington and Halton hospitals. The results were positive with an average score of 4.87 out of 5. A total of 96.7% of patients were likely to recommend the service.
- The outpatient manager had reinstated the friends and family test in the outpatient clinic but there was insufficient data at the time of the inspection.
- We observed interactions between patients and staff in several outpatient clinics including audiology, cardiorespiratory and eye clinic. Staff communicated with patients well giving clear explanations of their condition and ensured patients understood results and treatment.
- A nurse in eye clinic demonstrated an application on her personal phone that she used to explain to relatives the affects of Aged-related Macular Degeneration (AMD). She told us it gave the family greater awareness of the condition and an understanding of how the condition develops over time, without treatment.
- Staff provided patients with written information to explain their condition. We saw a large range of information for specific conditions including where to seek additional support.

Emotional support

- During the inspection, we spoke with 54 patients that were attending the hospital for care. The responses were positive, apart from car parking issues, and many praised staff for their caring compassionate attitude. We were told ""I think its perfect what they do, treated as an individual, not a number, they tell you what's what" and "We are exceptionally impressed with the highly professional service over the last 20-25 years." "We are really well cared for here" "Nurses here can't do better, it is relaxed, caring and helpful".
- Two patients told us that the specialist nurse had provided her mobile phone number to contact directly if they had any worries.
- A maternity patient told us they had been offered counselling following a miscarriage yet several other outpatient services told us there was not access to counselling services when it would have been appropriate.

Outpatients and diagnostic imaging

- Orthotics staff with financial assistance from the League of Friends charity arranged 'patch parties' for children that were identified as needing additional support with their condition. Twice a year the team arranged a fancy dress party in the hospital but away from the clinical environment. Children were encouraged to meet and play games together and parents had the opportunity to share their experiences. The aim was to improve patch compliance and provide a link for the parents. Feedback was requested and excellent responses received.
- We saw a selection of Thank you cards sent to staff in the eye clinic. Comments on the cards included "Thank you for giving me my sight, I would award you 1million out of 100. The only drawback is I can now see my dust" and "Thank you to everyone in the unit who was kind enough to give me the gift of sight".

Are outpatient and diagnostic imaging services responsive?

Good

We rated responsive as good because:

- Patients received timely access to initial assessment, diagnostic and urgent treatment at Warrington and Halton hospitals. The referral to appointment times were better than the national average in most specialties. Rapid access clinics were available where required and we saw evidence of this during the inspection.
- Waiting times for referral and treatment for cancer were better than the England average against all three cancer targets.
- Diagnostic waiting times were excellent where less than 1% of patients waited more than 6 weeks for an appointment. Comparisons with other trusts demonstrated that Warrington and Halton had shorter than average waiting times for CT, MRI and ultrasound.
- The outpatient and diagnostic clinics were visibly clean and had sufficient seating areas to meet demand. There was adequate water fountains and food and hot drinks were available to purchase.
- There were systems in place to meet the needs of individuals such as those living with dementia, a learning or physical disability.
- Improvements had been made in recent months to the telephone answering service as a result of patient feedback. A month on month improvement had been seen.

However:

- There was a lack of available rooms for counselling patients in the breast screening clinic.

Service planning and delivery to meet the needs of local people

- The hospital provided a free shuttle bus between the two sites. This was for patient and visitor use only and made 11 journeys per day. The hospital website provided the journey timetable.
- Car parking was the biggest concern of outpatients attending clinic. Patients told us it took longer to find a space than their appointment. The pay machine was also confusing for patients who had to estimate the length of stay and pay accordingly, incurring a fine if insufficient payment was made.
- During the inspection, we encountered a large number of patients who could not find the outpatient or imaging department that they required. The hospital signage was difficult to follow and some were misleading. Patients also told us they had difficulty finding the correct department
- General outpatients was visibly clean and had good wheelchair access. There were six clinic areas that each had a smaller waiting area. We saw a variety of chairs, of different heights, in clinic to suit a patients individual needs. During busy periods there was sufficient seating to accommodate patients and their relatives. We saw evidence of completed cleaning checklists in the toilet facilities and the toilets were visibly clean and tidy. There was sufficient water fountains and drinks vending machines in waiting areas to meet patient's needs.
- The electronic system known as 'Micheckin' to be launched in outpatients in the coming months. Staff champions were trained to help assist patients during

launch. Patients will have the choice to use the system to avoid queues at the reception desks during busy periods. Micheckin will be provided via kiosks and a mobile phone application.

- Whiteboards were used to inform patients of any clinic delays. There was a wide range of patient health information leaflets on display in all outpatient areas.
- In the main waiting area for diagnostic imaging there was a large reception desk that maintained patients privacy. The area for waiting was small and seating was limited. There was no natural light and the décor was old and uninviting.
- Considerations had been made to accommodate larger patients and a range of bariatric equipment was seen during the inspection.
- Childrens' play areas differed in standards across the outpatient and diagnostic services areas. In ophthalmics, there was a large spacious segregated waiting area for children. The area was carpeted, with bright décor and a large number of toys to suit a variety of ages. However, other areas including ultrasound, CT and the radiology hub there was little or no provision for children visiting the department. The fracture clinic had a small area with toddler toys and a television screen with a cartoon movie playing. We saw evidence in orthodontics that toys were cleaned weekly.
- Public health information was seen in the orthodontics clinic waiting area with food sugar content, smoking cessation posters and patient information leaflets, some specifically for children's conditions. A range of dental equipment was for sale including toothpaste and interdental brushes.
- There were counselling rooms available that were used when patients were receiving bad news. The rooms were carpeted and had comfortable seating. The breast screening department needed additional rooms for delivering bad news as they held symptomatic clinics and could see 8 to 10 patients in one clinic session. The position of the room did not consider the patient having to leave via the usual patients waiting area. We saw evidence that options and costings were being considered to solve the issues.
- Nuclear medicine had a separate seating area for patients that had received a radioactive injection and needed to be segregated to maintain radiation protection of the general public.
- The orthotics department had measured the 'did not attend' rates for new patients both during and after a text reminder service was in use. They found that were was an 8% increase of patients failing to attend appointments without the text reminder. The department had submitted a business case to reinstate the text reminder service.
- The trust 'did not attend' rates were higher than the national average at 10%. The outpatient manager told us that this would be addressed when the electronic system was embedded and full assurance had been received regarding the appointment issues. Following the inspection the trust has confirmed that the outpatients appointments team is currently running a courtesy calling scheme for Paediatric and Chemical Pathology clinics. This initiative started in June 2017 and has seen a reduction of 5% in these areas. The Trust is currently out to Procurement for an appointment reminder service which will further reduce the DNA rate.
- The Cardio respiratory department offered open access appointments to patients with a referral from their GP. The specialist children's service was a pre booked clinic held weekly and used toys and games to make the spirometer testing a pleasant experience.
- Spoke with three patients with appointment letters that were unhappy with the wording and felt the information they received was unclear.

Access and flow

- Almost 337,000 appointments were made at Warrington Hospital between December 2015 and November 2016 according to Hospital Episode Statistics. The number of patients who did not attend was slightly higher than the national average. Management were considering how to address this.
- The trust provided rapid access clinics for chest pain, gynaecology, breast surgery and head and neck lumps. The ophthalmology department provided a rapid

intervention clinic to provide treatment within 36 hours for age-related macular degeneration (AMD). Patients could receive an appointment within 48hours in audiology.

- Appointments were generated electronically following a referral. Follow up appointments were made in clinic if required within six weeks, but more distant appointments were sent by post.
- The incomplete referral to treatment targets for England is that 92% of patients have an appointment within 18 weeks. Between December 2015 and November 2016, 94.2% of patients had received an appointment within 18 weeks, the trust performed better than the England average consistently across the 12 month period recording over 97% for November and December 2016. Targets were met by waiting time initiative clinics.
- The trust also performed better than the England average for 2016 for incomplete patient pathways in eleven specialities. Four specialities were just below the England average including trauma and orthopaedics, general surgery, geriatric medicine and urology.
- Waiting times for suspected and diagnosed cancer patients at Warrington were better than the national average. The two week, 31 and 62 day targets were all exceeded. In the most recent figures reported, 98.8% of patients waited less than 31 days from diagnosis to first definitive treatment.
- Diagnostic waiting times for the hospital were excellent. Less than 1% of patients waited six weeks or more for an appointment within the previous 12 months for all tests. A benchmarking exercise comparing Warrington against 75 other trusts demonstrated lower than average waiting times for outpatients in CT, MRI and ultrasound. An improvement in report turnaround times was also seen in most imaging modalities.
- Patients were kept informed if there were delays in the outpatient clinics. They were informed individually if the delay was up to 20 minutes and staff wrote on a whiteboard anything longer. Notes in the clinic list were made if patients had arrived early and left the department to visit the café. We were told that diabetic patients were offered light refreshments, if required.
- Procedures were in place for reception staff to manage patients that did not attend clinic appointments. A letter was sent electronically to the GP. If the patient was a rapid access or cancer fast track patient then the receptionist would telephone the patient to offer a new appointment.
- Physiotherapy told us that there had been difficulties with appointments not being filled due to the booking process for specialist services. Administration staff were triaging appointments and time was not utilised efficiently due to lack of knowledge of the service.
- The trust undertook a monthly audit regarding answering the telephone. Over a four month period October 2016 to January 2017 a marked improvement had been seen both in the number of calls answered and the length of time staff took to receive the call. From 64% of calls and an average time of 5 minutes in October to 90% and 1.5 minutes in January. This was as a response from patient feedback and regarded as important patient engagement.
- Work was in progress at the time of the inspection to monitor patient waiting times after arrival in clinic. Two months data had been collected but analysis and decisions had not been made for improvements.
- The trust submitted data regarding the number of cancelled clinics within 6 weeks of appointment, which averaged 29 and over six weeks, which averaged 201 but did not provide a time frame for this number. There were 260 clinics in operation each week at Warrington hospital. Reasons for cancellations included annual leave and consultant sickness, over six weeks some clinics had been cancelled for service redesign. We inspected the audit sheets for 3 months prior to the inspection to assess the number of cancelled patients. There were none, which demonstrated the teams resourcefulness and dedication.
- The trust provided the additional narrative as follows:

  This information was submitted as part of PIR (OPD 3) and indicated the time frame as per the template. (September – December 2016). The monthly numbers given before were taken from a PAS report that did not factor in multiple codes running as part of one clinics session, therefore these figures are slighly inaccurate. The figure for the overall number of clinics running per week also did not take this factor into consideration. Therefore the more accurate information is as follows: Across all OPD areas (Warrington & Halton) there are 470

clinics running per average week. This equates to approximately 1962 per calendar month. Clinic cancellation data for the period September to December 2016 has been reviewed and updated. The average number of clinics cancelled at less than 6 weeks notice was 171 per month (8.7%) and greater than 6 weeks notice was 293 per month (14.9%).

Meeting people's individual needs

- Patients attending outpatients for the first time were always given a longer appointment time in order to make assessments and to allow the patient to ask questions.
- We saw patient information leaflets readily available throughout the areas we visited. Information regarding specific conditions was available along with additional contacts and assistance information such as Alzheimer's Society advice. Trust leaflets gave details of how to access the information in other languages. In the radiology waiting area there was a range of information leaflets that explained procedures and help patients know what to expect.
- In the breast screening unit we saw books for children of mothers undergoing breast cancer treatment that addressed the sensitive, difficult issue in a positive manner. There were two titles aimed at young children and 8-15 year olds the patients could take and keep.
- The clinic had a dedicated room used for fitting prosthetics. The room had been designed to put the patient at ease and resembled a spa rather than a clinical environment. The room was decorated and had a lace window dressing. The examination couch had a duvet and cover to create a 'homely' environment. The room was scented with candles and had inspirational messages on the wall. We were told that patients were always complimentary about their appointment.
- Services had been planned to allow access to clinics for patients with individualised needs. Wheelchair access was good and there were additional load bearing beds that could accommodate larger patients. Larger scanning trolleys were available in x-ray if needed.
- We observed a phone call whilst in ophthalmology. A known patient that was experiencing pain was offered an appointment within two hours. In CT we observed an outpatient appointment being offered for the same afternoon.
- A patient in ophthalmology told us he had attended the clinic for a diagnostic test and been offered a consultant appointment the same day for the diagnosed condition. We also observed a patient being offered an urgent appointment within one hour following a telephone consultation.
- Translation services and interpreters were available to support patients whose first language was not English. Staff confirmed they knew how to access the online service and showed us a laminated card with 28 languages for a patient to select. Requirements could be noted on the patients electronic healthcare record then arrangements could be made prior to their next appointment.
- The trust had a website that provided patients with practical information about appointments at the hospital and additional information about their condition. However, outpatient waiting times displayed on the website that stated updates were every two months, had not been updated since March 2015. Following the inspection the trust have provided assurance that this page has now been updated and also allows patients the option to cancel appointments and request a call back to reschedule. This accommodates patients who are not able to contact the contact centre in hours.

Learning from complaints and concerns

- We saw information leaflets in several locations that offered guidance on how to make a complaint and who to contact if unhappy with the service. The hospital had a Patient Advice and Liaison Service (PALS) who were the main contact for the patient or relative who wished to complain.
- We saw evidence in team meetings that incidents and complaints were discussed with staff in order to learn from experiences and improve service delivery.
- Between January 2016 and December 2016, there were 176 complaints relating to outpatient services. The trust took an average of 117 days to investigate and close

complaints, which was in line with their complaints policy, which states complaints should be closed within six months. There were 72 complaints open at the time of submission. They were open for an average of 192 days, which is longer than the trust's timeframe.

Are outpatient and diagnostic imaging services well-led?

Requires improvement

We rated well-led as requires improvement because:

- There was a lack of communication between the staff and management. There had been significant change to the management structure and changes to the clinical business units but staff felt disconnected.
- At local level, the staff were conscientious and were proud of the care they provided. However, there was little knowledge of the strategy and future vision of the hospital.
- In radiology there was little evidence of learning from incidents. A presentation was seen but learning and attendance records were not audited.
- Radiology risks on the register had not been managed and a risk rated 16 (high) had not been actioned from 2013. The risk had recently been downgraded but with no evidence or justification provided.
- Some specialist radiographers told us they felt excluded from the larger team and specialisms did not mix or work collaboratively.
- Public engagement took place in some clinical areas but a friends and family test had only recently been introduced across the division.
- Engagement sessions had begun in outpatients but the outpatients department did not fit into any clinical business unit and therefore lacked a direction within the trust.
- Whilst we saw there had been significant improvement in completion of annual personal development review for nursing staff at the time of the inspection.

However:

- Following the appointment issues identified ,patient access teams have implemented robust systems and pathways to manage patient referrals and follow up, with a daily validation report against this information.
- Cross-site culture was good and staff reported good collaborative working, staff were happy to move between hospital teams.
- Junior doctors in the region had voted Warrington and Halton hospitals as the 'Best Training Centre' from 24 local trusts.
- The orthoptics team had produced a large amount of research and audit data to improve the services that they provide. The team delivered education to other trusts and delivered care and treatment to children in their school to minimise the stress of a hospital appointment.

Leadership of service

- The diagnostic business unit had recently employed an Allied Health Professionals (AHP) lead, who had not started employment during the inspection. The local management team were unsure what the role of this lead would be or how their management responsibilities would be affected.
- Many diagnostic staff told us they didn't know the clinical business manager, who had been in post almost 12 months, and felt there no connection to the clinical leads for each speciality. There were regular meetings between clinical leads and business managers but we were told that there were no all diagnostic staff meetings. Information was emailed to each clinical area lead to be shared with staff. The principal radiographer told us there was an open door policy within diagnostic imaging for staff with concerns.
- The outpatient's matron had been in post seven weeks at the time of inspection and staff reported the positive difference they had experienced.
- Many staff were positive that their leaders were visible and approachable. Staff told us 'Supportive line manager, recommend as a place to work.' We saw evidence of this in revalidation folders, where line managers had supported learning.

- Since the change in directives to CBU some consultants and their teamswere unsure of who the leaders were. They had not been told the management structure, had no introductions to their line manager and didn't know who to contact for annual leave.
- We spoke with the nurse manager who had been addressing the low appraisal rate since commencing her post, and had already completed her immediate staff appraisal as a roll out programme and had achieved 82% by 31 January 2017. Although this was still below the trust target of 85%.

Vision and strategy for this service

- The trust had a vision that was High Quality, Safe Healthcare which was displayed in outpatient areas and in the corridor outside outpatients. Some staff were able to tell us what that meant to them.
- There was a lack of communication between the staff and management. There had been significant change to the management structure and changes to the clinical business units but staff felt disconnected. this is despite the trust holding engagement meetings during February at which 83 staff attended. Further engagement was held in June attended by 99 staff.
- The trust had recently introduced a new organisational structure including the formation of 8 new clinical business units across two divisions. The intention was to improve the support and engagement with staff at a clinical level and a new AHP lead post had been created to be part of the leadership triumvirate. The diagnostics clinical business unit sat within the acute care services division. The outpatients services however, had not been attached to any particular division as the clinical services were categorised by speciality.
- At local level, the staff were conscientious and were proud of the care they provided. However, there was little knowledge of the strategy and future vision of the hospital. A doctor told us they did not know who their line manager was and where to go with human resource issues such as booking holidays.
- Some departmental managers were planning services with colleagues from the neighbouring trusts in preparation for the sustainability and transformation plans to be introduced. Plans were established and progress was being made towards its delivery.
- The hospital had a learning and disability strategy that gave staff direction for assisting patients while visiting the hospital as an outpatient. The policy had a flow chart to be displayed in clinics and included reasonable adjustments such as longer appointment times and find a quiet area for the patient to wait.

Governance, risk management and quality measurement

- In radiology, there was poor evidence of learning from specific incidents as incidents were downgraded to a category that did not require review. There was one incident reported as serious, however during the inspection we were made aware of four. As incidents were not reported as level 3 or higher there was no evidence of reviews, root cause analysis or changes and learning from themes.
- A presentation had been prepared to demonstrate errors that occur in radiology. We were told this was shared with staff as evidence of learning, however no records were provided of when the presentation was given, staff attendance figures or any evidence that learning was achieved.
- A consent audit in interventional radiology was provided as evidence of quality assurance, however the audit was undertaken in 2013 and sampled ten patients. This was not a recent or proportionate example.
- There were four radiology risks on the register that were graded 12 or over. Three risks were originally rated 16 and all had been downgraded in January or February 2017. Justification for the rating change was not clear on the register as no mitigating reasons were provided. There was a risk from 2013 relating to the age of MRI equipment and in 2014 the CT waiting area was added as a privacy and dignity issue and not as a patient safety issued as we escalated during the inspection.
- We were told by the radiology governance lead, that no formal analysis was performed on rejected images. The information, if collected, could be used as a quality improvement tool to reduce patients exposure, reduce time and improve efficiency.

- Radiologists and reporting radiographers did have a sub-standard image folder that was monitored and training delivered based on analysis of the reoccurring problems such as poor positioning. We saw evidence of this in a presentation.
- The principle radiographer was concerned about future staff recruitment. Her ties to the local university provided her insight into the low number of undergraduates and therefore lack of new radiographers in coming years.
- There was a trained radiation protection supervisor for each imaging modality and protection issues were on the agenda of each clinical leads meeting. The staff reported a good relationship with the local independent radiation protection advisors, who had responsibility for staff, environmental and documentation monitoring.
- Following the IT system appointment issues identified, patient access teams have implemented robust systems and pathways to manage patient referrals and follow up, with a daily validation report against this information. A data quality team was also in place to support this continuing area of development.

Culture within the service

- Cross-site culture was good and staff reported good collaborative working, staff were happy to move between hospital teams, though regular cross site workers complained of commuting and parking issues. Staff were concerned about the planned introduction of toll fees on the bridge between the two hospital sites.Staff are supported to attend meetings and progress.
- Reception staff told us they felt part of the wider outpatients team. They were included in the engagement process with the clinical manager and felt valued and encouraged to contribute.
- Some specialist radiographers told us they felt excluded from the larger team and specialisms did not mix or work collaboratively.
- Many staff said they were supported by their managers and felt involved in service developments. We heard consistent comments from staff about the culture of openness and working together at the hospital.
- Staff had access to a "Speak out safely" link on the trust intranet to raise any concern anonymously. Staff described how this would generate a contact email response from the clinical governance department, however, we did not speak with any staff who had used this facility.

Public engagement

- Local 'what matters to you?' questionnaire undertaken in diagnostic imaging but information had not been collated or plans made as a result at the time of the inspection.
- Staff at Warrington had adopted the 'Hello my name is…' Kate Granger campaign badges and notices to improve communication with patients and visitors. We saw staff wearing badges and introducing themselves to patients.
- The trust had arranged an open evening with local GP's, however the meeting was cancelled due to a poor response. Further engagement is planned later in the year.
- There were examples of friends and family test in some of the specialist clinic areas, such as eye clinic but patients views and experiences were not gathered as a whole. The new nurse manager had reintroduced the friends and family test but there was insufficient data at the time of inspection.

Staff engagement

- The outpatient manager had arranged a series of engagement sessions across the two trust sites and across all outpatient administrative and clinical staff, in order to familiarise herself with the team and to encourage staff collaboration. A poster had been produced because of these sessions, which included staff beliefs and opinions about their role. The manager explained that her goal was a common vision "pledge for patients" to be established. Staff were motivated at these sessions and have ideas to fund raise and provide more health information.
- The 'what matters to you?' questionnaire was also given to radiology staff. 175 staff participated but again the results were not ready to be actioned.

Outpatients and diagnostic imaging

- Dental staff spoke of the positive experience of cross cover working with Halton hospital teams. The managers shared practice and discussed issues that led to an enhanced service.
- Staff told us about the regular weekly communication from the chief executive via hospital email. Staff were positive and felt connected to the board as a result.
- A staff recognition award scheme was in place, where staff could be nominated for 'going the extra mile" awards. The trust had an employee of the month and team of the month award.

Innovation, improvement and sustainability

- The outpatients department had considered the impact on the service during the introduction of the self- service check. Additional staff had been trained in the process and plans were in place to have dedicated assistants available to help during the introduction.
- Urology staff had developed a urinary catheter passport that provided patients help and guidance along with provided individualised information regarding care and treatment.
- The radiology team had won first prize in a poster award at UKRC in 2015 and were optimistic regarding the 6 submissions made in 2017.
- Junior doctors in the region had voted Warrington and Halton hospitals as the 'Best Training Centre' from 24 local trusts.
- The orthoptics team had produced a large amount of research and audit data to improve the services that they provide. The team delivered education to other trusts and delivered care and treatment to children in their school to minimise the stress of a hospital appointment.

Outstanding practice and areas for improvement

Outstanding practice

- The trust had developed the Paediatric Acute Response Team to deliver care in a health and wellbeing centre in central Warrington. This allowed children and young people to access procedures such as wound checks and administration of intravenous antibiotics in a more convenient location. It also allowed nurse-led review of a range of conditions such as neonatal jaundice and respiratory conditions in a community setting that would have previously necessitated attendance at hospital.

Areas for improvement

Action the hospital MUST take to improve

MATERNITY AND GYNAECOLOGY ACTIONS

- The hospital must ensure midwifery, nursing and medical support staffing levels and skill mix are sufficient in order for staff to carry out all the tasks required for them to work within their code of practice and meet the needs of the patient.
- The hospital must review the safety of the induction bay environment to ensure patient safety is maintained at all times and that the premises are safe to use for the purpose intended.
- The hospital must ensure that that the risk register and action plans are comprehensive, robust and adequate to improve patient safety, risk management and quality of care.
- The hospital must ensure all necessary staff completes mandatory training, including appropriate levels of safeguarding training.
- The hospital must ensure that the assessment and mitigation of risk and the delivery of safe patient care is in the most appropriate place.
- The hospital must review the impact of outlier patients on the access and flow within the gynaecology wards.
- The hospital must review the impact of the triage system on access and flow and the appropriate assessment of patient safety.
- The hospital must ensure that all staff receives medical devices training and this is recorded appropriately.

CRITICAL CARE ACTIONS

- Critical care services must improve compliance with advanced life support training updates and ensure that there is an appropriately trained member of staff available on every shift.
- The management team must ensure that the formal escalation plan to support staff in managing occupancy levels in critical care is fully implemented.
- The management team must ensure that there are appropriate numbers of staff available to match the dependency of patients on all occasions.
- The management team must ensure that all risks are formally identified and mitigated in a timely way as part of the risk management process.

CHILDREN ACTIONS

- The service must ensure staffing levels are maintained in accordance with national professional standards.
- The service must ensure that there is one nurse on duty on the children's unit trained in Advanced Paediatric Life Support on each shift.

Action the hospital SHOULD take to improve

MATERNITY AND GYNAECOLOGY ACTIONS

- The hospital should ensure that the Early Pregnancy Assessment Unit (EPAU) is opened seven days a week.
- The hospital should ensure that ward managers are supernumerary in order to support staff and identify risks.

Outstanding practice and areas for improvement

- The hospital should improve the multidisciplinary attendance at local and divisional meetings.
- The hospital should consider the safe storage of patient's notes on the wards.
- The hospital should consider the dignity and privacy of patients within the clinical areas and maternity theatre.
- The hospital should ensure that all staff are aware of the five-year business plan, vision and strategy plan and mission statement.
- The hospital should continue to review the medical cover for the daily obstetric list to ensure patient safety and avoid unnecessary delays and cancelations.
- The hospital should continue to monitor the induction of labour rates.
- The hospital should ensure all equipment is checked daily in all areas.
- The hospital should ensure that patient identifiable information is not on display in public access areas.
- The hospital should ensure that staff are aware of their role and the roles of others, should a major incident occur.
- The hospital should ensure that all staff is aware of the Duty of Candour.
- The hospital should continue to review the transitional care facilities available for babies on the maternity wards to avoid unnecessary separation of the mother and baby. Changes in practice should be reviewed and audited to monitor the impact.
- The hospital should ensure that maternity patients and gynaecology patients are not seated next to each other the waiting areas.
- The hospital should review the signage to the gynaecology department.
- The hospital should ensure that staff in the clinical areas are aware of the special equipment available for overweight and obesity patients and that they are easily accessible when needed.
- The hospital should ensure that all midwifery staff perform postnatal routine standard procedures and tests to ensure they maintain their skills and work to their potential, within their RCM training and competency levels.

SURGERY ACTIONS

- The trust should take action to provide and maintain an assurance system that all equipment in theatres is clean and ready for use.
- The trust should take action to provide and maintain an assurance system that all resuscitation equipment and anaesthetic machines are checked in line with trust policy.
- The trust should take action to provide and maintain an assurance system that all stocks are within their expiration date.
- The trust should take action to improve staffing levels across wards and theatres.The trust should take action to improve the number of suitably qualified staff in advanced life support.
- The trust should take action to improve in regards to documenting capacity and best interests decisions in patient records.
- The trust should take action to improve the numbers of medical outliers on surgical wards.
- Although mandatory training performance had improved since the last inspection. The trust should take action to improve their mandatory and clinical skills training performance across all core modules.

CRITICAL CARE ACTIONS

- The management team should consider ways in which to make sure that staff understand their responsibilities to report near-miss incidents so that improvements can be made when needed. Additionally, they should consider ways in which to action and close all reported incidents in a timely manner.
- The management team should consider ways in which to make sure that all mortality reviews are undertaken thoroughly and in a timely manner.

Outstanding practice and areas for improvement

- Critical care services should make sure that all staff, including the management team have a thorough understanding of when the legal responsibility of the Duty of Candour should be applied and discharged.
- Critical care services should consider ways in which they can increase the number of pharmacists so that they comply with the guidelines for the provision of intensive care services 2016.
- The management team should consider ways in which to make sure that fridge checks are always completed on a daily basis, in line with the medicines management policy.
- Critical care services should consider finding ways in which to comply with guidance from the intercollegiate document (2014) when managing adolescents in the unit. This means identifying staff who would have access to level 3 safeguarding training for adults and children.
- The management team should consider ways in which to make sure that all records are completed fully for every patient. This includes but is not limited to documenting admission times to critical care, all patient examinations as well as when a ward round has been undertaken, particularly in the evening.
- The management team should consider ways in which to make sure all patients are reviewed fully twice a day, in line with ICS standards.
- The management team should consider providing major incident training to all staff so that they are fully aware of what to do in the event of an adverse incident.
- Critical care should consider providing training in light restraint for all staff members.
- The management team should make sure that all standard operating procedures that are available for staff are up to date.
- The management team should make sure a MUST score is calculated for all patients and that referrals to dietetic services are made when needed.
- The management team should consider ways in which to ensure that full two stage mental capacity tests are completed when required.
- The service should reduce the number of delayed discharges and breaches of the Department of Health mixed sex accommodation standard.

CHILDREN ACTIONS

- The trust should ensure cleaning checklists are consistently completed within all departments.
- Adult areas were children are seen should be child-friendly.
- The trust should ensure staff attend mandatory training as required for their role.
- The trust should ensure daily temperatures of medicine fridges are consistently recorded.
- Expired controlled drugs should be returned to pharmacy in a timely manner.
- The trust should ensure the temperature of the fridge on the neonatal unit used for the storage of breastmilk is consistently recorded in line with trust policy.
- The trust should ensure all equipment used to provide care or treatment to a service user is properly maintained.
- The trust should ensure supplementary emergency equipment is checked in line with trust policy.

A&E ACTIONS

Medicines should be reconciled in 24 hours as specified in the trust policy.

- The trust should ensure staff attend mandatory training as required for their role.
- Adult areas were children are seen should be child-friendly.
- Mandatory training and safeguarding training rates for medical staff .
- The urgent and emergency care department should consider making improvements to the room used to see patients with mental health problems, particularly to the doors so that they open outwards.
- Reasonable adjustments for appropriate patients including those with a learning disability.
- Improved appraisal rates for nurses and medical staff.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Nursing care Termination of pregnancies Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** All risks that the service currently faced had not been formally identified with appropriate controls implemented to control the level of risk posed. The level of risk that had been identified had not always been reduced in a timely way. Regulation 17 (1)(2)(a)(b)(c)

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Nursing care Termination of pregnancies Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **How the regulation was not being met:** Premises within maternity, gynaecology and radiology services were not suitable for the purpose and not appropriately located for which they are being used. Regulation 15(c)(f)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** Staff on the children's unit were not compliant with Advanced Paediatric Life Support training. Regulation 12 (2) (c)

This section is primarily information for the provider

Requirement notices

Termination of pregnancies Treatment of disease, disorder or injury	The assessment and mitigation of risk and was not sufficiently robust to ensure the delivery of safe patient care is in the most appropriate place. Regulation 12 (2)(a)(b) All staff did not receive medical devices training. This did not ensure all equipment is used in a safe way. Regulation 12 (2)(c) In the radiology department, safety and quality assurance checks were not completed and documented for all radiology equipment, in accordance with Ionising Radiations Regulations 1999. Records of daily checks of resuscitation equipment were not maintained consistently in radiology departments. In the radiology department we found that equipment was not safely maintained at all times and reported repairs were not completed in a timely way.Ultrasound machines in radiology had been deemed unsafe and these had not been replaced for eight months. Regulation 12 (2)(e) The CR reader was located outside the X ray room in the Cheshire and Merseyside Treatment Centre presenting a risk of radiation exposure. Quality Assurance checks in accordance with IRR99 regulations for radiology equipment were not up to date. Records of daily checks of resuscitation equipment were not maintained consistently in radiology departments. Ultrasound machines in radiology had been deemed unsafe and these had not been replaced for eight months.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures	Regulation 18 HSCA (RA) Regulations 2014 Staffing **How the regulation was not being met:** The neonatal unit did not have sufficient numbers of suitably qualified staff. There was no dedicated paediatric pharmacist.

This section is primarily information for the provider

Requirement notices

Termination of pregnancies

Treatment of disease, disorder or injury

Staffing levels and skill mix in maternity were not sufficient for staff to carry out all the tasks required for them to work within their code of practice and meet the needs of the patient.

Sufficient numbers of suitably qualified, competent and experienced persons must be deployed. This was because there were a low number of staff who were up to date with advanced life support training. This meant that the service could not always ensure that there was an appropriately trained person on every shift.

Regulation 18(1)