Care Quality Commission

Countess of Chester Hospital NHS Foundation Trust

The Countess of Chester Hospital

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

The Countess of Chester Hospital is part of The Countess of Chester Hospital NHS Foundation Trust which provides a full range of acute and a number of specialist services including an urgent and emergency care, general and specialist medicine, general and specialist vascular surgery and full consultant led obstetric and paediatric hospital service for women, children and babies.

The Countess of Chester Hospital is situated within the Countess of Chester health park in Cheshire, and provides services to a population of approximately 412,000 residents mainly in Chester and surrounding rural areas, Ellesmere Port, Neston and the Flintshire area.

Over 425,000 patients attend the Trust for treatment every year. The Countess of Chester Hospital has approximately 680 beds.

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

We visited the hospital on the 16, 17, 18, 19 February 2016. We also carried out an out-of-hours unannounced visit on 26 February 2016. During this inspection, the team inspected the following core services:

• Urgent and emergency services

• Medical care services (including older people's care)

• Surgery

• Critical care

• Maternity and gynaecology

• Children and young people

• End of life

• Outpatients and diagnostic services

Overall, we rated Countess of Chester hospital as 'requires improvement'. We have judged the service as 'good' for effective, caring and well led. We found that services were provided by compassionate, caring staff and patients were respected and treated with dignity. However, improvements were needed to ensure that services were safe and responsive to people's needs.

Our key findings were as follows:

Leadership and Management

- The hospital was led and managed by an accessible and visible executive team. This team were well known to staff, visited most wards and departments regularly, and responded to issues that staff raised, however some staff on surgical wards did not feel they were as engaged with board members.

- We saw that the board had taken some steps to improve communication within all staff using a variety of methods of communication including department visits, drop in sessions, newsletters and social media.

- There was clear leadership and communication in services at a local level, senior managers were visible, approachable, and staff were supported in the workplace. Staff achievements were recognised both informally and though staff recognition awards.

Summary of findings

- There was a positive culture throughout teams in the hospital and staff were committed to being part of the trusts vision and strategy going forward.

Access and Flow

- The trust had established policies and both internal and external escalation procedures in place to support access and flow across the trust which were co-ordinated though meetings held at various points though the day to assess and prioritise patient movements in the trust. This included a designated hospital team who were responsible for patient flow, and provided senior nurse presence and clinical leadership across the trust out of hours.

- Access and flow remained a challenge in the emergency department, The trust achieved the 95% four hour target on two occasions between November 2014 and October 2015,

- There were issues with access and flow across the medical and surgical wards with high bed occupancy rates and delayed discharges due to the complexity of patient's needs. Some medical patients were being nursed in non-speciality beds. Trust data showed In August 2015 data showed that there were 34 patients in total, which rose to 120 in September and further increased to 130 in October 2015. We observed that this data included those patients who were supported in escalation beds within urgent care.

- A number of extra beds had been opened to help support flow though the hospital at both Countess of Chester Hospital and Ellesmere Port Hospital, which were focused on intermediate care delivery.

- At the time of our inspection, there were approximately 100 patients who remained in hospital due to delays in transfers of care. These were due to a variety of reasons including packages of care and decisions about community living arrangements.

- The trust was working closely with other strategic leaders to plan system delivery, strategy and plans in order to support elective and emergency admissions, attendances and discharges to the hospital. As part of this, the trust had introduced a number of initiatives including a general practitioner admissions unit (GPAU) which opened at the end of the announced aspect of this inspection. During the unannounced inspection, we observed that the general practitioner admissions unit (GPAU) was having a positive impact on flow though the hospital and there had been a reduction in patients who were delayed in being transferred from the hospital.

- Medical services met the national 18-week referral to treatment time targets in all specialities from September 2014 to September 2015.

- The maternity service had closed six times during 2015 due to staff activity. This had been managed safely through the escalation policy, which involved working with other local maternity services and emergency ambulance services.

- In January 2016, the trust achieved the referral to treatment (RTT) targets, of 95%, in all areas and specialities with the exception of ear, nose and throat at 94%.

- All three cancer wait measures (patients seen within two weeks, 31 day wait and 62 day wait) were generally better than the England average from 2013/14 to 2015/16, although October and November 2015 were below the target of 85% for 62-day wait at 77% and 79.8% for the planned care division.

Cleanliness and Infection control

- Clinical areas at the point of care were visibly clean; however, we did identify some cleanliness issues in urgent and emergency services, outpatients and in non clinical areas specifically related to an area within maternity services.

- The trust had infection prevention and control policies in place, which were accessible to staff and staff were knowledgeable on preventing infection.

Summary of findings

- There was enough personal protective equipment available, which was accessible for staff and staff used this appropriately.

- Staff generally followed good practice guidance in relation to the control and prevention of infection in line with trust policies and procedures.

- Between April 2015 to December 2015, there were two cases of MRSA bacteraemia reported across the trust. Lessons from all cases were disseminated to staff for learning across directorates.

- The hospital undertook early screening for infections including MRSA during patient admissions and preoperative assessments. This meant that staff could identify and isolate patients early to help prevent the spread of infection.

Nurse Staffing

- The trust had established process in place to assess nurse staffing levels, which included using an evidence based tool. The trust was also in the early stages of using a workload management tool (NHPPD) from the recently published Lord Carter model hospital review. The hospital was also piloting an national activity monitoring tool, to gain robust data on required nurse staffing levels going forward.

- The trust undertook biannual nurse staffing establishment reviews as part of mandatory requirements. As part of this, key objectives were set though this work to support safer staffing. Data provided as part of this review in January 2016 identified that over-all the trust had maintained over 95% of staffing levels planned against actual levels for nine months, however there was the recognition that additional nurse recruitment was required.

- There were a number of initiatives in place to support recruitment, notably the trust had recently appointed 20 – 30 registered nurses from Spain.

- The trust had systems in place to review midwifery staffing levels using national guidance (National Institute of Clinical Excellence : Safe Midwifery staffing for Maternity units 2015 NG4) and were in the process of employing additional midwives following the most recent review in January 2016.

- However, nurse-staffing levels, although improved, remained a challenge across most areas. Staffing levels were maintained by staff regularly working extra shifts and with the use of bank or agency staff. Inductions were in place for new staff in order to mitigate the risk of using staff that were not familiar with the hospital.

Medical Staffing

- Medical treatment was delivered by skilled and committed medical staff.

- The information we reviewed showed that medical staffing was generally sufficient at the time of the inspection.

- Data from January 2016 showed minimal use of locum cover.

- Trust data at the time of inspection showed a turnover rate of 17.7% and a sickness rate of 0.41% for medical staff.

- A shortage of a paediatric consultant was recorded on the divisional risk register on 21/10/15 however; approval had been obtained to increase medical staffing in this area.

- The number of palliative care consultants was below the recommended staffing levels outlined by the Association for Palliative Medicine of Great Britain and Ireland, and the National Council for Palliative Care guidance, which states there should be a minimum of one WTE consultant per 250 beds.

- The trusts medical staffing information confirmed 60 hours consultant cover for the delivery suite. This meant the service met the recommendation in the safer childbirth best practice guidelines.

- Interventional radiologists worked on a rota system. There were seven consultants covering 24 hours per day, seven days a week. The trust had recently recruited three interventional radiologists to manage the increasing workload.

Summary of findings

Mortality Rates

- Mortality and morbidity reviews were held in accordance with trust policies and were underpinned by policies and procedures. All cases were reviewed and appropriate changes made to help to promote the safety of patients. Key learning Information was cascaded to staff appropriately.

- The Summary Hospital-level Mortality Indicator (SHMI) is a set of data indicators, which is used to measure mortality outcomes at trust level across the NHS in England using a standard and transparent methodology. The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die based on average England figures, given the characteristics of the patients treated at the hospital. Between August 2014 and July 2015 the trust score was 103, which was slightly higher than the national average.

- Notably the hospital had achieved a 'A' rating for the Senital Stroke National Audit Programme (SSNAP) in 2014, which was a significant improvement from an "E" rating in 2013. The stroke service had been recognised regionally for using innovation to improve outcomes for patients.

Nutrition and Hydration

- Patients had access to food and drink whilst in emergency assessment unit (EAU) and staff offered refreshments throughout the department.
- We found that there were policies and procedures in place to support patients nutritional and hydration needs. Patients nutritional needs were risk assessed and results were acted upon appropriately.
- Most patients were supported with hydration; however, we observed that within surgical wards, there was no clear system in place to identify patient in need of assistance with eating and drinking. We found that most patients received assistance with eating and drinking as needed.
- Patients we spoke with said they were happy with the standard and choice of food available. The menus were comprehensive and there was a wide variety for patients to choose from.
- Staff and patients had access to specialist nutritional advice from the dietician team who responded promptly to patient referrals.
- There was an infant feeding team and 'Bosom buddy' volunteers to provide breast-feeding support. Mothers with babies on the neonatal unit were encouraged and supported to express milk for their babies.
- Women on the maternity and gynaecology units were provided with snacks, meals and drinks while on the unit, fluid balance charts were completed so that oral intake could be monitored when required and when intravenous fluids were administered.
- The trust were rolling out care and comfort worker roles to work across the wards to assist patients with nutrition and hydration.

We saw several areas of outstanding practice including:

- The sentinel stroke national audit programme (SSNAP) latest audit results rated the trust overall as a grade 'B' which was an improvement from the previous audit results when the trust was rated as a grade 'E'.
- The trust were rolling out care and comfort worker roles to work across the wards to assist patients with nutrition and hydration.
- We observed a theatre morning briefing which included all staff within the theatre areas. This briefing ensured that all staff were aware of theatre wide issues and safety concerns and also ensured that staff felt they were part of the wider theatre team.

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

Importantly, the trust must:

Summary of findings

- Ensure that adequate numbers of suitably qualified staff are deployed to all areas within the surgical services to ensure safe patient care.
- Ensure that patients placed in areas outside their speciality meet the trusts criteria and ensure that there is suitably qualified staff to meet their needs.
- Ensure that patients nutritional and hydration needs are met at all times.
- Ensure that all staff are able to understand and apply the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.
- Ensure that there are sufficient staff trained in adult and children's safeguarding procedures in the accident and emergency department.
- Ensure there are sufficient numbers of suitably qualified and skilled staff on medical wards.
- Ensure that all medications are stored in a secure environment at all times.
- Ensure staffing levels are maintained in accordance with national professional standards on the neonatal unit and paediatric ward.
- Ensure that there is one nurse on duty on the children's ward trained in Advanced Paediatric Life Support on each shift.
- Improve the waiting times for reporting of radiology investigations.

In addition the trust should:

In urgent and emergency care services :

- The trust should review medical record storage to ensure that records are accessible for staff easily, but mitigate the risks of the public being able to access records.

- The trust should ensure all premises and equipment used by the service provider are clean.

- The trust should review processes to improve access and flow through the accident and emergency department.

- The trust should review processes of managing patients own medications in accident and emergency areas.

In medical care services :

- The trust should ensure the electronic paper records system is robust and staff are sufficiently trained and competent in using and understanding the system.

- The trust should ensure all patients' records are secure.

- The trust should ensure at all patients and staff across the trust have access to dementia services.

- The trust should ensure that all staff receive mandatory training including mental capacity act training.

- The trust should consider that basic monitoring equipment (blood pressure machine) is available in the discharge lounge.

In surgery :

- The trust should ensure that all staff receive the adequate level of safeguarding training.
- The trust should ensure that all staff are treated with dignity and respect during their course of employment.
- The trust should ensure that staff are able and feel comfortable to raise concerns.
- Staffing levels on some wards were below 95% of the planned target with levels less 90% on some occasions. Staff worked extra shifts and agency staff were used on a regular basis to ensure patient safety. At night the staff skill mix on the wards was not always sufficient to meet the needs of the patients as staff with specialised competencies for their area of work would be moved to support ward areas that required additional staff.

In critical care:

Summary of findings

- Ensure that all critical care staff are aware of Duty of Candour regulations and their responsibilities within this.

- Ensure that there are robust procedures in place to monitor impact and reduce the numbers of patients that are delayed in being discharged from the critical care unit.

- Ensure that there are robust procedures in place to monitor impact and reduce delays of patients waiting to be admitted to the critical care unit.

- Consider supporting critical care patients who have been discharged from hospital to identify any psychological support that may be needed.

- Ensure that the critical care unit achieves 50% of nursing staff have a specialist critical care qualification.

In maternity and gynaecology :

- The trust should ensure that all areas, all fridges and equipment are clean and checked as required.
- The trust should ensure robust systems are in place to evaluate and improve their practice in respect of incidents and all investigations relating to the safety of the service.
- The service should review procedures for evacuation from the birth pool and consider regular drills including practising removing women from the pool.
- Undertake robust risk assessment for the women and children's building so that the risks associated with baby safety are maximised.
- The provider should provide staff with opportunity to and need for staff to receive yearly individual appraisals.
- The provider should consider producing regular updates specifically about the stages maternity and gynaecology audits have reached.
- The provider should consider ways of supporting women to feel confident in choosing a birth plan which does not require intervention unless necessary.

Children and young people's services:

- The trust should take steps to ensure that resuscitation equipment is checked in line with trust policy.
- The trust should ensure that the door to the kitchen on the children's ward is locked and access restricted as appropriate.
- Consideration should be given in relation to safe storage of records on the children's ward. The notes trolley and storage cupboard should be kept locked to ensure safe storage.
- The trust should ensure controlled medicines are checked daily in line with trust policy.
- Consideration should be given to the introduction of a routine nutritional assessment tool for all patients on the children's ward.
- The trust should ensure staff attend mandatory and safeguarding training as required for their role.
- Consideration should be given for the development of a winter management plan.

End of Life:

- Ensure the roll out of the Care and Communication documentation across the trust.

- Ensure all staff have appropriate End of Life training and support.

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

- Ensure all staff are aware of the vision and strategy for end of life services.

In outpatients and diagnostic imaging services:

- The trust should improve the waiting times for reporting of radiology investigations.

- The trust should ensure staff are assured that equipment has been maintained safely.

Summary of findings

- The trust should consider the layout of the waiting area to provide privacy for patients when confirming confidential details.

- The trust should consider improving the environment for children in the outpatients department as it is not child-friendly.

- The trust should ensure that all resuscitation equipment is checked and positioned appropriately in order that it is available in an emergency.

- The trust should ensure all equipment and clinical areas are free from dust.

- The trust should ensure that all guidelines are clear and followed using national guidance for best practice.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	**Good** 🟢	We rated emergency and urgent services as good because:

We rated emergency and urgent services as good because:

- Staff were committed and proud of the service they provided.
- There were staff vacancies and bank and agency staff were successfully used to fill gaps.
- Medical cover was sufficient and staff worked well together.
- Staff treated patients and their relatives with respect and dignity and communicated with them well.
- Patients were involved in care planning and felt informed.
- Incidents were reported via an electronic system and staff could access the system.
- Staff reported receiving feedback and learning from incidents.
- Risk assessments were completed and staff implemented measures to reduce risks.
- Equipment was available and serviced.
- Medicines were stored safely.
- Risk registers were in place.
- Staff were aware of the trusts values and vision.
- Staff felt well supported by the multi-disciplinary team and worked collaboratively to ensure patients were cared for.

However,

- Access and flow was a challenge due to bed capacity, and some patients were in the emergency department for long periods.
- Four hour targets were not being met, however patients were cared for and their needs met.
- Clinical areas at the point of care were visibly clean, however, we observed some none clinical storage areas that were dusty.
- We observed a storeroom with a ladder to an unlocked hatch to the roof space near the resuscitation room, action was taken during the inspection.

Summary of findings

- Two storerooms were found to have doors propped open; the door to the dirty utility was also propped open and the lock was sealed with tape to ensure the door did not lock.
- There were three tubs of chlorine tablets on the shelf in the dirty utility and access to cleaning materials.

Medical care (including older people's care)	**Good** ●	We rated medical care as good because:

- Incidents and complaints were reported via an electronic system and staff could access the system.
- Most staff reported receiving feedback and learning from incidents and complaints.
- Risk registers were in place; however, action plans with timelines were not documented, however risks identified in this division were reflected in trust wide initiatives in place to mitigate risks.
- Wards were visibly clean, staff followed good hygiene practices.
- There were good systems for handling and disposing of medicines.
- Equipment was available and serviced as required.
- Staffing across medical services was on the risk register and actions had been taken including recruitment overseas and regular monitoring of staffing levels during the day to help mitigate the risk. The trust biannual review stated that overall the trust had maintained over 95% of the planned staffing levels.
- The trust had identified this as an area for improvement and a pilot of a new roster was commencing in April 2016. The trust were also undertaking a number of initiatives relating to measuring patient acuity to help plan staffing.
- Patients risk assessments were completed and staff implemented measures to reduce risks.
- Staff were aware of the trusts values and vision. Staff enjoyed working at the hospital, felt well supported by their managers and worked collaboratively together to ensure patient were cared for.

Summary of findings

- Staff treated patients and their relatives with respect and dignity and communicated with them effectively. Patients were happy with their care, felt informed, and were involved in care planning.

However,

- Data provided showed there were occasions when the nurse staffing levels were less than 90 %.
- There were issues with access and flow across the medical wards with high bed occupancy rates and delayed discharges due to the complexity of patient's needs. Some patients were being nursed in non-speciality beds and on occasions in mixed sex wards, although this was based on clinical need.
- There was a risk that personal information was accessible to members of the public as patient's records were not always stored securely.
- Monitoring documentation for input and output, bowel charts and cannulation checks were not always consistently completed.
- On one ward, a large quantity of medication was found in an accessible unlocked cupboard, which was a risk to patients and members of the public.
- Compliance with mandatory training for the majority of staff was below trust target. The trust target was 95%.

Surgery

Good

We rated surgery as good because:

- We found that staff were aware of how to report incidents and we saw evidence that the service undertook robust and appropriate incident investigations.
- The uptake levels of mandatory training were high for both nursing and medical staff.
- Staff were fully aware of how to raise and manage safeguarding issues appropriately.
- Staff managed medicines well and nurse staffing levels in the theatre areas were sufficient.
- Patients received surgical care which was evidence based and met national guidelines.

Summary of findings

- Clinical audits were routinely undertaken and action as a result of these was evident.
- Patients were assessed and provided with appropriate pain relief.
- Knowledge of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards was good in most areas however, most staff did not receive training in these areas.
- Staff treated patients with kindness, dignity and respect and patients told us that they were happy with the care they received.
- The surgical services were responsive to the needs of patients.
- Information was readily available for patients in a variety of formats, which could be adapted to individual needs.
- The access and flow within the surgical services was challenging at times, however staff managed this effectively.
- Patients had timely access to consultant led care. The service was well led and staff respected their local leaders.
- Staff could not articulate the trusts vision and values; however they were aware of significant work programmes taking place
- There were robust governance frameworks and managers were clear about their roles and responsibilities.
- There was clear leadership in the service and senior managers were visible and approachable.
- We found the culture within the service was open and managers made efforts to engage with staff and the public.
- We found evidence that the trusts board made attempts to engage with staff through different mediums and had implemented a speak out safely campaign.

However,

- In some areas we found that the learning from these investigations was not disseminated fully.
- We found that Nurse staffing levels on the surgical wards were not always sufficient to meet patients needs.

Summary of findings

- Some staff raised concerns about leaders at trust board level, and these concerns included lack of visibility and support and fear of raising concerns.

Critical care

Good ●

We have rated critical care services as good because:

- Incidents were reported and acted upon and used continuously as a service improvement tool
- Safety thermometer data was collected and displayed in public areas for patients and relatives to view.
- Performance results were also shared with staff in critical care in a monthly unit newsletter, together with results from relative's surveys.

- There were sufficient numbers of suitably skilled nursing and medical staff to care for the patients.
- The service took part in the intensive care national audit and research (ICNARC) data so we were able to bench mark its performance and effectiveness alongside other similar specialist trusts.
- The trust performed well, however data indicated some concerns regarding delayed discharges.
- The trust had an outreach team with five critical care trained, dedicated members of staff who supported wards in the early detection and treatment of acutely unwell patients.

- There was evidence if a multidisciplinary approach to caring for the patients. Ward rounds included consultants, a physiotherapist, a pharmacist, a junior doctor, a nurse, SHO and a member of the outreach team.

- There was adequate number of nursing and medical staff to provide a seven-day service.

- Staff were aware of the vision for the service and had strategies in place for innovation and improvement.

However,

Summary of findings

- We did find that that the unit fell below the intensive care society's recommended level of staff who held a post registration award in critical care nursing.

Maternity and gynaecology	**Good**	🟢	We rated Maternity and gynaecology as good because:

- The trust had systems in place to review midwifery staffing levels using latest national guidance (National Institute of Clinical Excellence : Safe Midwifery staffing for Maternity units 2015 NG4) and were in the process of employing addition midwives following the most recent review in January 2016.
- Clinical areas at the point of care were clean.
- The trust provided clear procedures for reporting incidents and the electronic reporting system was accessible to the majority of staff.The trust treated incidents seriously and ensured completed investigations.
- Multiagency and disciplinary working was established and promoted the best outcome for mothers and their babies.
- The record keeping systems were effective ensured accurate and up-to-date information about patients was readily available.
- Women were cared for with kindness and compassion and were positive about the standard of care and treatment provided by the maternity and gynaecology services.
- The service encouraged and supported learning and development. The ratio of supervisors of midwives to midwives was 1:14 which better than the recommended 1:15.
- The trust ensured staff followed best practice guidance and participated in national and local audits in relation to care and treatment.
- The majority of staff felt communication between ward staff and senior managers was effective.
- Midwives subscribed to the philosophy of the nursing and midwifery council six of compassionate care and we saw this in practice.

Summary of findings

- There was an active local maternity network which involved stakeholders and service users in place to help inform maternity services going forward.
- The gynaecology ward and clinics were well run by the gynaecology service and ward managers.

However,

- The number of midwives employed did not meet best practice Birthrate Plus recommendations. This resulted on the closure of the unit and delays in procedures for women using the service on rare occasions.
- The layout and security detection arrangements meant mothers and babies weren't always monitored, however access to the unit was monitored by close circuit television at key points across the unit, and access was restricted either by a staffed reception or swipe access door.
- General cleanliness in non clinical areas on the central labour suite and Cestrian ward needed to improve.
- During inspection we did not find evidence of emergency response training did not included drills for dealing with common obstetric emergencies. However, the trust informed us that this was covered on induction and also using innovative methods of teaching.
- The trust did not provide midwives, health care assistants and midwife assistants with individualised appraisals.
- The trust did not employ a specialist bereavement midwife; however, there were two link bereavement midwives.
- The management system for audits needed to be improved and sharing the lessons learnt from incidents, audits and complaints was not well established.
- There were not enough opportunities for midwives to meet and review the safety of the ward or unit during each shift.

Summary of findings

Services for children and young people

Good ⬤

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

- We saw evidence that incidents were being reported and that information following clinical incidents was fed back to staff in daily safety briefings.
- Cleanliness and hygiene was of a high standard in areas we visited and staff followed good practice guidance in relation to the control and prevention of infection.
- Care was delivered by caring and compassionate staff and the differing needs of children and young people were considered when delivering care.
- Facilities were available for parents to stay with their children.
- 97.6% of children and young people were seen within the 18 week target time and correspondence with GPs following admission or treatment was sent in a timely fashion.
- The hospital at home service enabled children to be treated in their own home or reduced their stay in hospital.
- Managers had a good knowledge of performance and were aware of the risks and challenges to their service.

However,

- Nurse staffing levels on the children's unit did not reflect Royal College of Nursing (RCN) standards (August 2013) and nurse staffing levels on the neonatal unit did not meet standards recommended by the British Association of Perinatal Medicine (BAPM).
- The neonatal unit lacked storage space and resources for barrier nursing.
- There was not always a member of nursing staff on duty with Advanced Paediatric Life Support (APLS) on the children's unit.

End of life care

Requires improvement ⬤

We rated end of life services as requires improvement over-all because :

- There was an insufficient number of general nursing staff who had received appropriate

training regarding end of life care and the replacement for the withdrawn Liverpool Care Pathway [LCP] the care and communication record [CCR].

- The trust performed worse than the England average in five of the seven organisational key performance indicators for the National Care of the Dying Audit 2014. However an action plan is currently in place to address the issues identified in the 2014 audit.

However,

- There was a three-year vision developed by the trust's end of life committee. We found this had been communicated to most general ward teams. We found evidence of an overarching monitoring of the quality of the service across the trust. Complaints were responded to appropriately.
- Specialist palliative care nurses we spoke with were able to describe safeguarding procedures and provided us with examples of how these would be used.
- All of the general nursing staff we spoke with were aware of how to report an incident or raise a concern.
- Appropriate equipment was available to patients at the end of their life; the equipment at the hospital was adequately maintained.
- Medicines were managed appropriately.
- Patients were involved in care planning and decision making. Staff were respectful and treated patients with compassion.
- Specialist nurses were visible, competent, and knowledgeable.
- The trust had a dedicated specialist palliative care team [SPCT] who provided good support to patients at the end of life. Care and support was given in a sensitive and compassionate way.
- On the wards staff worked hard to meet and plan for patient's individual needs and wishes.

Summary of findings

- Staff within the [SPCT] team were very motivated and committed to meeting patients' different needs at the end of life and were actively developing their own systems and projects to help achieve this.

Outpatients and diagnostic imaging

Good ●

Overall we found the outpatient and diagnostic service as good because:

- There was strong reporting culture with staff reporting incidents via the trusts electronic system. There was some learning from incidents, although similar incidents continued to be reported in radiology areas.
- Systems were in place for the maintenance of equipment. Processes were in place for daily checking of resuscitation equipment.
- Any prescribed medications were stored in locked cupboards and there was no controlled drugs or intravenous fluids stored in outpatients at COCH. Patients' records were maintained on paper and via electronic systems, although; plans for changes in electronic systems were in place.
- Staff had received mandatory training, although some groups were not up-to-date with safeguarding requirements. There was some staff shortages identified, although recruitment processes were in progress.
- There was a caring culture embedded in all areas visited and from all members of staff we met. We observed good, compassionate care being delivered.
- Reception staff were polite and helpful. Patients and their relatives were very positive about the staff in outpatients and radiology. They said they were supportive and communicated well. We observed respectful interactions between staff and patients.
- Staff actively involved those close to patients with initiatives in place to support relatives of patients who attended regularly.
- There was specialist staff in clinics with good multidisciplinary working, although not all had been appraised annually.
- Services were available seven days a week.

Summary of findings

- Consent for procedures was obtained although by different clinicians.
- There were audit plans in place and good use of the WHO safety checklist, for radiological interventions, was observed.
- The outpatient and diagnostic services were available at both Countess of Chester Hospital (COCH) and Ellesmere Port Hospital (EPH). The main activity was at COCH with a small department at EPH for routine care of patients in the local area.
- Targets of referral to treatment targets were within national guidelines, however; there was a wide variation in waiting times for individual consultants. Extra clinics were arranged, out of hours and at weekends to manage the demands of the local population.
- There was support for patients with individual needs including visually impaired, hearing impaired, learning disability or dementia.
- There was evidence of learning from complaints and how changes had been implemented.
- There was a clear vision and strategy for the future.
- The management teams were stable and committed to patient well-being in both out patients and diagnostics despite challenges.
- There were governance processes embedded with action plans in progress to improve services. Waiting list initiatives took place to meet demands of the local population.
- There were regular meetings, at all levels. Staff felt supported by their line managers and there was good team working in the departments.
- There were several innovations taking place with plans to increase services.

- Radiology trust guidelines and standard operating procedures were in place although not always clear and robust. There had been recent reviews of procedures.
- There were delays in reporting in radiology, which meant there could be delays in treatment. The trust had responded to increased demand by outsourcing x-ray reporting.

Summary of findings

However,

- There was dust found on some medical equipment.

- In the nuclear medicine department of radiology, we observed that a prescribed medication was not always signed as administered.
- There were delays in reporting in radiology, which meant there could be delays in treatment. The trust had responded to increased demand by outsourcing x-ray reporting.

The Countess of Chester Hospital

Detailed findings

Services we looked at

Urgent and emergency services; Maternity (community services); Surgery (gynaecology); 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

Detailed findings from this inspection	Page

Background to The Countess of Chester Hospital

The Countess of Chester Hospital is one of two hospital sites managed by The Countess of Chester NHS Foundation Trust. The hospital is the main site and provides a full range of hospital services including emergency care, critical care, a comprehensive range of elective and non-elective general medicine (including elderly care) and surgery, a neonatal unit, children and young people's services, maternity and gynaecology services and a range of outpatient and diagnostic imaging services.

The Countess of Chester Hospital is situated within the Countess of Chester health park in Cheshire, and provides services to a population of approximately 412,000 residents mainly in Chester and surrounding rural areas, Ellesmere Port, Neston and the Flintshire area. Over 425,000 patients attend the Trust for treatment every year. The Countess of Chester Hospital has approximately 680 beds.

Our inspection team

Our inspection team was led by:

Chair: Elizabeth Childs

Head of Hospital Inspections: Ann Ford, Care Quality Commission

The team included an inspection manager, 9 CQC inspectors, an inspection planner, an assistant planner, a senior analyst and a variety of specialists including : a director of nursing, a safeguarding nurse, a nurse consultant, an accident and emergency nurse, a nurse consultant in accident and emergency, an intensive care consultant, an intensive care advanced nurse practitioner, a consultant obstetrician and gynaecologist, a senior neonatal midwife, a clinical nurse specialist in medicine, an associate medical director in radiology, a nurse consultant in acute medicine, a consultant paediatrician and neonatologist, a paediatric nurse, a consultant in vascular surgery, a theatre manager and a student nurse.

Detailed findings

How we carried out this inspection

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

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

Before visiting the hospital, we reviewed a range of information we held about Countess of Chester Hospital and asked other organisations to share what they knew about it. These included the Clinical Commissioning Groups, NHS England, Health Education England, the General Medical Council, the Nursing and Midwifery Council, the Royal Colleges and the local Health watch.

We held a listening event for people who had experienced care at either Countess of Chester Hospital or Ellesmere Port Hospital on 9 February 2016 in Countess of Chester Hospital. The event was designed to take into account people's views about care and treatment received at the hospital. Some people also shared their experiences by email and telephone. The announced inspection of Countess of Chester Hospital took place on 16 – 19 February 2016.

The inspection team inspected the following core services:

- Urgent and Emergency Services
- Medical care (including older people's care)

- Surgery
- Intensive/critical care
- Maternity and gynaecology
- Children and young people's services
- Outpatients and Diagnostic Imaging
- End of life care

As part of the inspection, we held focus groups and drop-in sessions with a range of staff in the hospital, including nurses, trainee doctors, consultants, midwives, student nurses, administrative and clerical staff, physiotherapists, occupational therapists, pharmacists, domestic staff and porters.

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

We undertook an unannounced inspection between 3pm and 8pm on 4 March 2016 at Countess of Chester Hospital. As part of the unannounced inspection, we looked at the emergency department, outpatients and radiology, and medical care wards. We would like to thank all staff, patients, carers and other stakeholders for sharing their balanced views and experiences of the quality of care and treatment at Countess of Chester Hospital.

Facts and data about The Countess of Chester Hospital

The Countess of Chester NHS Foundation Trust serves a population of approximately 445,000 people in and around Western Cheshire, Ellesmere Port, Neston and North Wales. The Trust was one of the first 10 in the country to gain foundation status in 2004. In 2010, Ellesmere Port Hospital came under the management of

the Countess of Chester Hospital NHS Foundation Trust. Ellesmere Port Hospital is a rehabilitation unit providing Physiotherapy, Radiology, Mental Health and COCH Consultant clinics.

The Countess of Chester Foundation Trust has approximately 683 beds and employs 4105 staff.

Detailed findings

The health of people in Cheshire West and Chester is varied compared with the England average. Deprivation is lower than average, however about 15.4% (9,000) children live in poverty. Life expectancy for both men and women is similar to the England average.

In 2014/15 there were 74,404 emergency department attendances and 444,045 outpatient attendances.

Our ratings for this hospital

Our ratings for this hospital are:

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

Notes

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

Urgent and emergency services

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

Information about the service

The Emergency Department (ED) at the Countess of Chester Hospital treats 72,000 patients serving a population of over 250,000. The department includes a team of eight consultants and a matron, supported by a team of middle grade doctors, junior doctors, emergency nurse practitioners (ENP) and advanced nurse practitioners (ANP).

The department is a designated trauma unit and receives acute stroke patients, facilitating thrombolysis where appropriate. ED also acts as the receiving point for the South Mersey Arterial Centre (SMArt), all surgical GP referrals and acutely unwell medical admissions. The department is also a designated place of safety for patients on Section 136 of the Mental Health Act.

The department consists of a three bedded resuscitation room, 14 'major's' cubicles, an ENP led 'minor's' area, a 22 bedded emergency assessment unit (EAU) and a separate children's waiting area. Patients have a clinical assessment prior to registration providing early assessment and appropriate streaming of patients.

A Primary Care Unit is co-located within the department which is ANP led.

ED attendances were 56, 756 of patients aged 17 years and over, and 12, 330 under 16's between April 2013 and March 2014. The ED department was originally built for 30,000 attendances but is currently seeing in excess of 70,000 patients per year and on average treats approximately 190 patients per day.

During our inspection, we visited ED, ambulatory care and the GPAU, spoke to 22 staff including doctors, nurses and allied health professionals, five patients and relatives, reviewed 10 patient records and reviewed information provided by the trust and the public.

Urgent and emergency services

Summary of findings

We rated emergency and urgent services as good because:

- Staff were committed and proud of the service they provided.

- There were staff vacancies and bank and agency staff were successfully used to fill gaps.

- Medical cover was sufficient and staff worked well together.

- Staff treated patients and their relatives with respect and dignity and communicated with them well.

- Patients were involved in care planning and felt informed.

- Incidents were reported via an electronic system and staff could access the system.

- Staff reported receiving feedback and learning from incidents.

- Risk assessments were completed and staff implemented measures to reduce risks.

- Equipment was available and serviced.

- Medicines were stored safely.

- Risk registers were in place.

- Staff were aware of the trusts values and vision. Staff felt well supported by the multi-disciplinary team and worked collaboratively to ensure patients were cared for.

However,

- Access and flow was a challenge due to bed capacity, and some patients were in the emergency department for long periods.

- Four hour targets were not being met, however patients were cared for and their needs met.

- Clinical areas at the point of care were visibly clean, however, we observed some none clinical storage areas that were dusty.

- We observed a storeroom with a ladder to an unlocked hatch to the roof space near the resuscitation room, action was taken during the inspection.

- Two storerooms were found to have doors propped open; the door to the dirty utility was also propped open and the lock was sealed with tape to ensure the door did not lock.

- There were three tubs of chlorine tablets on the shelf in the dirty utility and access to cleaning materials.

Urgent and emergency services

Are urgent and emergency services safe?

Good ●

We rated safe as good because:

- Staff knew how to report incidents and received feedback and lessons learned information.

- Staff understood 'Duty of Candour' (the regulation introduced for all NHS bodies in November 2014, meaning they should act in an open and transparent way in relation to care and treatment provided) and felt confident to practice it.

- Staff had access to safeguarding training and could access support as required, however 27 out of 71 staff still required level three safeguarding children's training.

- Records were electronic and paper based. Records were generally of a good standard.

- The department had a copy of the trust major incident plan and felt clear about their role within it.

- Clinical areas at the point of care were visibly clean.

- We observed appropriate use of personal protective equipment (PPE) and hand washing. Infection control audits were completed.

However,

- There were staffing vacancies within the department, however staff did extra shifts to provide cover and agency was used to fill any gaps.

- Medicines were stored securely; however, the process was unclear with storage of patients' own controlled drugs.

- Clinical areas at the point of care were visibly clean, however some non clinical storage areas were dusty. The staff did not have cleaning rota's within the department but there was designated domestic support who had cleaning schedules displayed on notice boards.

Incidents

- There had been no never events reported for urgent and emergency care between February 2015 and January 2016.

- Urgent and emergency care reported 432 incidents between February 2015 and January 2016, 227 of these were reported as no or low harm. Five incidents required further investigation. We reviewed incident investigations which included appropriate action planning and shared learning cascaded to all staff.

- There were policies and procedure in place for reporting incidents..

- Staff knew how to report incidents using the electronic reporting system.

- Learning was shared via a departmental newsletter and communication board.

- Staff understood 'Duty of Candour' and their responsibilities related to this.

- Duty of Candour was included within trust induction and all mandatory training programmes. There was a staff information leaflet about Duty of Candour, which was included within the welcome event information pack and was also available on the intranet.

Cleanliness, infection control and hygiene

- The trust had introduced MRSA screening to test all patients for MRSA skin carriage prior to admission. Results showed that 18% of positive results originated from initial screening in ED between July and September 2015. Therefore, the screening programme supported early identification of MRSA colonised patients.

- The trust completed a Patient Led Assessment of the Care Environment (PLACE) in November 2015 and the report highlighted 11 actions. The audit identified that there was no cleaning schedule in place, which reflected initially what we saw. Senior staff told us this was being developed and it was put in place during this inspection.

- The PLACE audit identified 11 areas for action in the department, which were being monitored by the trust board. At the time of the visit, there were eight actions outstanding, however some of these required access to patient areas for maintenance work.

Urgent and emergency services

- Hand hygiene results were displayed on an infection control notice board. Results from hand hygiene audits between January 2015 and January 2016 showed that the department scored between 61-100% compliant. It was unclear if any action plans had been formulated to target hand hygiene compliance.

- Hand hygiene audits for ambulatory care showed overall compliance at 96% between June and November 2015.

- There was good availability of personal protective equipment (PPE), hand gel and sufficient hand washing facilities and we observed staff following infection prevention policies and procedures.

- There was good availability of personal protective equipment (PPE), hand gel and sufficient hand washing facilities and we observed staff following infection prevention policies and procedures.

- An audit was completed in September 2015, undertaken by the supplier of the sharps containers. The results showed compliance with use of the temporary closure mechanism had improved significantly with 89% noted to be in use from the 2015 audit compared to 64% from 2014. As part of our inspection we observed, all sharps bins were signed and dated, however none were partially closed when not in use (in line with best practice).

- Two cubicles in the major's area and two in the minors could be used for isolation of patients when required.

- Clinical areas at the point of care were visibly clean. We observed dirty floors in store cupboards and dust on stored items. There were also issues with dusting of high and low surfaces and some areas were visibly dirty. Senior staff were alerted to this and action was taken to address our concerns.

Environment and equipment:

- Staff had access to the equipment they required to do their jobs and equipment was serviced regularly. We found one thermometer that was overdue for service.

- A mattress on a trolley in the resuscitation area had a sensor pad and tape on the underside and a slit in the cover. This was highlighted to staff, however this mattress was still in use the next day. Staff were alerted again and the mattress was replaced.

- Resuscitation equipment was being checked daily as per trust guidance however the equipment and trolley were visibly dusty despite the checklist asking for daily damp dusting. This was highlighted to senior staff.

- There was a designated separate children's waiting area accessed from the main waiting area. Access was via a buzzer system from reception.

- Fridge temperatures were not recorded daily, there were five days missing out of the two weeks prior to inspection.

- Five stock boxes in a cupboard for use in major incidents were out of date. We alerted senior staff who actioned this immediately.

- The department had a psychiatric assessment room available, however there were chairs available that could be used as weapons and a possible ligature risk from the ceiling/ lighting. We highlighted this to senior staff and the chairs were removed immediately and advice from health and safety regarding the ceiling was sought. Senior staff told us that they had secured agreement with the estates department to replace the ceiling.

- There was good access to the diagnostic imaging services which was next to the department.

- Equipment we observed within the department were visibly clean and had 'I am clean' stickers attached.

Medicines

- The department used secure systems for storage of medicines. This incorporated keypad or fingerprint access.

- Allergies were clearly recorded in patients' records.

- Medicine systems were reviewed during the inspection by our pharmacy advisor. Our advisor found that there were no patient group directives (PGD) used within the department however staff could administer up to three doses of simple remedies such as paracetamol. This was as per trust policy, which described which drugs could be given, how and when.

- The matron received a daily report on access to the drug storage systems to ensure the system was used efficiently and staff followed processes.

Urgent and emergency services

- Intravenous (IV) fluids were stored in a locked clinical room and random checks of expiry dates showed they were within date.

- Pharmacy re-stocked stores. The pharmacy department operated a full pharmacy service Monday to Friday 9-5pm and provided a dispensary service on Saturday and Sunday mornings.

- Medication was prescribed on the emergency department treatment cards for administration. There was a separate emergency department system from the main acute electronic system. We reviewed these and found there was some communication between the two systems but that medicines did not automatically transfer between the two. This could potentially mean missed or double doses of medicines.

- We reviewed current IV fluid prescription charts on the emergency assessment unit and these were fully completed and signed.

Records

- Paper and electronic records were used within the department.

- The paper record used was an emergency department card printed off in the area designated following streaming.

- The medical staff recorded interventions via the electronic record system. This was visible to staff on the wards, however other speciality medical staff used paper records, this meant not all treatment plans were recorded in the same way.

- We observed ten completed observation charts in use for early warning scores (EWS), comfort and care, Fluid intake and output, which were legible, signed and dated.

Safeguarding

- Staff accessed training for safeguarding children and adults. The trust had designated leads for both. 89% of nursing staff and 59% of medical staff had completed safeguarding adult's level 2 training against the trust target of 80%.

- Senior staff told us that 27 out of 71 staff required level 3 children training. 100% of nursing staff and 80% of medical staff had completed safeguarding children level 2 training against the trust target of 80%.

- The trust had safeguarding policies in place and staff knew how to access it via the trust intranet.

- There was no electronic flagging system for children who presented with child protection plans or previous safeguarding concerns. This would be picked up when reviewed by the clinician. There was a lead consultant and nurse for safeguarding in ED departments.

- Staff were able to access the trust safeguarding teams for specialist advice via telephone and staff from the trust children's safeguarding team attended ED daily to collect notifications and ensure appropriate referrals had been made.

Mandatory training

- Staff received mandatory training on a range of subjects including infection control, risk and governance, medicine management, safeguarding and resuscitation.

- The department mandatory training completion figure was 69% for nursing staff and 100% for medical staff against the trust target of 95%.

- The matron told us that department staff attended advanced life support training and paediatric life support training each month, however we did not see current completion rates.

Assessing and responding to patient risk

- Initial assessment and management of patients commenced via a triage system, which commenced at 9am until 9pm seven days a week and could be allocated to be Band 5, 6 or 7. Patients took a number on arrival and then were called to be triaged by a nurse. Patients were assessment by a registered nurse within 15 minutes of arrival and this included an assessment of pain. The nurse determined which area of the department the patient needed to access: majors, minors or primary care. Observations and a basic history were taken at this point.

- Outside of these hours, reception reviewed attendees and liaised with staff to direct patients to the correct area.

Urgent and emergency services

- Early warning scores were introduced in November 2015 and should be completed as a minimum every four hours. The escalation process was noted on the chart. Early warning scores (EWS) was used throughout the trust to alert staff if a patient's condition was deteriorating. This was a basic set of observations such as respiratory rate, temperature, blood pressure and pain score used to alert staff to any changes in a patient's condition. The records reviewed showed completion of EWS on EAU and appropriate escalation as per guidance. Documentation of these scores was discussed at team meetings and noted in minutes.

- There was a rapid assessment and treat (RAT) team available from 10am-5pm.

Nursing staffing

- The trust did not use an acuity tool to determine staffing within accident and emergency. Best practice recommendations were followed for staffing for level two and major trauma patients.

- Staffing levels agreed were 11 trained nurses on an early shift, 13 in the afternoon and nine overnight. There was also two additional staff to cover until midnight.

- The staff held handovers at 8am and 8pm. Senior staff held a 'huddle' at 5pm to determine access and flow in the department. There were two consultants with paediatric experience and one ANP in primary care who was paediatric trained.

- At the time of inspection, there were two staff on sick leave, five on maternity leave and four more due to start maternity leave. Senior staff told us that maternity leave was back filled and they did this by offering a six month temporary contract to new staff or a permanent contract if staff were experienced.

- There were three nursing vacancies and the department had a turnover rate of 18.6% in November 2015. Figures to January 2016 showed staff budgets for 89.8 wte and an actual staffing of 90.9.

- The sickness rate in November 2015 was 3.08%.

- There was good skill mix within the department with emergency nurse practitioners, advanced nurse practitioners, nurses, physiotherapist, and doctors.

- There was use of agency and bank nurses. Rotas showed use of their own staff doing extra shifts and regular agency staff. For the week inspected there were seven shifts uncovered and the week after there were ten trained nurse bank shifts uncovered and four untrained shifts.

Medical staffing

- The staff skill mix showed there were fewer consultants than the England average.

- Data from January 2016 showed a budget for medical staff of 31.4 wte and actual staffing levels of 31.7 wte. This meant there was very low use of locum cover.

- Trust data showed a turnover rate of 17.7% and a sickness rate of 0.41%

- Staff conducted handovers at 8am and 8pm and the matron, team lead and consultant had a 'huddle' at 5pm to review current activity and flow. We did not observe a handover during our inspection.

- Consultant cover was available 9am to midnight seven days per week and then on call overnight. There were two consultants with paediatric experience.

Major incident awareness and training

- The department had a copy of the major incident plan. Senior staff told us that a desktop exercise had taken place and from that, the plan was being reviewed, responsibilities, and action cards being updated.

- The business continuity plan was easily accessible to staff and could show us where it was kept.

- A security office was based on the corridor by the department and the cameras in operation at the nurses' station were operated from there.

- The hospital had hazardous materials and items (HAZMAT) arrangements in place and had identified an area away from the main entrance for initial decontamination. Trust data showed that 30 staff had received decontamination training and four had attended emergency preparedness, resilience and response (EPPR) training.

Urgent and emergency services

Are urgent and emergency services effective?
(for example, treatment is effective)

Good ●

We rated effective as good because:

- Staff followed national and local guidelines and policies.

- The division participated in local and national audits, such as the Royal College of Emergency Medicine (RCEM) audits. Action plans were formulated and shared.

- Patients were assessed for pain relief and were offered analgesia. Patients' nutrition and hydration needs were assessed.

- Staff had appraisals and access to training and development. Multi-disciplinary team working worked well, working collaboratively to plan and provide care.

- Staff obtained consent to treatment and discussed care planning.

- Trust policies for mental capacity and deprivation of liberty safeguards were in place.

Evidence-based care and treatment

- Policies in place based on national guidelines such as National Institute for health and Care Excellence (NICE). For example; Pressure ulcer prevention and falls.

- Staff had training on the mental capacity act and understand the requirements of the mental health act.

- Care and treatment was provided in line with evidence based, best practice guidance such as the 'Clinical Standards for Emergency Departments' guidelines.

- Guidelines followed included those for management of sepsis, stroke and fractured neck of femur. The department had updated their pathways following the national auditing progress and r-audited internally following changes to monitor progress.

- We observed the updated fracture neck of femur pathway and this worked well. This was updated following results from the previous national audit results.

- Staff adhered to local policies and procedures and could access them via the intranet.

Pain relief

- Patients we spoke with told us they received pain relief in a timely way.

- Patients were asked at streaming if pain relief was required. This was assessed by the nursing staff and appropriate action taken, however only paracetamol was given in streaming.

- Drug rounds were undertaken on the emergency admissions unit and staff asked patients if pain relief was required.

- During the inspection we observed staff discussing pain relief with patients and administering as required.

Nutrition and hydration

- Patients had access to drinks whilst in emergency assessment unit (EAU) and staff offered refreshments throughout the department.

- There was a stock of sandwiches available for patients who were in the department for extended periods..

- Meal trolleys were used for patients in beds within EAU.

- We observed water jugs on tables for patients in beds, on EAU and also within majors.

- The EAU had access to hot drinks outside the day room and were offered to patients in bed.

- Staff told us they had volunteers who would help with providing drinks.

- We observed seven intravenous charts and fluid charts. These were fully completed and up to date.

Patient outcomes

- Unplanned re-attendance rates to ED within 7 days were better than the England average between October 2013 and September 2015.

Urgent and emergency services

- The Royal College of Emergency Medicine (RCEM) consultant sign-off audit shows three indicators were about the same as other trusts and one was below the England average. New electronic records had improved compliance and are were audited.

- Audit results for the severe sepsis audit showed a mixed performance with five indicators around the same as other trusts in middle England. Following this audit, the trust reviewed their pathways. We observed the pathway in practice and found staff followed it appropriately. The pathway was easy to follow and on one sheet and improvements included having pre-mixed antibiotics available from pharmacy.

- The fitting child audit showed three indicators in the middle England quartile and two in the lower England quartile.

- The mental health audit showed six indicators in the middle England quartile and two indicators in the lower England quartile.

- The older people audit showed three indicators in the middle England quartile and two in the lower England quartile. All audit results and recommendations were monitored and actioned though departmental governance arrangements.

Competent staff

- Records showed 95% of appraisals in the department had been completed.

- Staff received corporate and local inductions and had access to a named mentor.

- Local induction included staff being supernumerary and shadowing all areas including specialities such as safeguarding and surgery.

- Newly qualified staff had a local induction and a six month preceptorship with a mentor. Staff we spoke with found this induction very comprehensive and supportive.

- Staff reported having access to training relevant to their job role, including venepuncture and cannulation.

- Medical staff had training sessions weekly in the department.

- There were link nurses for various areas, such as safeguarding and infection control, identified who would cascade information and training.

Multidisciplinary working

- Handover took place at 8am each morning and again at 8pm. The matron held a huddle with the consultant and team lead at 5pm to review the current access, flow though the department, and identify any issues.

- There was evidence of good multidisciplinary team working throughout the department involving doctors, nurses, occupational therapists and physiotherapists. Senior staff and medical staff reported good liaison with other departments.

- We observed team working within EAU and therapy staff liaising with staff, patients and relatives.

Seven-day services

- Medical cover was provided consistently over seven days.

- There was access to the multidisciplinary team and diagnostics over seven days and discharges were planned over the weekend.

- Pharmacy provided a dispensary service on Saturday and Sunday mornings.

Access to information

- Information boards were visible in staff areas and these displayed audit information, link nurse details and trust wide correspondence.

- Staff had access to the information they needed to provide appropriate care and treatment including care plans and risk assessments

- White boards behind the nurse's station identified bed capacity within EAU.

- A department newsletter included updated trust wide information as well as any issues raised. This included new policies, any new incidents and trust updates.

- Staff had access to the trust intranet and accessed policies and procedures when required.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Urgent and emergency services

- Staff sought consent from patients prior to undertaking any treatment or procedures and documented this clearly in patient records where appropriate.

- Staff had the appropriate skills and knowledge to seek consent from patients. Staff were able to clearly articulate how they sought informed verbal and written consent before providing care or treatment.

- Staff had a good understanding of the legal requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

- Staff gave us examples of when patients lacked the capacity to make their own decisions and how this would be managed.

- A trust-wide safeguarding team provided support and guidance for staff in relation to any issues regarding mental capacity assessments and deprivation of liberties safeguards during working hours.

Are urgent and emergency services caring?

Good 🟢

We rated caring as good because:

- Patients felt positive about the treatment and care they received and felt supported to make informed choices.

- Staff engaged with patients and offered kind and considerate care to patients and those close to them.

- We saw that privacy and dignity was maintained and their needs were met.

- A bereavement follow up service was offered to bereaved relatives and they were invited back to the department for a one to one conversation with a consultant to discuss the care and treatment of their loved one.

Compassionate care

- In the ED friends and family test the trust remained below the England average from November 14 to

October 15 with rates ranging from 78% to 86% recommending the service. In January 2016, the response rate was 16% and 84% recommended the service.

- Curtains were used to maintain privacy and dignity during assessment and treatment.

- All questions in the CQC A&E survey relating to the caring domain are about the same as other trusts.

- We observed staff providing compassionate care to patients and supporting their carers and relatives.

Understanding and involvement of patients and those close to them:

- We observed staff communicating with patients and relatives in a way they could understand.

- Patients told us that staff kept them informed about their treatment and care. They spoke positively about the information staff gave to them either verbally or via discharge information leaflets specific to their condition.

- The department scored about the same as other trusts in England in relation to questions about the amount of information patients received and how involved they were with their care in the 2014 A&E survey.

Emotional support

- We observed staff offering patients and relatives support within the department.

- Rooms were available to provide privacy to support loved ones during difficult times.

- A bereavement follow up service was offered to bereaved relatives and they were invited back to the department for a one to one conversation with a consultant to discuss the care and treatment of their loved one.

Urgent and emergency services

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

Requires improvement ●

We rated responsive as requires improvement because:

- Facilities were not sufficient for the number of attendances. This meant that there were not always enough areas for patients to be seen and treated in which impacted upon access and flow.

- The four-hour waiting target was not met, except for July and August 2015.

- There were a high number of black breaches; January 2015 showed the highest number of breaches with 74. Black breaches are those cases where it has taken over one hour from the time the ambulance arrives at a hospital, until the clinical and patient handovers have taken place.

However,

- Patients had their needs assessed and their needs were met. Complaints were investigated and compliments were displayed on staff notice boards.

Service planning and delivery to meet the needs of local people

- The facilities and premises were not large enough for the services that were planned and delivered. Staff told us that the facilities were built to accommodate 30 000 attendances, however they now had over 70 000 attendances. The trust had identified this and plans were agreed to update and improve facilities within a two year timeframe. Discussions around service provision included the trust, the clinical commissioning group and the local council.

- The waiting room was small and overcrowded on the first day of inspection, with people standing in the main waiting area. Children had access to a separate waiting area that was not overcrowded. Bed meetings were held every day to review capacity and staff liaised with colleagues on the wards to identify bed availability.

- Engagement with other trusts in the area assisted with planning services for the population and supporting neighbouring trusts.

Meeting people's individual needs

- Staff worked collaboratively to meet the needs of patients with complex needs.

- The health of the local population varied compared with the England average. Deprivation was lower than average, however about 15.4% (9,000) children live in poverty. The trust worked with the local council and clinical commissioning groups to ensure services meet the needs of the community.

- There were link nurses in the department for dementia, safeguarding and infection control. They supported colleagues and cascaded training.

- The trust had translation and language services available via language line, deafness support and translation. Staff we spoke to had not accessed the services.

- People with a dementia diagnosis were highlighted via an alert on the bed board. Staff had access to dementia training.

- The Spiritual Care Centre at the hospital was open 24hours, seven days a week and offered space for patients, relatives and staff of all faith and no faith. In particular for Muslims there were washing facilities, and prayer mats available. There were Christian prayers held on Tuesday, Wednesday and Thursday lunchtimes, and on a Sunday at 11am volunteers would bring patients to the Holy Communion service. There were special services held at the main Christian Festivals, together with an annual Hospital Thanksgiving service. Meditation classes led by a Buddhist monk were also held in the Spiritual Care Centre.

Access and flow

- Attendances resulting in an admission between April 2013 and August 2015 were consistently higher than the England average.

- Bed occupancy rates had been higher than the England average from April 2013 to September 2015. Occupancy rates for January – March 2014 and 2015 reached 99%.

Urgent and emergency services

- The unit included a 22 bedded emergency admissions unit for patients awaiting an acute bed. During the inspection all patients were waiting a medical bed. Some patients were discharged direct from this unit and were reviewed daily whilst on the unit by medical staff. There was access to physiotherapy and occupational therapy also.
  - There were issues with patient flow due to medical bed capacity. Additional bed provision was made available within the minor's area to await an in-patient bed. There were toilet facilities, however these were in the x-ray department next to the department. Food and drink was provided and privacy and dignity maintained.

- Waiting times regularly breached the four hour target between April 2015 and January 2016. During this time the results were between 76-93%, except for July and August 2105 when the 95% target was reached.

- There were 382 black breaches from May 2014 to November 2015. January 2015 showed the highest number of breaches with 74. December 2014 to March 2015 there was a high number of black breaches reported from around 30 - 74.

- The number of patients waiting four to12 hours to be admitted was generally higher (worse) than the England average from November 2014 to October 2015 (except in August 2015 when there was a decrease below the average by 2%). Data for October 2015 showed 20% of patients waited four to 12 hours to be admitted compared to the England average of 8%

- The total time in ED performance remained higher (worse) than the England average from September 2013 to September 2015 with times ranging from 160-180 minutes compared to the England average of 130 minutes.

- The trust had a mixed performance for the number of patients leaving before being seen. Over-all between January 2015 and December 2015 this rate was 3.2%. The emergency assessment unit and primary care unit aimed to improve flow.

- Ambulance journeys with a 30-60 minute turnaround made up approximately 40% of all journeys between June 2014 and May 2015 with January 2015 rising to approximately 50%.

- We visited the general practitioner admissions unit (GPAU) as part of the un announced inspection. GPAU is where patients were assessed following referral by GP's, and we observed that this new initiative had reduced access and flow issues within the emergency department. This department had opened since the conclusion of the announced inspection on 19 February 2016 in order to improve access and flow across the hospital.

Learning from complaints and concerns

- Complaints and compliments were displayed on staff notice boards. This included anonymised complaints for staff to review.

- Staff had access to a department newsletter and bulletin which included information on complaints.

- Complaints were formally discussed at the divisional governance board meetings on a monthly basis.

- Staff tried to resolve complaints locally where possible.

- Compliments and thank you cards were also displayed on the staff noticeboard.

Are urgent and emergency services well-led?

Good 🟢

We rated well-led as good because:

- Staff at all levels were enthusiastic and felt well supported.

- Staff were aware of the trust values and were proud of the services they provided.

- Governance meetings were held and incidents and risks discussed.

- Staff felt involved in forward planning and service development.

- The trust held an annual awards event to celebrate success and achievements.

- Compliments and complaints received were shared.

- Lessons were shared and discussed in team and divisional meetings.

Vision and strategy for this service

- Staff were aware of the trust's vision and values but not of the Model hospital concept. This is where the NHS would have a 'model NHS hospital' to help providers aspire to best practice across all areas of productivity.

- Senior staff had developed strategies for improving services within the department, including reviewing pathways and engaging staff and staff reported being involved in discussions.

Governance, risk management and quality measurement

- Medical staff had weekly governance meetings and information was cascaded.

- Senior staff attended governance meetings and this was discussed at team meetings and included in the newsletter and bulletin. The meeting minutes showed discussions included incidents, risks, performance and staffing.

- Staff discussed risks that had been reported and escalated including staffing issues.

- The department had a risk register with review dates clearly documented. Risks on the register reflected those identified by staff and managers.

- There were regular team meetings and huddles to discuss issues and wards displayed information on notice boards.

- The department had a risk folder which included trust wide risk assessments as well as local risk assessments.

Leadership of service

- Staff stated that the executive team were accessible and responsive.

- Appraisals were conducted with staff and one to one meetings could be requested when required.

- Staff felt supported by their line managers and senior management. Staff felt confident to raise issues with line managers and had access to the trust whistle blowing policy.

Culture within the service

- Staff were positive and enthusiastic and felt valued by the organisation and the department. They felt they worked well with colleagues and supported each other where required.

- The trust had a performance management policy which was implemented at departmental level.

- Staff felt encouraged to raise issues and concerns and felt confident to do so.

Public engagement

- Patients could feedback to the trust about their care and experiences via friends and family test, inpatient experience survey and via social media, all of which could be accessed via the hospital's website.

- Feedback from patients was collated at departmental level.This was discussed with staff in meetings, and actions were taken to improve patient experience, for example changing electronic signage to show patient flow in the department.

- Annual board meeting agendas and minutes were accessible to the public via the trust website. These provided details of the upcoming meetings the public could attend including board meetings and annual members meetings.

Staff engagement

- Staff told us they received a weekly newsletter from the trust via email which kept them up to date with current or on going issues and information.
- The department held a range of targeted focus groups for all staff grades which supported staff engagement and involvement.
- Team meetings were used to give staff the opportunity to "speak out" and staff were encouraged to talk about morale within the department.
- Senior staff told us that the executive team would complete a walk round and visit the department each month. This meant that executives were visible to staff and they could review the work within the department.
- The trust performed within expectations for 14 questions in the general medical council survey. They scored worse than expected for 'Feedback'. Medical staff in the department now have weekly meetings to discuss governance issues and to provide training.

Urgent and emergency services

- In 2015, the trust introduced a 'who cares, we do' and 'you said, we listened ' report which gave a brief summary of the results and actions going to be taken by the trust.

Innovation, improvement and sustainability

- The trust has recognised that changes were required within the ED Department. A 'project build' summary presentation had been before the trust executive team and they have given approval to move to the next stage. This is a two year build plan. One of the changes is to create two cubicles in EAU (PODS) for isolation and the plan is to also increase waiting room capacity.

- During the unannounced inspection, we observed the general practitioner admissions unit (GPAU) where patients were assessed following referral by GP's and this reduced access and flow issues within the emergency department.

Medical care (including older people's care)

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

Information about the service

The medical care services at the hospital provide care and treatment for a wide range of medical conditions, including general medicine, cardiology, respiratory, gastroenterology and stroke services. The stroke service is part of the Greater Manchester regional thrombolysis service. There are 683 beds at the hospital and around 4100 members of staff employed at the trust. The hospital provides medical care services to a population of 445,000.

We visited Countess of Chester as part of our announced inspection on 16th to 19th February 2016. We also conducted an unannounced inspection on 4th March 2016.

During the inspection we visited ward 33 (stroke), 42 (cardiology), 43 (geriatric), 48(respiratory), 49(gastroenterology), 51 (frailty ward), the renal unit, acute medical unit (AMU), discharge lounge, cardiac catheterisation suite and the endoscopy unit.

We reviewed the environment and staffing levels and looked at 18 care records and 15 medication records. We spoke with 10 family members, 23 patients and 50 members of staff of different grades, including nurses, doctors, ward managers, matrons, ward clerks, allied health professions, such as physiotherapists and occupational therapists and the senior managers who were responsible for medical services.

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

Summary of findings

We rated medical care as good because:

- Incidents and complaints were reported via an electronic system and staff could access the system.

- Most staff reported receiving feedback and learning from incidents and complaints. Risk registers were in place; however, action plans with timelines were not documented, however risks identified in this division were reflected in trust wide initiatives in place to mitigate risks.

- Wards were visibly clean, staff followed good hygiene practices.

- There were good systems for handling and disposing of medicines.

- Equipment was available and serviced as required.

- Staffing across medical services was on the risk register and actions had been taken including recruitment overseas and regular monitoring of staffing levels during the day to help mitigate the risk. The trust biannual review stated that overall the trust had maintained over 95% of the planned staffing levels.

- The trust had identified this as an area for improvement and a pilot of a new roster was commencing in April 2016. The trust were also undertaking a number of initiatives relating to measuring patient acuity to help plan staffing.

Medical care (including older people's care)

Patients risk assessments were completed and staff implemented measures to reduce risks.

Staff were aware of the trusts values and vision. Staff enjoyed working at the hospital, felt well supported by their managers and worked collaboratively together to ensure patient were cared for.

Staff treated patients and their relatives with respect and dignity and communicated with them effectively. Patients were happy with their care, felt informed, and were involved in care planning.

However,

Data provided showed there were occasions when the nurse staffing levels were less than 90 %.

There were issues with access and flow across the medical wards with high bed occupancy rates and delayed discharges due to the complexity of patient's needs. Some patients were being nursed in non-speciality beds and on occasions in mixed sex wards, although this was based on clinical need.

There was a risk that personal information was accessible to members of the public as patient's records were not always stored securely.

Monitoring documentation for input and output, bowel charts and cannulation checks were not always consistently completed.

On one ward, a large quantity of medication was found in an accessible unlocked cupboard, which was a risk to patients and members of the public.

Compliance with mandatory training for the majority of staff was below trust target. The trust target was 95%.

Are medical care services safe?

Good 🟢

We rated safe as good because:

- Incidents were reported by staff through effective systems and lessons learnt and improvements made following investigations were shared at team meetings

- Most staff reported receiving feedback and learning from incidents and complaints.

- Wards were visibly clean, staff followed good infection control practices.

- There were good systems for handling and disposing of medicines.

- Equipment was available and serviced as required.

- Staffing across medical services was on the risk register and actions had been taken including recruitment overseas and regular monitoring of staffing levels during the day to help mitigate the risk. The trust biannual review stated that overall the trust had maintained over 95% of the planned staffing levels.

- The trust was also undertaking a number of initiatives relating to measuring patient acuity to help plan staffing.

- Staff had knowledge regarding safeguarding and were aware of how to access the safeguarding team.

- Equipment had up to date electrical safety certificates and the majority of equipment observed was visibly clean.

However,

- data provided showed there were occasions when the nurse staffing levels were less than 90 %.

- In addition, staff told us they were regularly moved to other wards, which meant some wards did not have the appropriate skill mix. The trust had identified this as an area for improvement and a pilot of a new roster was commencing in April 2016.

Medical care (including older people's care)

- There was a reliance on some wards to use agency staff and some staff would work extra shifts as part of the nurse bank to support ward areas.

- Records were accessible to the public as most were kept in open trolleys that did not have the capability to lock. The trolleys we observed were positioned open at the nurse's station or on the ward corridor.

- Some staff found the electronic patient record system in place to record and monitor patient care difficult to use and time consuming.

- Some treatment rooms did not have a door and all medications were locked away on all wards apart from on the frailty ward where we observed a large quantity of medications in an unlocked cupboard and therefore accessible to patients and the public. We found some used sharps containers which had been left open in unlocked areas, which were accessible, by patients and the public and cleaning chemicals had been left out in an unlocked room on a number of wards.

- Staff attended mandatory training courses but compliance rates were below the trust target for the majority of staff.

Incidents.

- There were systems for reporting actual and near miss incidents across medical services. Staff were familiar with and encouraged to use the trust's procedures for reporting incidents.

- All incidents were reviewed by the ward manager who ensured all appropriate measures had been taken, for example when a fall had occurred, risk assessments and preventative measures were put in place and if injuries were sustained this had been managed appropriately. Any incidents with harm or near misses were escalated to the risk and patient safety team for full investigation.

- The executive serious incident panel met on a weekly basis and reviewed incident trends and any individual incidents which resulted in moderate harm or greater. The level of investigation would be determined and those that were considered a NPSA (national patient safety agency) level one or two were reported to StEIS (Strategic Executive Information System).

- From November 2014 to October 2015 there had been no never events reported across medical services at the hospital. Never events are serious, wholly preventable patient safety incidents, which should not occur if the available preventative measures are implemented.

- From 1st December 2014 to 30th November 2015 medical services across the hospital reported 2475 incidents, 51 of these were escalated for further investigation.10 of the reported categories accounted for 76% of the incidents, the most being slips, trips and falls.

- Across the trust there were 67 serious incidents reported from 1st February 2015 and 21st January 2016. 48% (34) of those were reported in medical services, which included pressure ulcers, and hospital acquired infections. All serious incidents had been investigated and action had been taken to prevent re-occurrence. Trust data suggests that ten of these were still ongoing at the time of report.

- Staff we spoke to felt they were well supported when they reported incidents. Incidents were disseminated at ward staff meetings, although three members of staff stated they did not always get personal feedback for every incident reported.

- There were examples of learning and changes to practice following incidents. For example staff told us that following an incident relating to supporting patients who require enteral feeding, the 'feed me up 30 degrees' was implemented. Patients who were enterally fed were now positioned 30 degrees and above. We observed this during our inspection.

- The trust had a duty of candour process in place to ensure that people had been appropriately informed of an incident and the actions that had been taken to prevent recurrence. 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. Senior staff and some junior staff understood the principles of duty of candour and we saw evidence of the policy being applied appropriately.

Medical care (including older people's care)

- Duty of candour was included in mandatory training and a leaflet was given to staff as part of induction training. Duty of candour was included in the policy for investigating incidents.

- Multidisciplinary mortality and morbidity reviews were held on a monthly basis, which was chaired by the medical director. All cases were reviewed through this process to identify key learning and to identify any actions if appropriate. Actions and learning were discussed at key governance meetings and some staff told us this was shared with them.

Safety thermometer

- The trust was required to submit data to the health and social care information centre as part of the NHS Safety Thermometer (a tool designed to be used by frontline healthcare professions to measure a snapshot of specific harms once a month). The measurements included pressure ulcers, falls and catheter acquired urinary tract infections

- From January 2015 to January 2016 there were 27 new pressure ulcers, eight catheter acquired urinary tract infections, 34 venous thromboembolism (VTE) and 10 falls reported across medical services at the hospital. The data provided by the trust did not clarify which incidents reported on the safety thermometer resulted in harm.

- Harm reviews were conducted and reports completed for all in-patient falls and pressure ulcers reported across the trust from April 2015 to September 2015. Each report included a review of falls and pressure ulcers including mitigating reasons and impact. Learning points were highlighted, key actions identified and recommendations were made including improvement in communication and documentation.

- Harm data was reviewed by the Director of Nursing and reported to the integrated board to monitor compliance against local and national target.

Cleanliness, infection control and hygiene

- From April 2015 to December 2015, there were three cases of MRSA bacteraemia reported across the trust. One was reported from medical services and a case review concluded it was unavoidable and no recommendations were identified. The other two required a post infection review in which recommendations with time lines were documented. Lessons from all cases were disseminated to staff for learningacross directorates.

- There were 17 cases of MSSA (Methicillin susceptible staphylococcus aureus) reported across the trust from April 2015 to December 2015, this was higher than the England average.

- From April 2015 to December 2015 there were 18 cases of Clostridium difficile (C dif) reported. A root cause analysis investigation identified contributory factors, lessons learnt along with recommendations, which included communicating to the relevant teams regarding inappropriate prescribing of antibiotics.

- In September 2015, the trust reported a marked increase in C-dif with eight cases reported across five wards. A strategy meeting was held in October 2015 and action plans were implemented including continuing with staff awareness, staff training and sharing of any learning.

- Staff followed good practice guidance in relation to the control and prevention of infection in line with trust policies and procedures and we observed staff following hand hygiene practice, bare below the elbow and using personal protective equipment (PPE) where appropriate. However, on one occasion, we saw poor hand hygiene practice prior and during administration of intravenous therapy and at another time a member of staff did not use all PPE available whilst dealing with a contaminated area; both were highlighted to the ward managers.

- There were sufficient number of hand washing sinks and hand gels. Hand towel and soap dispensers were adequately stocked and personal protective equipment such as gloves and aprons was available throughout the ward areas

- Side rooms were used as isolation rooms for patients identified as an increased infection risk. There was clear signage outside the rooms so staff and visitors were aware of the increased precautions they must take when entering and leaving the room.

Medical care (including older people's care)

- The trust used the national colour-coding scheme for hospital cleaning materials and equipment.This ensured that these items were not used in multiple areas, therefore reducing the risk of cross infection. Cleaning storerooms were generally clean and tidy.

- Infection, prevention and control (IPC) audits were carried out on a regular basis in medical services. From June 2015 to December 2015 medical wards achieved above 92% compliance. Following audits, action plans were implemented and updated when completed.

- In June 2015, the trust completed an audit of commodes across 26 areas and found that 25 % of the commodes were soiled and a third required replacement due to damage. This showed a decline in cleanliness compared to the previous year. Key actions were identified including ensuring training posters were visible in 'dirty' utility areas. A further audit is planned for 2016. During the inspection, we saw the training posters in some areas and all the commodes we observed were clean and in a good state of repair.

- Hand hygiene audits across medical services from May 2015 to October 2015 showed variable compliance ranging from 71 % to 100%. Reasons were highlighted including for non-compliance with bare below elbow policy. The trust target was 95%. Following these results, action plans were put in place and were being monitored by the PLACE committee. Data received shows none of the actions had yet been completed.

- The majority of equipment was visibly clean but there were inconsistencies across the wards in the use of the 'I am clean stickers' which may make it unclear to new or temporary staff on the correct process for identifying whether equipment was clean and ready for use.

- During the inspection, we observed four stand aids that were stained. These were brought to the attention of staff and acted upon immediately.

Environment and equipment

- Resuscitation equipment for each ward was readily available. There were systems and records in place to ensure that emergency equipment was checked and ready for use on a daily basis. Records indicated that the majority daily checks of equipment had taken place on the wards we visited.

- There were systems in place to maintain and service equipment. We observed portable appliance testing (PAT) had been carried out on all electrical equipment regularly and electrical safety certificates were in date.

- Most cleaning chemicals were stored safely, however we observed that some were kept in unlocked areas on three wards. These should have been stored securely as the chemicals were potentially hazardous. This was brought to the attention of staff who took appropriate action.

- A trust wide sharps handling and disposal audit in September 2015 showed that the trust had improved in sharps management compliance including use of the temporary closure mechanism of 89% compared to 64% in 2014. However, compliance had decreased slightly from 56 % to 52 % regarding the use of a bracket/trolley in which to store sharps containers. During our inspection not all sharps containers were stored in a bracket or trolley.

- We observed that the disposal of sharps followed good practice guidance. Most sharps containers were dated and signed upon assembling. However, on ward 51 we observed that there were four sharps containers left open which was accessible to patients and the public. We raised this with staff who acted upon this.

- Across medical services Patient Led Assessments of the Environment (PLACE) in 2015 showed a score of 98.18% which was above the England average of 97.57% for cleanliness. However, other areas including food, privacy, dignity and well-being, dementia, condition appearance and maintenance across the trust were below the England average. The England average was 90%.

- Most wards were fit for purpose however there was an issue with lack of space on some wards, for example the staff office (cardiology ward) or day room (stroke ward) were used to give patients and families sensitive information. On ward 48, clean linen and food was

stored in the same cupboard, this was raised to the nurse in charge who did not see it as a risk. The trust were aware of issues with lack of storage and plans were in place to address this.

Medicines

- All wards had systems in place for the safe handling and disposal of medicines. Ward staff told us there was regular pharmacist presence on wards and they could access a pharmacist as required.

- The pharmacy department operated a full pharmacy service Monday to Friday 9-5pm, and provided a dispensary service on Saturday and Sunday mornings. A pharmacist was available out of hours for urgent advice.

- Prescriptions were via an e-prescribing system. On the system, VTE assessments and antibiotic stop dates were mandatory which ensured prescribing was within local guidelines. Patient's medicines to take home on discharge (TTO) were visible and could be reviewed electronically by staff on the tracker system.

- All medicines on the wards were found to be in date, indicating that there were good stock management systems in place.

- We reviewed 15 patient's prescription records which were fully completed, dated and had the patient's allergy status documented. Staff told us the system was easy to use and they had received training.

- Suitable locked cupboards and cabinets were in place to store medicines. All drugs we checked were within date. We observed on one ward several strips of medication not in their original packaging in a locked drawer, which was secure; however, this may make it difficult to identify drug expiry dates.

- All treatment rooms with doors were locked apart from ward 48 where a broken lock was awaiting to be replaced. We observed no doors to the treatment rooms on wards 51 and ward 42. All medications were locked away on ward 42.

- On ward 51, we found two unlocked cupboards in the treatment room containing a large quantity of oral medication, intravenous medication and bags of intravenous fluids

- An audit of safe and secure storage of medicines in November 2015 identified some wards including ward 51 had medication stored inappropriately and had unlocked cupboards. An action plan was implemented to address concerns with the ward and clinical area managers. A memorandum was issued in December 2015 following the trust audit, however due to our findings it was unclear whether this method of escalation was effective. There were plans to re audit in March 2016.

- There were suitable arrangements in place to store and administer controlled drugs (medicines that are required to be stored and recorded separately). Stock balances of controlled drugs and patients controlled drugs were correct and two nurses checked the doses and identified the patient before medicines were administered. We observed that not all liquid controlled drugs were dated upon opening and recording errors were not recorded consistently in the CD book for example not all amendments in the controlled drug register were signed.

- Medicines requiring cool storage were appropriately stored in locked fridges. Records indicated that fridge temperatures were checked daily on most wards.

- Medication errors and risks identified were discussed at the medicines clinical quality meeting. There were 489 medication errors reported between April 2015, September 2015, of those 92% resulted in no harm, 7% low /minimal harm, and 1% were moderate/short term harm. All had been investigated and appropriate action taken.

Records

- There were paper and electronic patient records. The electronic system would prompt staff to take certain actions for example when completing the multifactorial falls risk assessment if patient met the criteria which increased risk of falling a flag would be seen to refer the patient to the physiotherapist.

- Most staff we spoke to stated inputting information was time consuming and that they were not made aware of new information that would be added to the system for completion. We also observed a member of staff unable to locate care plans and another who could not find retrospective results. Staff told us they received electronic system training on induction.

Medical care (including older people's care)

- We reviewed 18 patients care records during our inspection. The records we reviewed had detailed information regarding planned care and treatment. Electronic documentation kept to record people's vital signs along with risk assessments including malnutrition universal screening tool (MUST), and falls were completed. However, on occasions we noted that paper based documentation regarding bowel movement, weight, cannulation checks and fluid balance charts were not always completed fully.

- In most wards, records were stored in an unlockable trolley on the corridor or at the nurse's station and therefore accessible to the public. This increased the potential for patient confidentiality to be breached if these areas were not staffed.

Safeguarding

- Training statistics for medical services showed that some staff had completed safeguarding adult training. Nursing and midwifery staff were just above trust target with 81.3% in level two training however were below with 66.7% in level three training. Medical and dental staff were below trust target with 41.3% and 57.1% in level two and level three training. The trust target was 80%.

- At the time of our inspection there was not a safeguarding adult and learning disability coordinator in place to take the strategic and operational lead for Safeguarding Adults at the trust, however this vacancy had been recruited too and the trust were being supported by the lead from the local clinical commissioning group. Staff had access to a named doctor and named nurse along with five other staff who acted as points of contacts for advice and guidance in safeguarding.

- The trust had a safeguarding strategy board who met to discuss safeguarding issues, reports and incidents. Strategies and action plans were implemented to improve safeguarding, this included increasing awareness and training.

- A safeguarding adults policy was in place, which included standard operating procedures with key points and clear guidance for staff. Staff we spoke to were aware of the policy and who to access for guidance and support.

- Between February 2015 and January 2016 there had been 47 safeguarding referrals made from medical services trust wide. Reasons for referral included neglect, physical, financial and psychological, abuse or self-neglect.

Mandatory training

- Staff received mandatory training in areas such as mental capacity, health and safety, fire, manual handling, infection control and medicine management. Staff we spoke to said they were up to date and had completed all there mandatory training.

- Information provided by the trust at the time of our inspection showed across medical services that all medical, dental staff were 100% compliant with mandatory training apart from mental capacity act which was 35%. Compliance rates for staff was below the trust target of 95 %.

Assessing and responding to patient risk

- Upon admission to medical wards, staff carried out risk assessments to identify patients at risk of harm. Those patients at high risk were placed on care pathways and care plans were put in place to ensure they received the right level of care. The risk assessments included falls, pressure ulcer and nutrition (Malnutrition Universal Screening Tool or MUST).

- We reviewed 18 patients' records and found that all appropriate risk assessments had been completed to ensure that patients were assessed and care was managed safely, although some were not recorded immediately.

- A modified early warning score system (MEWS) was used throughout the trust to alert staff if a patient's condition was deteriorating. This was a standard set of clinical observations such as respiratory rate, temperature, blood pressure and pain score used for early detection of any changes in a patient's condition

- The trust had arrangements in place to evaluate compliance in responding to patient risk. In October 2015, a MEWS audit was conducted on 334 records across 21 wards in the trust. The report highlighted

Medical care (including older people's care)

good practice and areas for improvement including patients not having treatment escalated. Action plans were implemented with timescales including sharing of audit results and re auditing monthly.

- We saw effective handover meetings including the 'safety brief 'and 'huddles' where staff discussed patients and highlighted key risks. Each member of staff also had a paper list of patients to help ensure all relevant information was shared with staff. This included patients with dementia, deteriorating patients, and those at risk.

- We observed the World Health Organisation (WHO) endoscopy and surgical checklist completion in the endoscopy unit and catheterisation suite. The WHO checklist is an international tool developed to help prevent the risk of avoidable harm and errors during and after surgery. These were fully completed.

- In November 2015, staff on the cardiology ward reported an incident where they were unable to gain contact with staff on another ward with regard to patient with an arrhythmia, which is an abnormal heart rhythm. The trust has responded to this and at the time of our inspection, mobile devices had been ordered which staff could carry and therefore be contactable at all times. This remains on the risk register as a moderate level of risk.

- There was no observational /monitoring equipment or medication storage in the discharge lounge. If the patient required observations to be taken for example blood pressure, discharge lounge staff would go to A & E to obtain equipment and contact ward medical staff for support. If the patient required medication, it was administered by ward staff attending the discharge lounge. During our inspection, we observed a sister from a ward administering medication to a patient in the discharge lounge.

Nursing staffing

- The trust had previously used a safer staffing tool, which included measuring patient acuity to identify safe staffing levels; however, it was in the early stages of using a workload management tool (NHPPD) from the recently published Lord Carter model hospital review and piloting an activity monitoring tool to gain robust data going forward.

- Data provided in January 2016 by the trust shows the number of nurse vacancies in medical services was 1.9%. The turnover rate of nursing staff was 10.69% and staff sickness was reported at 3.7%.

- The trust undertook biannual nurse staffing establishment reviews as part of mandatory requirements and set key objectives though this work to support safer staffing. Data provided as part of this review in January 2016 identified that over-all the trust had maintained over 95% of staffing levels planned against actual levels for nine months.

- Data provided for registered nurse staffing levels for December 2015 and January 2016 showed that Ward 42 was the only ward to achieve the planned registered nursing level in December 2015 and exceeded the level in January 2016. In December there were 4 wards that were below the 95% planned staffing levels with the lowest being ward 51 with 86% and in January 2016 there was ward 43 with 88% and ward 48 with 83% of the planned level of staff. Data was not provided regarding untrained staffing levels.

- We reviewed nurse staffing levels for nine medical wards in July, September and October 2015. The average percentage of nursing shifts filled as planned during the day was variable. Concerns were identified each month with staffing levels below 90 % on a number of wards;in July ward 51 (86.8%), in September ward 43 (84.6%), ward 48 (85.4%) and ward 51(88.9%). In October 2015 nurse staffing was below 90% on five wards: ward 43 (85.6%), ward 50 (89.1%), ward 48 (79.9%), ward 51 (87.8%) and AMU (87.3%).

- For the same period, the average percentage of nursing shifts filled as planned during the night were over 90% on all wards. However in October 2015 AMU had 93% qualified and 87.7% unqualified staff.

- Each ward had a planned nurse staffing rota and managers reported on a regular basis if shifts had not been covered. The National Institute for Health and Care Excellence (NICE) guideline 'Safe staffing for nursing in adult inpatient ward in acute hospitals', nurse sensitive indicators and professional judgement were used to determine their staffing needs.

- Medical wards displayed nurse staffing information on a board at the ward entrance. This included the

Medical care (including older people's care)

staffing levels that should be on duty and the actual staffing levels. This meant that people who used the service were aware of the available staff and whether staffing levels were in line with the planned requirement.

- Matrons and managers met regularly to discuss nurse staffing levels. Where there were shortfalls, staff would be moved from wards to support areas with a higher patient acuity. Some staff we spoke to were concerned that this addressed the number of staff required but not the skill mix, for example, staff with specialised skills required for a specific ward were moved elsewhere and potentially replaced with a nurse who did not have specialist skills.

- Staff told us there were nurse staffing issues particularly at night due to staff being moved to other wards. This had been identified by the trust and senior staff told us they were currently reviewing staffing and were planning to pilot a different way of working in April 2016using the existing workforce to match patient acuity as reflected in 'the Model Hospital' and this was evidenced in board papers we reviewed. This will evaluate a change in shift pattern to support an extra member of staff on a nightshift as part of metrics identified in the Department of Health efficiency work programme.

- Staff told us when they would complete an incident form if they had to move to another ward due to staff shortages. We observed that 574 falls were reported trust wide,of those 49 (8.5%) were reported as being impacted upon by staffing with the highest issue reported in obtaining staff for 1-1 supervision or zoned observation. 41 % were unwitnessed (patient found on the floor) falls. The top three affected areas were all medical wards.

- The trust were currently working with the Department of Health looking at processes and procedures related to patients requiring 1-1 support as part of a pilot scheme.

- On the day we inspected the majority of shifts across medical services were filled as planned. We reviewed rotas and saw the majority of shifts were filled however, staff told us on occasions extra staff would

be needed for patients requiring 1:1 care. When staff were moved to support other wards this was not always updated on the rota, therefore it did not give a true representation of staffing and skill mix per shift.

- The trust had a pool of bank staff, which they have used along with agency staff. Trust data showed the number of agency staff was variable across the medical wards from May 2014 to March 2015. The highest use of agency staff was ward 51 with 33.6 % - 48.5 % and AMU 16% - 41.6% from November 2014 - March 2015.

- Nurse staffing levels was on the risk register and rated as a high risk. Senior managers told us following the successful overseas recruitment they were looking at going overseas to recruit again.This was part of measures identified in the biannual safe nurse staffing review in January 2016.

Medical staffing.

- There was sufficient medical cover outside normal working hours and at weekends should patients need to see a doctor. Consultant cover was available on site from 9am to 6pm daily and on call outside of these hours. We were told that all consultants were within 30 minutes of the hospital.

- At weekends, there was a cardiologist from 08.00 to 12.00 who provided input to cardiac patients on AMU, Coronary Care Unit and the cardiology ward as required. Stroke Physicians were on-call 24 hours 7 days a week. There was also a gastroenterologist who provided daily input along with in reach support with access to endoscopy.

- Senior managers told us there are regular hand overs between medical staff with wards rounds every day including weekends and this reflected what we saw.

- Trust data showed that across medical services trust wide there were four consultant vacancies in each of the service: cardiology, acute, gastroenterology and respiratory. Vacancies for trainee doctors posts was 19 and for F1 doctors was one across medical services.

- The use of locum medical staff for the hospital during April 2014 and March 2015 was variable between 0% up to 27% at times across eight wards however on two occasion's locum agency levels were 100% on the acute frailty unit. The Acute Frailty Unit was

Medical care (including older people's care)

established in July 2015 and formed part of the acute core medical trainee programme. We were advised that gaps in rotation were to be addressed via the current ward reconfiguration.

- The turnover rate for medical staff across medicine was 8.1% and 1.25% staff sickness for the last financial year.

Major incident awareness and training

- The trust had a major incident plan in place, which listed key risks that could affect the provision of care and treatment. There were clear instructions for staff to follow in the event of different types of major incidents.

- Staff we spoke with were aware of the major incident plan and how to access it.

Are medical care services effective?

Good ⬤

We rated effective as good because:

- Care and treatment was provided in line with national and best practice guidelines.

- Medical services participated in the majority of clinical audits where they were eligible to take part, for example the stroke and diabetes audit. Recent national audits indicated that there had been positive progress made to improve care for people who had a heart attack, stroke or heart failure.

- Patient's pain relief was monitored effectively.

- Nutrition and hydration assessments were completed and patients requiring assistance were supported. Patients with swallowing difficulties on the stroke ward had their needs and requirements assessed in a timely manner.

- Staff were supported and had received their annual appraisal.

- Staff on specialist wards had completed specific competencies to deliver safe and effective care and treatment.

- The endoscopy unit had been formally recognised that it had competence to deliver against the measures in the endoscopy GRS standards and has received JAG accreditation in 2010.

- There was good collaborative working across medical services with focus on discharge planning.

- There was evidence that most services were delivering or working towards a seven days a week.

- We found senior staff had a good understanding and awareness of assessing people's capacity to make decisions about their care and treatment and they would carry out the assessments.

- Junior staff had basic understanding of the Mental Capacity Act and processes in place.

however,

- Mental Capacity Act training across medical services was well below the trust target

Evidence-based care and treatment

- Medical services were using national and best practice guidelines to care for and treat patients, for example diabetes care and nutritional screening. The trust monitored compliance with NICE guidance and were taking steps to improve compliance where further actions had been identified.

- The trust took part in a regional advancing quality audit programme aimed to improve standards of healthcare provided in hospitals across the northwest of England, so that more patients had a better outcome from their treatments and care. Hospitals who participate in this programme collect data to see whether the required standards of care have been met, for example whether the correct assessment and treatment was provided at the right time.

- Medical services participated in clinical audits for which it was eligible through the advancing quality programme. In March 2015, audits demonstrated the trust was not meeting the appropriate target in some areas including chronic obstructive pulmonary disease. The service had actions plans in place, which had improved performance

- There were examples of recent local audits that had been completed on the wards, including the care

metrics monthly audit. The results were shared on the ward noticeboard, staff told us the results of the audits, and any learning was disseminated in team meetings. We observed this on the minutes of a team meeting.

- Medical services participated in the joint advisory group on GI endoscopy (JAG) and received JAG accreditation for the endoscopy unit in 2010. The unit was due to be re-accredited in March 2016. JAG accreditation ensures the quality and safety of patient care by defining and maintaining the standards by which endoscopy is practiced.

- Guidelines and polices were available on the trust intranet. Staff were aware of how to access guidelines and policies on the trust intranet and in ward areas. Staff had access to previous audits and findings, which were also discussed and recorded as part of ward minutes

- A monthly audit of VTE assessments showed that VTE assessments were consistently above the trust target of 95 % from October 2014 to 0ctober 2015.

Pain relief

- Pain was assessed using a pain tool and pain relief was managed on an individual basis. This was regularly monitored for efficacy. Patients said they were consistently asked about their pain and supported to manage it.

- We saw completed pain assessments in patient's records.

Nutrition and hydration

- Nutritional risk assessments (MUST) were completed in all of the patient's records we reviewed.

- Patients who could not maintain adequate nutrition with oral intake were supported via a percutaneous endoscopic gastrostomy (PEG). Staff were trained in providing adequate nutrition using PEG administration.

- Dieticians and speech and language therapists were available on weekdays across the trust and staff knew how to access the services. Patients requiring urgent dietician support were seen promptly.

- Qualified staff on the stroke ward were trained in performing swallowing assessments. This ensured patients were assessed in a timely manner and could commence on diet and fluids at the earliest opportunity.

- During our inspection, we observed patients being offered and provided with drinks and food including finger food, which supported nutritional intake. Drinks were within reach of patients. We saw staff assisting patients to eat and drink whilst promoting compassion, dignity and independence.

- Catering services provided patients who lived alone with food to take home on discharge.

- Some ward areas used additional visual prompts for staff in order to easily identify those patients who may need additional support with eating and drinking.

Patient outcomes

- The risk of readmission across the hospital for all elective and non-elective admissions was generally lower than the England average of 100 however there was increased risk of readmission in elective clinical haematology of 136, respiratory medicine of 128 and non-elective geriatric medicine of 111.

- The average length of stay (LOS) at the Countess of Chester hospital for all non-elective and elective admissions was longer than the England average aside from cardiology, which was six days shorter.

- The trust took part in the National Diabetes Inpatient Audit in September 2015. Data showed that there was a higher diabetes prevalence of 38% compared to a national average of 17%. The trust performed within range for four indicators and better than the England average in 14 out of 18 indicators, for example diabetic foot assessment within 24 hours (69%) compared to the England average (29%) and patients admitted with active foot disease who were seen by the multi-disciplinary team within 24hrs (93%) compared to and England average of 58%. Emergency admissions for patient with diabetes was slightly higher (88%) compared to an England average (86%) and patients with active foot disease were more likely to be admitted than the national average.

- The sentinel stroke national audit programme (SSNAP) is a programme of work that aims to improve the

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quality of stroke care by auditing stroke services against evidence-based standards. The latest audit results for April to June 2015 rated the hospital overall as a grade 'A'. This had improved from a grade 'D' in July – December 2014 with particularly good performances in discharge processes.

- The trust implemented actions in 2014 following the National Clinical Audit and Patient Outcomes Programme 'NCAPOP' included appointing a cardiology specialist nurse, redrafting of the category two chest pain pathway and redefining the acute medical ward with cardiology monitored beds which was proven effective as demonstrated in the MINAP results.

- The myocardial ischaemia national audit project (MINAP) is a national clinical audit of the management of heart attacks. The MINAP audit 2013/14 showed that the trust was higher than average for two of the three Nstemi indicators.

- The heart failure audit in 2015 showed the trust is better than the England average for all in hospital and discharge indicators apart from cardiology follow-up.

- The Summary Hospital-level Mortality Indicator (SHMI) is an indicator, which reports on mortality at trust level across the NHS in England using a standard and transparent methodology. Between August 2014 and July 2015, the SHMI score for the Countess of Chester hospital was 103.The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die based on average England figures, given the characteristics of the patients treated at the hospital. Risk is the ratio between the actual and expected number of adverse outcomes.A score of 100 would mean that the number of adverse outcomes is as expected compared to England.A score of more than 100 means more adverse (worse) outcomes than expected.

Competent staff.

- According to trust figures in January 2016 over 98 % of allied health professionals, nurses and medical staff across medical services had received their annual appraisal.

- All new nurses on the wards we visited were supernumerary for the first two weeks. The purpose of clinical supervision is to provide a safe and confidential environment for staff to reflect on and discuss their work and their personal and professional responses to their work. The focus is on supporting staff in their personal and professional development and in reflecting on their practice to encourage improvement.

- Staff across medical services had completed specific competencies to deliver care within their specialised service for example on the respiratory ward staff were trained in caring for patients with tracheostomies, pleural suction and non-invasive ventilation which meant that all patient's with tracheostomies were cared for in a safe environment.

- The ward manager told us nurses on the renal unit were also specialist link nurses for transplantation, anaemia, diabetes and home care.

- Some staff on the endoscopy unit had completed gastrointestinal nurse training packs and had received training in ionising radiation (Medical exposure). The unit had four nurse prescribers and health care assistants who could cannulate. Some nurses on the endoscopy unit were trained up to undertake endoscopy procedures.

- In response to the change in the NMC revalidation process in April 2016 the trust had formulated a revalidation group, facilitated awareness sessions and identified staffs revalidation dates to ascertain which group would require support first. An action plan was devised and we saw it had been updated when actions completed.

Multidisciplinary working

- Multidisciplinary team (MDT) was well established on the wards with patients having input from a range of allied healthcare professionals (AHP) including Occupational, physio and speech and language specialist. Plans of care would be available to staff to review patients goals.

- There was a cohesive and thorough approach to assessing the range of people's needs, setting individual goals and providing patient centred care. Nursing staff worked alongside therapy staff to provide

a multidisciplinary approach. For example, the critical care outreach team worked closely and provided support to staff on the respiratory support unit and AMU. All staff we spoke to described good collaborative working practices.

- The respiratory early discharge team consisted of nurses and physio who supported and managed patients with the aim to keep them at home for example taking arterial blood gases, home oxygen and nebuliser.

- There were specialist teams, which could be accessed for support, advice and provide joint patient care including the tissue viability team, diabetes and cardiac rehab team.

- MDT meetings took place every day Monday to Friday to discuss patients on the frailty ward who were potentially for discharge along with any ongoing or new concerns that required actions.

- We observed a MDT, which was led by a geriatrician and included AHP, rapid response team, dementia nurses and social work team handovers. Staff had good understanding and awareness of patients and the meeting was structured with effective communication and planning. Actions were agreed and designated to the appropriate individual

- Daily ward meetings were held on the wards we visited. They reviewed discharge planning and confirmed actions for those people who had complex factors affecting their discharge. On the stroke ward they would daily identify which patients could be stepped down from an acute bed to a rehab bed, this promoted flow of patient's requiring intensive stroke therapy.

- Senior nursing and medical staff would meet at 9pm every day to handover patients including those at risk or deteriorating, determine priorities capacity and demand.

Seven day services.

- Not all services were providing a seven-day service including the endoscopy unit, which was open Monday to Friday, and the renal unit, which delivered

a satellite service Monday to Saturday. However, staff on the endoscopy unit told us that there were plans to increase the service to 24 hours a day seven days a week along with increasing bed numbers.

- Consultant cover was available seven days a week with on call cover overnight.

- There was a designated clinical coordinator on duty seven days a week who supported nurses and managed any issues at the hospital. A senior manager was also on call overnight.

- The bed management team worked 24 hours a day, seven days a week and who supported staff in ensuring that patients were placed on the most appropriate ward to meet their needs.

- The discharge lounge was not open at weekends and therefore patients awaiting transport or medication to take home would wait on the ward.

- Patients on the stroke ward had access to stroke co coordinators every day from 8am until 8pm along with daily rehabilitation therapy.

- Patients on the frailty ward had access to rehabilitation therapist seven days a week.

Access to information

- On discharge from the endoscopy unit, patients would be provided with advice and instruction leaflet following their procedure; in addition, they would also receive a copy of their report, which included medication received and results of procedure. A copy would also be sent to their GP.

- Staff had access to information they needed to deliver effective care and treatment to patients. All staff we spoke to were aware they could easily access to Trust information including policies, procedures and on the ward computers.

- There were computers available, which gave staff access to patient and trust information.

- On the wards, files which included minutes to team meetings and previous audits were available to staff and staff were encouraged to read them.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Medical care (including older people's care)

- Data provided by the trust stated that those staff that required mental capacity act training were below the trust target of 80% with registered nurses 61.8 % and medical staff with 35.4 % compliance. However, additional professional scientific and technical staff who were 100%.

- Senior Staff on the wards had good understanding of safeguarding and the key principles of the Mental Capacity Act (2005), restraint and how these applied to patient care was basic on the wards we visited.

- Senior staff had knowledge and understanding of the procedures relating to the Deprivation of Liberty Safeguards (DOLS). DOLS are part of the Mental Capacity Act (2005). They aim to make sure that people in hospital are looked after in a way that does not inappropriately restrict their freedom and are only done when it is in the best interest of the person and there is no other way to look after them. This includes people who may lack capacity. Senior Staff would complete all assessments as required.

- Junior staff had basic knowledge regarding Mental Capacity Act (2005), restraint and Deprivation of liberty Safeguarding and understood when to escalate concerns to senior staff.

Are medical care services caring?

Good ●

We rated caring as good because:

- Patients told us staff were caring, kind and respected their wishes.

- We observed positive patient centred interactions with patients.

- Patients received compassionate care and their privacy and dignity was maintained.

- Both patients and relatives were complimentary about the staff that cared for them and told us they were involved in their care and were provided with appropriate emotional support.

- Provisions were made for carers and staff encouraged them to be integrated as part of the team. Chaplaincy services were available throughout the hospital for patients, relatives and staff.

Compassionate care

- During our inspection we observed patients being cared for with dignity, respect and kindness with privacy maintained at all times. The majority of patients who were at their bedside or in bed had access to call bells and staff responded promptly.

- All the patients we spoke with were positive about their care and treatment. Comments included ''the nurses are fantastic, nothing is too much trouble''. Patients said that staff always introduced themselves and they were aware who was caring from them.

- The Friends and Family test (FFT) average response rate for the Countess of Chester hospital was 39% which higher than the England average

- The NHS Friends and Family test (FFT) asks patients how likely they are to recommend a hospital after treatment. Between August 2014 and July 2015, five medical wards scored above 88%. The gastroenterology ward scored 100% on nine occasions, ward 51 scored 100% on four occasions, respiratory ward scored 100% on three occasions and the coronary care unit scored 100% on 10 occasions, which indicated that patients were positive about their experience.

- In the cancer patient experience, survey the trust sored in the middle 20% for 16 out of the 34 questions. The trust scored in the bottom 20% for staff telling patients they could get free prescriptions.

- The trust performed about the same as similar trusts in all areas of the 2014 CQC inpatient survey.

Understanding and involvement of patients and those close to them.

- Patients and those close to them told us that clinical staff were approachable and noted that although the staff were busy they would always try to take the time to talk to them when they needed to.

- All patients we spoke with said they had received ongoing clear information about their condition and treatment.

Medical care (including older people's care)

- Relatives we spoke to said they were well informed of patient's condition and plan of care. We saw evidence in patient's records that relatives were kept informed of patient's condition.

- Patients with learning disabilities were encouraged to visit and have a tour of the endoscopy unit prior to admission or their carers could attend and take photographs of the unit to share with and minimise stress to the patient's.

- Passes were provided to carers of patients with learning disabilities or dementia, this ensured all staff were aware of who they were and staff told us they liked to integrate carers as part of the team. The pass also allowed for subsidised meals at the hospital canteen. In a carer's survey in 2015, 88% of carers felt supported by the care and information the hospital gave them whilst their relative/friend was an inpatient.

Emotional support

- At the Countess of Chester hospital there was a chaplaincy team available 24 hours a day, seven days a week. The team consisted of one full time and three part time chaplains and 50 volunteers, including catholic and protestant. Leaders of other faiths could be contacted if required. Staff would visits wards and offer support as required and would take patients to Holy Communion at the Spiritual Care Centre on a Sunday.

- There was a Spiritual Care Centre which was accessible to patients, relatives and staff of all faith and no faith. Regular Christian prayers were held along with meditation classes led by a Buddhist monk. Facilities included prayer mats and hand washing facilities for Muslims.

- Visiting times met the needs of the relatives we spoke too. Open visiting times were available if patients needed support from relatives.

- On the endoscopy unit and cardiac catheterisation suite there was a consulting room, which could be used to discuss results, and patients had access to a bereavement nurse specialist if required.

- On the endoscopy unit, family and friends could wait in the separate waiting area however, staff were aware of the positive impact of having carers present for those with additional needs. Carers were allowed to stay with the patient throughout the process if this was the patient's choice.

Are medical care services responsive?

Requires improvement ●

We rated responsive as requires improvement because:

- There were on going issues with access and flow of patients across medical services mainly due to high occupancy rates and difficulties in discharging medically optimised patients due to limited provisions in primary care.
  - Across medical services, there was a high bed occupancy rate, which also impacted on the amount of outliers on other wards.

- There was a number of patients who were being cared for in non-speciality beds some of these patients were acutely ill and not medically stable therefore not in line with the trust flow policy.

- The trust had enrolled in the dementia friendly charter however; they were not consistently meeting all people's needs as the dementia services were not accessible to all patients and staff on all the wards.
- The ward environment were not dementia friendly throughout although staff implemented the 'this is me' for patients. People with dementia were highlighted on the electronic patient record.
- There were mixed sex breaches on specialised wards such as the stroke and respiratory support unit. We were informed this mainly due to clinical reasons where the patient could not be cared for or managed safely on an alternative ward.

However,

- The discharge to assess project was implemented to help reduce the acute hospitalisation time of elderly patients.

- Regular meetings were held by senior staff to try to mitigate pressures and the trust had implemented new ways of working to help facilitate flow and patients discharges.

Medical care (including older people's care)

- Escalation beds were used across the trust to help with the volume of patients including eight on ward seven beds on the acute medical unit.

- The trust had a team, which managed complaints although not all complaints were responded to within the trust target. There were clear visible notice boards and leaflets around the hospital with contact numbers, advice for anyone who had any concerns or complaints.

Service planning and delivery to meet the needs of local people.

- The trust were working with commissioners in planning and delivering services to meet the needs of the local population including the 'west Cheshire way' and the 'model hospital'. Medical services were involved several service development and transformational initiatives jointly with the clinical commissioning group (CCG) such as respiratory, stroke, heart failure and frailty services.

- The premises and facilities on the endoscopy unit and decontamination unit were appropriate for the services that were planned and delivered.

- Staff told us that patients who lived in England could access dementia services at the hospital however; those patients from Wales were referred via the electronic system to psychiatric services for support. This was being reviewed by the trust at the time of inspection.

- The facilities and premises were not all appropriate for patients with dementia for example there was no designated ward that had been adapted to have a dementia friendly environment or any kind of reminiscence room.

Access and flow

- Medical services met the national 18-week referral to treatment time targets in all specialities from September 2014 to September 2015. All specialities achieved 100% compliance apart from gastroenterology who achieved 99.7% from March to September 2015.

- Trust-wide performance for the average length of stay for all elective and non-elective admissions was longer than the England average apart from elective cardiology, which was six days shorter.

- A teleconference call regarding patient activity and bed status at the trust was held daily with the clinical

commissioning groups (CCG). Actions would be agreed and assigned to an appropriate person. CCG would disseminate this information to services in primary care including General Practitioners at times of escalation..

- The trust had a patient flow policy, which provided clear guidelines to staff including the site co-ordinator team to follow in responding to capacity and demand. The policy included allocation, clarification of roles and responsibilities in the process. Senior managers we spoke to had good knowledge and understanding of the policy.

- Between April 2014 and March 2015, the occupancy rate at the hospital was between 94.2% and 99.9%. It is generally accepted that, when occupancy rates rise above 85%, it may affect the quality of care provided to patients and the orderly running of the hospital.

- Trust data showed that at there were eight escalation beds on ward 51 and seven on the acute medical unit. During our inspection, staff on AMU told us there were seven escalation beds on the ward, which had not closed for the past 15 months. According to the 'flow policy', beds on AMU should only be used once all capacity has been filled.

- Data showed that during 1st May to 31st October 2015 10% of patients across medical services had more than one ward move during their stay. It was unclear how many patients were moved at night as the trust stated there was no administration staff to collate this information.

- Staff on the respiratory support unit, AMU and stroke ward told us there had been mixed sex breaches due to 'clinical need'. However, data provided by the trust shows in October 2015 there was a breach on the stroke ward, which was not clinically justified. The patient was moved six hours later. There were no breaches in November 2015.

- On the acute stroke ward, there had been nine breaches in January 2016 and eight were reported so far for February. Staff told us they were all due to clinical need and all the patients in the bay had been given an explanation for this happening. Staff would promote dignity and respect for example keep curtains partially closed. Senior staff told us bed breaches were communicated at bed meetings, monitored closely and patients would be moved within 24 hours.

- Information provided by the trust showed there were a large number of patients being cared for in non-speciality beds, which may not be best suited to

Medical care (including older people's care)

meet their needs (also known as outliers). The patient flow policy states 'outliers' should be patients with an imminent discharge date (preferably within 24-48 hours) whose clinical state is not likely to be adversely affected by ward transfer. Data showed in August 2015 there were 34 patients in the month, which increased to 120 in September 2015, and 130 in October at the hospital. We observed that this included those patients that were supported in escalation beds within Urgent Care.

- The number of outliers was visible on the electronic system for all staff. Senior staff including consultants and bed managers reviewed and monitored these patients daily and completed risk assessments.

- During the inspection, we reviewed the records for nine medical patients who were outliers on the surgical wards, and found they had been seen daily by a member of the medical team. Wards that had outlying patients had contact arrangements for the relevant speciality teams in and out of hours.

- In March 2015, the trust introduced pilot in which GP's could talk directly with the physician to discuss potential medical admissions prior to directing the patient to hospital. This has been successful in helping to manage patient flow and this is now a permanent arrangement from November 2015.

- To assist with the access and flow of patient's two extra consultants and two nurse practitioners were employed to work at weekends to respond to the high demand, review patient's and facilitate discharge. Transport home was also provided over the weekend to assist in patient discharge.

- The trust had implemented the discharge to assess project to reduce unnecessary prolonged acute hospital stay for the elderly and give patients the opportunity for further rehabilitation in a 24-hour care environment with the plan to discharge home. In 2015, the acute frailty ward was opened at the hospital and 16 'discharge to access' beds were opened at Ellesmere Port hospital.

- The target length of stay on the frailty ward was 72 hours and patients were referred to the discharge liaison team on admission. Trust data shows the average length of stay on the ward was between 5 to 10 days with 20 -27% of patients being discharged within 72 hours. Staff told us patients would stay in longer due to delays in primary care. Data provided by the trust shows that 89-97% of patients were discharged under 21 days.

- At the time of our inspection on ward 51 there were 19 patients' out of 28 who were medically fit and awaiting discharge. On our unannounced inspection 0n 04/03/2016 there were 14 patients out of 26 who were medically optimised, two of whom were still awaiting discharge since our last inspection.

- During our inspection on 04/03/2016 staff told us, the frailty consultant had started to go to ED /EAU and triage patients to help to improve patient flow. The previous day the consultant had triaged 11 elderly patients and was able to send nine home and two were admitted to ward 51.

- The discharge team reviewed patients daily to identify who was suitable for discharge and implemented plans for discharge. Staff across medical services told us there were issues with the flow of patients, which was mainly due to difficulties in discharging patients who were medically fit. Data from April 2013 to April 2015 showed that the highest reasons patients were not discharged at the hospital was due to patient or family choice (32.6%), awaiting nursing home placement (20.4%) and waiting further NHS non-acute care (19.1%).

- Trust data showed that at the time of inspection there were 70 patients across medical services that were medically optimised, of those 16 were awaiting a transfer of care. Staff on one ward told us a patient had been waiting over three weeks for a specialist placement in an elderly mental health home.

- The hospital held bed management meetings regularly throughout the day during the week to review and plan bed capacity and respond to acute bed availability pressures. A report of the trust patient activity was sent out to all members of staff to keep them informed.

- Senior nurses met weekdays with the divisional leads and discussed any issues including staffing and sickness.MDT meetings which included senior managers were held every Friday to discuss plans to help mitigate problems that could arise at the weekend for example staff sickness. These plans were clearly documented for the clinical site co coordinator covering the weekend to follow.

Meeting people's individual needs

- Volunteers were available at the front desk of the hospital to assist in patients, friends and family find specific locations.

Medical care (including older people's care)

- There was a diabetic specialist medical and nursing team along with a diabetic pharmacist available to all patients across the trust. Staff we spoke to were aware referrals could be made through the patient electric record.
- There was a red flag on the electronic patient record for patients with dementia and learning disabilities (LD). This would act as a reminder to staff to make reasonable adjustments for example patient be placed in a quiet area or in a side rooms and to ensure health passports were in place to help determine specific needs of the patient. Staff had access to a LD coordinator if support was required. Staff on one of the wards showed us an assessment tool, which is being piloted along with RA sign that would go on the board at the back of the patient's bed.
- The Trust used three NHS Framework approved interpretation and translation provider organisations: Deafness Support Network, Language Line Solutions Ltd and Manchester Council: M4 Translations and staff knew how to access these services,
- Data provided stated that staff would make reasonable adjustments for blind and deaf patients. Documentation was accessible in electronic format along with text and email messaging to support their assessment. During a forum meeting it as confirmed that staff on a ward had arranged for British Sign Language interpreters to support effective communication for a patient and their partner.
- In September 2015 the trust had signed up to the dementia friendly charter which aimed to create dementia friendly hospitals for people living with dementia and their carers for example signage that uses pictures and text which is hung at a height it can be seen and having a dementia lead and champions. Trust data showed that over 5000 people had attended the Dementia awareness sessions, which incorporates dementia friends. During our inspection, we noted yellow signs with black writing stating each specific area on the corridors of the hospital however, they did not state the ward name or number this could add confusion to locating a specific place.
- Access to the Dementia team was limited as they were not accessible across the trust for all patients, only patients on designated wards. During our inspection, the ward manager on the cardiology ward told us there was a dementia patient but the patient or staff could not access the service.

- On the frailty ward, we observed 'forget –me- not 'stickers on patient's boards. This was a discreet flower symbol used as a visual reminder to staff that patients were living with dementia or were confused. This was to ensure that patients received appropriate care, reducing the stress for the patient and increasing safety.
- The trust used the 'this is me' documentation for carers to record information about patients living with dementia or a learning disability. This ensured that staff knew the patients' likes, dislikes, and ensured their needs were met. Staff on the stroke ward told us this was effective and was also used this for patients who had difficulty expressing themselves due to speech problems.
- Information for patients about services and care they received could be accessed via the trust intranet. We did observed information boards and a selection of leaflets visible on the wards. There was a limited accessible format those whose first language was not English. Staff told us they gave information leaflets to patients to help and educate them about procedures or conditions.
- There was a wide range of specialist nurses and teams for example alcohol liaison service, cardiac rehab and heart failure nurse who offered specialist advice to staff caring for people with these conditions. Staff told us they knew how to contact these specialists and felt supported by them.

Learning from complaints and concerns.

- The trust had complaints and PALS team who were responsible for the day-to-day management of complaints. These were recorded electronically on the trust-wide system.
- Patients and relatives could raise concerns in various ways including email, in writing, in person or over the phone. Staff told us patients were given the complaints /PALS leaflet on admission to hospital and we observed complaint and PALS information and leaflets available around the hospital.
- Complaints were discussed at governance meetings across the trust including monthly divisional board meetings, patient experience operational group meeting and the quality safety patient experience committee. Lessons learned and common trends and themes would be identified.
- The trust told us they aimed to acknowledge all formal complaints within three working days and responded to

formal complaints within an agreed timescale. In 2014-15, the trust acknowledged 93% of all formal complaints within three working days, and responded to 69% of all complaints with the agreed timescale.

- Data showed that between December 2014 and November 2015 there had been 222 complaints raised across the trust, of those 37 were regarding medical services. The highest proportion of complaints related to all aspects of clinical care. All patients and relatives we spoke with told us they were happy with all care provided.

- Staff understood the process for receiving and handling complaints and were able to give examples of how they would deal with a complaint effectively. Staff shared an example of learning from a complaint in which a patient had complained about meals times being too late. As a result, patients were served tea at an earlier time of 5pm, which also meant staff told us more staff were available at this time to assist patients.

- Senior staff told us patients were asked on ward rounds if they have any issues they wish to discuss.

Are medical care services well-led?

Good ⬤

We rated well-led as good because:

- Medical services were well led with evidence of effective communication within teams.

- The visibility of senior management was good and there was strategy with actions, which most staff were clear about.

- Risk registers were in place and although we could not see any documented plan of actions or if the risks were reviewed at meetings, however key risks reflected trust wide initiatives in place to mitigate risks.

- Medical services captured views of people who used the services with learning highlighted to make changes to the care provided.

- Staff knew how their ward performed and worked collaboratively to make positive changes.

- There was good staff engagement with staff were involved in making improvements for services. All staff were committed to delivering good, compassionate care and were motivated to work at the hospital.

Vision and strategy for this service

- Values and behaviours demonstrated by ward staff included putting patients at the heart of everything they do, to have a 'can do' attitude, have pride in the service they provided, strive for improvement, to be welcoming, friendly, caring and respect each other.

- The trust had a five-year strategy plan (2014-2019) to deliver high quality care, which consisted of three programs: West Cheshire way, integrating specialist services and Countess 20:20. Objectives included providing the right services to meet the quality standards, clinical outcomes along with needs and expectations of patients, promoting sustainable partnerships and promoting integrated services. The plans also identified operational and strategic risks and actions to be taken.

- Staff we spoke to were aware of the values and strategic plan however, some staff told us they were unclear how this would affect them.

Governance, risk management and quality measurement

- There was ward level, divisional and corporate risk registers across the trust.

- Staff at all levels knew that there was a risk register and senior managers were able to tell us what the key risks were for their area of responsibility.

- Each risk had the date the issue was raised, the review date and assigned person to deal with it. No plans of actions were recorded through the urgent care division, however key risks reflected trust wide initiatives in place to mitigate risks and plans were in place to develop action plan processes which included a narrative of how the risk was being managed.

- There was a clear governance reporting structure in medical services. It was clear from the minutes we reviewed discussion had taken regarding incidents, complaints and performance. It was also apparent that learning was shared.

Medical care (including older people's care)

- Regular meetings were held with senior staff and management to discuss issues arising and mitigate risk at the earliest opportunity.

Leadership of service

- Staff could explain the leadership structure within the trust and the executive team were accessible and approachable.

- All staff said the team leads and ward managers were supportive regarding any issues on the ward. The ward manager's told us they had access to leadership and management training.

- 30% of staff who participated in the NHS staff survey reported good communication from senior management to staff; this was higher than the 2015 national average of 32%.

- Doctors told us that senior medical staff were accessible and they received good support.

- We observed positive working relationships within all teams. Staff we spoke to said they had received their annual appraisal.

Culture within the service

- The trust supported the 'speak out safely' campaign and encouraged all staff to raise any concerns about patient safety.

- This was also accessible on the hospitals intranet site with links to the 'Speak Out Safely' (Raising Concerns About Patient Care) and the 'Whistle Blowing Policy'. Ward staff were aware of these initiatives and said they would feel comfortable accessing them.

- Staff said they felt supported and able to speak up if they had concerns. They said that morale fluctuated but was overall good across medical services and staff felt proud of what they do.

- In the 2015 staff survey staff who felt motivated at work scored 3.89, which is higher than the national average score of 3.87. The number of staff felt secure when reporting unsafe clinical practice was 3.65, which was higher than the national average score of 3.62.

Public engagement

- Patients on medical wards were encouraged and had access to various opportunities to give feedback about their care or experience at the hospital for example on the bedside TV screens, friends and family test, inpatient experience survey and via social media, all of which could be accessed via the hospitals website.

- Feedback from patients was collated at departmental level. This was discussed with staff at meetings, and actions were taken to improve patient experience.

- In 2015, the trust attended health and well-being forums, which gave members of the DSN, Lesbian, Gay, Bisexual, and Transsexual people and the Older People Network an opportunity to give feedback to the trust about their care and experiences along with any recommendations they had.

Staff engagement

- Some staff told us the executive team would walk around and visit the wards on the first of every month. All staff we spoke to recall the chief executive visiting the wards on New Year's Day.

- Staff told us they received weekly newsletter from the trust via email, which kept them up to date with current or ongoing issues and information.

- The trust celebrated the achievements of staff at an annual event. At the last event, medical services were winners of awards including the stroke and dementia team who won the Partnership award.

- This hospital participated in the NHS friends and family test giving staff the opportunity to speak out about their place of work. In September 2015 of staff would recommend this hospital to friends and family in need of care /treatment and 88% would recommend it as place to work to friends and family. Results were discussed at departmental level and some wards were involved in a pilot scheme to understand findings at a local level.

- Following the survey the trust in 2015 produced 'who cares, we do' and 'you said, we listened' report which gave a brief summary of the results and actions going to be taken by the trust.

Innovation, improvement and sustainability

Medical care (including older people's care)

- The Stroke service was recently awarded Innovative Team of the Year 2015 by North West Coast Research and Innovation Awards for the work the team had undertaken to develop a robust auditing tool.

- To meet the needs of the increasing elderly population and to assist in patient flow the trust had introduced the GP to clinician screen and is working collaboratively with other agencies in delivering the discharge to assess (DTA) project which included introduction of frailty ward at the hospital and the GP led ward at Ellesmere port hospital.

- Staff on AMU ward had participated in events such as zip wire and fell running to raise funds for a room on the ward to be converted to a relative's room with a bed. The fundraising was on going at the time of inspection with a curry night planned.

- Ward areas were rolling out care and comfort worker roles to work across the wards to assist patients with nutrition and hydration feeding, and any other basic assistance including getting newspapers.

Surgery

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

Information about the service

The Countess of Chester Hospital carries out a range of emergency and planned surgical services including urology, ophthalmology, orthopaedics and general surgery. There are seven surgical wards and 15 theatres including designated day case and gynaelogical theatres; that carry out emergency and elective procedures including day case procedures.

Data provided by the surgical services showed that 30,742 patients were admitted for surgical care between July 2014 and June 2015 at the Countess of Chester Hospital. The data showed that 67% of patients had day case procedures, 14% had elective (planned) surgery and 20% required emergency surgery.

As part of the inspection we visited the main theatre areas including the recovery area, observed parts of four operations and we visited six inpatient surgical wards and the Jubilee day surgery unit. We observed three scheduled theatre briefing meetings, one nursing handover and one medical handover.

We spoke with 14 patients and observed care and treatment. We reviewed 18 care records and spoke with 38 staff members of different grades and specialities including nurses, doctors, ward managers, a clinical director, a divisional director, theatre manager head of nursing and matrons.

Summary of findings

We found that the Countess of Chester Hospital was providing a good service overall to the patients accessing their surgical services because:

- We found that staff were aware of how to report incidents and we saw evidence that the service undertook robust and appropriate incident investigations.

- The uptake levels of mandatory training were high for both nursing and medical staff.

- Staff were fully aware of how to raise and manage safeguarding issues appropriately.

- Staff managed medicines well and nurse staffing levels in the theatre areas were sufficient.

- Patients received surgical care which was evidence based and met national guidelines.

- Clinical audits were routinely undertaken and action as a result of these was evident.

- Patients were assessed and provided with appropriate pain relief.

- Knowledge of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards was good in most areas.

- Staff treated patients with kindness, dignity and respect and patients told us that they were happy with the care they received.

Surgery

- The surgical services were responsive to the needs of patients.

- Information was readily available for patients in a variety of formats, which could be adapted to individual needs.

- Patients had timely access to consultant led care.

- The service was well led and staff respected their local leaders.

- There were robust governance frameworks and managers were clear about their roles and responsibilities. There was clear leadership in the service and senior managers were visible and approachable.

- We found the culture within the service was open and managers made efforts to engage with staff and the public.

However:

- In some areas we found that the learning from these investigations was not disseminated fully.

- We found that Nurse staffing levels on the surgical wards were not always sufficient to meet patient needs.

- The access and flow within the surgical services was challenging at times, however staff managed this effectively.

- Staff could not articulate the trusts vision and values; however they were aware of significant work programmes taking place.

Are surgery services safe?

Requires improvement ●

Summary

We found that surgical services at the Countess of Chester Hospital required improvement in relation to safety because:

- Feedback from incidents was not consistent on an individual staff basis.

- Learning from serious incidents and never events was not always disseminated to all areas. Which increased the risk of a reoccurrence.
  Most staff did not display an understanding of duty of candour.

- Training levels for level 2 safeguarding adults, were lower than the trust target of 80% for both medical and nursing staff and only 33% of medical staff who required level 3 safeguarding adults training had completed this training.

- There were no curtain changing schedules in the surgical wards or the jubilee day surgery unit. When asked; one senior sister told us that they did not know how long the curtains had been in situ and could not recall the last time that they were changed.

- We found some theatre areas to be dusty and there were a large number of free standing medical gas cylinders which posed a risk of injury.

- We also found that three trolleys in the main theatre areas which were found to be rusty.

- We found that medications were sometimes pre drawn into syringes in the theatre areas. This posed a risk of these medications being administered incorrectly as they were not labelled.

- We also found that some medications were stored in an unlocked cupboard and fridge in a day surgery unit.

- Bank and agency staff were not always able to use the electronic records system. Staff told us that this put additional pressure on permanent staff.

- We found that the 'five steps to safer surgery' procedures, including the use of the World Health

Surgery

Organization (WHO) checklist were not always followed in the day surgery theatre areas. The WHO checklist is an international tool developed to help prevent the risk of avoidable harm and errors before during and after surgery.

- We found that the surgical ward areas were frequently short staffed and that for six out of seven surgical wards over a two month period there were less than 90% of the registered nursing staff required on duty.

However:

- We saw evidence that the service had responded and learned from adverse incidents in some areas.
- The service collected and displayed safety thermometer data and rates of avoidable harm were within national averages.
- The uptake levels of mandatory training were high for both nursing and medical staff.
- Staff were aware of how to raise and manage safeguarding issues.
- Infection rates were low within the surgical services and staff observed appropriate measures to protect patients from avoidable infections.
- The environment and equipment were suitable for providing patient care and equipment was well maintained.
- Nurse staffing levels in the theatre areas were sufficient and there was evidence of planning to meet the demands of the service.
- Medical staffing was sufficient and patients had access to suitably qualified doctors when required.
- Staff were aware of the trusts major incident policy and were able to show us a folder which contained details on what staff were to do in the event of a major incident.

Incidents

- There was an electronic incident reporting system in place which was available to all staff. When staff did report incidents, managers reviewed them and took appropriate responsive actions. We saw evidence of this in the reviews we undertook of incident reports. All staff told us they did not always receive feedback from incidents that they had raised on an individual basis.

- Staff reported 2040 incidents across surgical services between 1st December 2014 and 30th November 2015. 49 of these incidents were assessed as requiring further investigation which was undertaken by the trust in all cases.
- There were 16 serious incidents reported between October 2014 and September 2015.
- Of these 16 serious incidents three were categorised as never events between January 2014 and March 2015. Never events are serious, wholly preventable patient safety incidents that should not occur if the available preventative measures are in place. In response to these incidents, the trust had undertaken root cause analysis (RCA) reviews. These reviews were thorough and robust however key areas of learning had not been disseminated to staff in some of the areas affected.
- One example of this was in relation to the learning from two incidents relating to incorrect tooth extraction. These incidents occurred in the theatre area of the day surgery unit. When we spoke with four staff in the day surgery unit at registered nurse and sister level, two staff told us that they were aware of an incident but did not know the details or the learning from this incident. Two of the four staff told us that they were not aware of any never event incidents and had not been informed of any lessons learned as a result of these incidents.
- Staff were unable to tell us of recent examples where they had improved their practice because of an investigation.
- One of eight staff were able to demonstrate an understanding of duty of candour. Seven out of eight staff were unable to demonstrate an understanding in this area.
- Staff were aware of the types of incident they should report and were able to give us examples of incidents they would need to report such as pressure ulcers and patient falls. We found one example where a patient had developed a pressure ulcer and this had not been reported. The patient had not been informed of the ulcer and a timely apology had not been provided.

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), was monitored on a monthly basis.

- The service was recording and monitoring data in line with this initiative. Ward areas displayed this data for staff and members of the public to view.

- Safety Thermometer information between September 2014 and September 2015 showed that the service performed within the expected national range for falls with harm, catheter urinary tract infections and pressure ulcers.

Mandatory training

- Uptake levels of mandatory training were high.98% of nursing staff and 100% of medical staff had undertaken their mandatory core induction training which contained subjects such as fire safety and infection control and prevention. This was above the trusts target of 95%.93% of nursing staff and 100% of medical staff had also completed the full day mandatory training course. This was a one day course which encompassed all mandatory training subjects including infection control and fire safety.

- Staff told us that they were offered mandatory training but this was sometimes cancelled due to staffing pressures on the wards. Managers on the surgical wards and in the theatre areas monitored rates of mandatory training and prompted staff to undertake training when it was due.

Safeguarding

- The trust had safeguarding policies and procedures in place. Staff were aware of how to refer a safeguarding issue to protect adults and children from suspected abuse. Staff showed us how they would access the trust intranet page relating to safeguarding. The trust had an internal safeguarding team who could provide guidance and support to staff in all areas on safeguarding matters.There were visible signs around the ward and theatre areas displaying the contact details for the safeguarding team.

- Training data provided by the trust in relation to safeguarding showed that 100% of nursing staff within the surgical services had completed level 1 safeguarding adults training; this was higher than the trusts target of

80%. 74.4% of nursing staff and 29.1% of medical staff within the surgical services had received level 2 safeguarding adults training, which was lower than the trust target of 80%.33% of medical staff who required level 3 safeguarding adults training had completed this training. This was lower that the trust target. 100% of nursing staff who required level 3 safe guarding training had completed this training. This was above the trust target of 80%.

- Training data provided by the trust showed that 79% of nursing staff and 61% of medical staff who required level 2 safeguarding children training had undertaken this training. This was below the trust target of 80%.

- Staff told us that they received feedback from safeguarding concerns and referrals they raised. This was cascaded from the trust safeguarding team to frontline staff through their line managers.

Cleanliness, infection control and hygiene

- The surgical ward areas effectively managed cleanliness, infection control and hygiene. Rates of infections were low and staff followed measures to protect patients from infections.

- We observed dust on surfaces and equipment in three theatre areas

- Staff were not aware of curtain changing schedules in the surgical wards or the jubilee day surgery unit. When asked; one senior sister told us that they did not know how long the curtains had been in situ and could not recall the last time that they were changed. However, domestic services recorded curtain changes as part of a three monthly changing schedule.

- The ward and theatre areas we inspected were visibly clean and well maintained with the exception of the three theatre areas which were found to be dusty.

- Staff were aware of current infection prevention and control guidelines, and were able to give us examples of how they would apply these principles.

- Cleaning schedules were in place, with allocated responsibilities for cleaning the environment and decontaminating equipment.

- There was adequate access to hand washing sinks and hand gels in all areas.

Surgery

- Staff were observed using personal protective equipment, such as gloves and aprons and changing this equipment between patient contacts. We saw staff washing their hands using the appropriate techniques and all staff followed the 'bare below the elbow' guidance. Staff followed procedures for gowning and scrubbing in the theatre areas.

- We observed that patients with an infection were isolated in side rooms where possible. Staff identified these rooms with signs and information about control measures in these rooms was clearly displayed.

- The service undertook early screening for infections including MRSA during patient admissions and preoperative assessments. This meant that staff could identify and isolate patients early to help prevent the spread of infections.

Environment and equipment

- In the main theatre areas we observed a large number of free standing medical gas cylinders. Such cylinders should be safely secured to minimise the risk of injury and fire. This was raised with staff in the theatre area.

- Equipment on the wards and in theatre areas was visibly clean and well maintained with the exception of three trolleys in the main theatre areas which were found to be rusty. This was highlighted to the trust and they were removed immediately.

- Staff in the theatre and ward areas told us they had access to the equipment and instruments they needed to care for patients. An optiflow stock system was in use in the main theatre areas which automatically listed items removed for stock reconciliation. This system was secure and allowed staff to access the equipment necessary quickly and securely.

- Staff carried out regular checks on key pieces of equipment in all areas. Emergency resuscitation equipment was in place and records indicated that it had been checked daily in all areas, with a more detailed check carried out weekly as per the hospital policy.

- There were adequate arrangements in place for the handling, storage and disposal of clinical waste, including sharps.

- Bariatric equipment used for obese patients was readily available.

Medicines

- We found three vials of out of date medications in the main theatre area. These were immediately discarded by staff and replaced. It is important that medications are not used after their expiry date as this can affect the efficacy of the medication.

- In the main theatre areas we also found syringes of pre drawn up medications. This posed a risk of these medications being administered incorrectly as they were not labelled. This was highlighted to staff and they were removed immediately.

- We observed nurses undertaking medication rounds, where they undertook appropriate checks when administering medication including checking the patient's name, date of birth and allergy status. Staff also ensured patients took their medication and did not leave medication unattended.

- Staff locked and secured medication trolleys when they were not in use. Cupboards used to store medications were secure and locked appropriately in all areas with the exception of one cupboard which we found unlocked in the day surgery unit. This was highlighted to staff who arranged for it to be locked immediately.

- Fridges used to store medicines were locked in all areas except one recovery area. The fridges were used to keep medication only and no other items were present, ensuring minimal risk of contamination to the medication from other sources.

- The temperatures of the fridges in all areas were within expected ranges except for one ward area. Records indicated that staff checked and recorded the temperatures on a daily basis.Medications stored within the fridges were kept at the appropriate temperature.

- Records indicated that staff carried out checks on controlled drugs on a daily basis. This was to ensure that medicines were reconciled correctly. Controlled drugs were stored in secure cupboards in line with legislation on the management of controlled drugs. Controlled drugs require additional checks and special storage arrangements because of their potential for abuse or addiction

Surgery

- Medical staff were aware of the trust's policy for prescribing antimicrobial medicines and had access to a formulary which guided them in prescribing the correct doses. Appropriate antimicrobial prescribing helps prevent patients developing certain infections associated with antibiotic use.

- A pharmacist visited ward areas daily and checked prescriptions to provide support and advice in relation to medication stock reconciliation and prescribing.

- We reviewed six electronic medication charts and medical staff had completed all sections on all six charts fully. The prescribing was clear and legible which minimised the risk of medication errors.

- Ward managers reviewed incident data regularly to ensure any medication incidents were investigated in a timely way.

- Discharge medications and prescriptions were managed well and completed in a timely way.

Records

- The service and trust used electronic, computer based patient records. These records were found to be difficult to navigate between sections of the records when we reviewed three full sets of records. Four staff told us that they felt the electronic records system was sometimes difficult to navigate.

- Bank and agency staff were not always able to use the electronic records system. Staff told us that this put additional pressure on permanent staff. We observed an agency staff member on one ward area and they were unable to use the electronic records system. As a result a permanent member of staff had to undertake the recording of patient care for patients under the care of this member of staff in addition to their own patients.

- Both medical and nursing records were up to date, legible and signed.

Assessing and responding to patient risk

- On admission to the surgical wards and before surgery, staff carried out risk assessments to identify patients at risk of specific harm such as venous thromboembolism (VTE), pressure ulcers and risk of falls. If staff identified patients susceptible to these risks, they placed patients on the relevant care pathway and treatment plans.

- We reviewed five records specifically in relation to these risk assessments. We found that in two out of five records we reviewed in relation to VTE assessments, these assessments were not completed. We found that in all five records patients' risk of falls and risk of pressure damage had been completed fully and appropriate measures to reduce these risks had been put in place.

- An early warning score (EWS) system was in use in all areas. The EWS system was used to monitor a patient's vital signs and identify patients at risk of deterioration and prompt staff to take appropriate action in response to any deterioration.Staff carried out monitoring in response to patients' individual needs to identify any changes in their condition quickly. We saw examples of staff seeking appropriate help when a patient's condition deteriorated.

- Most patients received observations at the frequency specified by the medical teams. However we found that in one case full sets of observations including blood pressure, pulse, temperature and respiratory rate were delayed over a number of days. These delays ranged between five hours and nine hours.

- We observed parts of four operations and saw the theatre teams undertaking the 'five steps to safer surgery' procedures, including the use of the World Health Organization (WHO) checklist. The WHO checklist is an international tool developed to help prevent the risk of avoidable harm and errors before during and after surgery.

- We found that this checklist and process was followed appropriately in the main theatre areas and included all the relevant staff required.

- In the day surgery unit we observed that anaesthetic staff were not included in the sign in step of this process on two occasions and on two occasions we observed that staff were undertaking other duties and not present in the theatre area during the silent focus and time out stage of this process. It is important that all staff are included in all stages of this process as evidence has shown this reduces the risk of errors occurring. It was confirmed with theatre nursing staff, that anaesthetic staff did not usually participate in this sign in step.

- We also observed that a radio was also playing music in the theatre area during this process in the day surgery

unit. Guidance recommends that there is minimal disturbance and disruption during all stages of this process to reduce the risk of errors and avoidable harm to patients.

Nurse staffing

- The staffing and skill mix in theatre areas was sufficient, with some periods of reduced staffing in areas because of last minute sickness and unexpected events.

- Staffing in the ward areas was not sufficient at times and was not always planned to ensure that the skill mix was appropriate for the patient groups who were being cared for. This was reflected in the average fill rates for shifts on the surgical ward areas.

- Data provided by the trust showed that over a two month period the average fill rate for shifts fell below 80% in relation to registered nurses on three out of seven surgical wards. This rate was also below 90% on an additional three wards over a two month period. This means that on six out of seven surgical wards over a two month period there were less than 90% of the registered nursing staff required on duty.

- Some staff working on surgical wards raised concerns about staffing levels and the impact they felt this was having on patient care. Staff told us that care was often delayed due to staffing shortages and that they felt under significant pressure as a result of this.

- We observed that care was delayed in some cases on wards where there was not the required level of staffing. One example of this was on a surgical ward which had one less registered nurse than required, we observed that pain relief to one patient was delayed for over 30 minutes and intentional comfort rounding was delayed for four patients. These four patients were at risk of pressure damage and required regular comfort rounding to ensure pressure relief and reduce the risk of pressure ulcers developing.

- Each clinical area openly displayed the expected and actual staffing levels on a notice board and staff updated them on a daily basis. The staffing numbers displayed on the boards were correct at the time of the inspection and reflected the actual staffing numbers in all areas.

- Ward and theatre managers carried out daily staff monitoring and escalated staffing shortfalls to matrons and senior managers.

- We observed one nursing staff handover which was comprehensive and well structured. . Safety information was handed over as part of this so that staff were aware of any issues which could affect patient safety.

- The surgical services used a nationally recognised acuity tool twice a year to determine the staffing levels required on each area. There was no acuity tool in use to assess and establish the number of staff needed on an ongoing basis within the day centre.

Medical staffing

- There were sufficient numbers of suitably qualified medical staff within surgical services.

- Junior and middle grade doctors told us that they were well supported by their seniors and consultants and were able to access senior advice and support, as they needed.

- There was sufficient consultant cover available 24 hours a day, including outside of normal working hours. Consultant cover out of hours was available on an on call basis.

- We observed one medical handover which was comprehensive and well structured. Medical staff were informed of important issues or patients who were at risk of deteriorating.

- The staffing skill mix was sufficient when compared with the England average. Consultants made up 35% of the medical workforce across the trust which was lower than the England average of 41%.

- Consultants and registrars led ward rounds consistently on a daily basis. We saw evidence of this in patient's records and we observed one ward round on an acute surgical ward and saw that medical staff undertook the ward round effectively with appropriate communication with other disciplines and patients themselves.

- Nursing staff told us that they were able to access 24-hour medical assistance and advice easily.

Major incident awareness and training

Surgery

- The trust had a major incident policy in place which was available on the trust intranet site. Staff were able to tell us how they would access it and showed a good understanding of the policy and processes relating to major incidents.

Are surgery services effective?

Good ●

Summary

We found that the surgical services at the Countess of Chester Hospital were good in the effective domain because:

- Patients received care and treatment in line with evidence based practice and national guidelines. Clinical audits included monitoring compliance with National Institute for Health and Care Excellence (NICE) and Royal Colleges' guidelines.

- Most patients nutritional and hydration needs were met and managed appropriately.

- Patients were assessed and provided with appropriate pain relief.

- The service participated in local and national audits and the results of these varied between specialities.

- The service performed better than the England average in the Hip Fracture audit.

- Most staff had received their annual appraisal and worked well with other members of the multi-disciplinary team.

- Services were available seven days a week including emergency services.

However:

- The service did not perform as well as would be expected in the NELA 2014 audit. The service had developed an action plan to address areas of improvement.

- Most staff knew how to apply the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards to patients in their care however most staff did not receive training in these areas

Evidence based care and treatment

- Patients received care and treatment in line with evidence based practice and national guidelines. Clinical audits included monitoring compliance with National Institute for Health and Care Excellence (NICE) and Royal Colleges' guidelines.

- Staff on the surgical wards used care and recovery pathways and plans, in line with national guidance.

- Policies and procedures reflected current national guidelines and were easily accessible via the trust's intranet site.

Nutrition and hydration

- The guidelines for fasting before surgery (the time period where a patient should not eat or drink) were not clear. We found that most patients received the correct advice on fasting despite this and in line with national guidelines.

- In one case we found that patient had not been given the correct advice and had been fasted for over 12 hours for a procedure which national guidelines suggest should have a six hour fasting period.

- Most patients were supported with hydration and we observed staff actively assisting patients with their hydration needs.

- We found that there was no clear system in place to identify patient in need of assistance with eating and drinking. However despite this we found that staff correctly identified patients patients who required assistance nd these patients received assistance with eating and drinking as they required..

- In most of the records we reviewed fluid intake was recorded correctly and appropriately. However we found that Fluid intake it was not recorded accurately on four fluids charts we reviewed. It is important that charts to record fluid intake and output are maintained accurately as this can affect a patients overall care and treatment.

- Food intake was recorded accurately for most patients; however we found that charts used to record the intake of food for two out of six patients were not completed

Surgery

every mealtime as directed. It is important that these charts are completed fully when they are in place to ensure that patient's dietary intake is monitored appropriately.

- The trust had a protected meal time's initiative which ensured that there were minimal interruptions to patient's meal times.

- Staff told us that they were able to access specialist dietetics advice and support easily.

- Patients told us that staff offered them a variety of food and drink and did not highlight any concerns about the food and drink provided.

Pain relief

- Staff assessed patients pre-operatively for their preferred post-operative pain relief. Staff used pain assessment charts to monitor pain symptoms at regular intervals.

- There was a team specialising in the management of pain available to support staff in the surgical wards and theatres during in hour periods of 9am to 5pm.

- Patient records we reviewed showed that staff gave patients appropriate pain relief when required, which was also confirmed by the patients we spoke to.

- We observed one patient encounter a delay in receiving requested analgesia on one surgical ward.

Patient outcomes

- Surgical services participated in national and internal audits to monitor patient outcomes. Outcomes for patients receiving treatment in the service were mostly better than the England average.

- The surgical services participated in a number of national clinical audits including the national hip replacement audit, national bowel cancer audit and the national emergency laparotomy audit.

- The national hip fracture audit measures a set of outcomes for patients who have suffered a hip fracture and been admitted to hospital. The service performed better than the England average for four of the nine outcomes measured in the national hip fracture audit. The service performed worse in five of the nine outcomes measured; these outcomes were the number of patients developing pressure ulcers and the total

length of stay for patient who suffered a hip fracture. There was no action plan in place at the time of the inspection. However there were a number of audits in progress during the time of the inspection to address this issue. These were detailed in the orthopaedic audit plan.

- The national bowel cancer audit measures a number of outcomes, which give an indication of how well patients with bowel cancer are treated. The service performed better than the England average for all the indicators measured.

- The national emergency laparotomy audit (NELA) report from 2014 showed that eight out of the 28 standards were available at the Hospital. The audit highlighted that the hospital did not have 20 of the 28 required standards these included a dedicated surgical assessment unit and did not have key policies related to the care of emergency general surgery patients. Senior managers had reviewed the findings of this audit and had implemented an action plan to address the issues raised at the time of our inspection.

- Performance reported outcomes measures (PROMs) data between April 2014 and March 2015 showed that the percentage of patients with improved outcomes following groin hernia, hip replacement, knee replacement and varicose vein procedures was either similar to or slightly better than the England average. This means that patients undergoing these procedures had a similar outcome or a slightly better outcome compared to patients in other areas of England.

- Data on hospital episode statistics June 2014 to May 2015 showed the number of patients who were readmitted to this hospital after discharge following elective and non-elective surgery was similar or lower than the England average for all specialties except ENT where readmission rates were slightly worse. There was no action plan in place to address this at the time of inspection.

Competent staff

- Newly appointed staff had an induction and senior staff assessed their competency before they were allowed to work unsupervised.

- Agency and locum staff did not undergo local inductions and were not required to complete an

induction checklist when they attended a new ward area. We requested to see any induction paperwork for two agency and four bank staff members and none of these staff had received a local induction to the ward they were working on.

- Senior managers managed performance effectively and were able to tell us about examples of how they managed performance in previous situations.

- Data provided by the service showed 92.4% of annual appraisals during the year (April 2015 to November 2015) had been completed; this was above the trust target of 90%.

- Medical staff told us they received routine clinical supervision and appraisal and had no concerns relating to revalidation.

- The medical staff we spoke with were positive about on-the-job learning and development opportunities and told us they were supported well by their line management.

- Most staff felt supported; however three nursing staff we spoke with told us that they felt that their managers did not offer them opportunities to develop in their role. They told us that they were not routinely offered any training or development over and above their mandatory requirements.

Multi-disciplinary working and coordinated care pathways

- There was effective daily communication between multidisciplinary teams and between specialities and we saw examples of this during the inspection. One example was the daily review of patients who were placed on wards outside their speciality. We observed that staff worked collaboratively to ensure they received the specialist, daily reviews they required.

- One staff member told us that there was not always effective daily communication between specialities. However we only found oneoccasion which reflected this. We found that a referral was sent on a Friday to the medical team from the surgical team and the patients discharge was awaiting this review. The next Thursday this referral was found to be lost and the medical team

declined to see the patient until a new referral was completed despite the fact that the referral was electronically available. This delayed the patients discharge.

- Staff handover meetings took place during shift changes and 'safety huddles' were carried out on a daily basis to ensure all staff had up-to-date information about risks.

- The ward staff told us they had a good relationship with consultants and ward-based doctors within the surgical specialities.

- Staff across the services told us they received good support from pharmacists, dieticians, physiotherapists, occupational therapists, social workers and diagnostic support.

- Medical staff told us that they often experienced delays in receiving reports from diagnostic imaging and this affected patient treatment times and outcomes.

Seven day services

- Acute and emergency surgical services were available seven days a week. Out of hours cover by medical staff was adequate and nursing staff told us they felt well supported outside normal working hours. This included 24 hour seven day a week anaesthetic support and cover.

- Elective surgery was carried out five – six days per week dependent on demand.

- Junior and middle grade doctors provided out of hour's medical care to patients in the surgical wards. There was also on-call cover provided by consultant surgeons.

- At weekends, a consultant saw newly admitted patients, and the ward-based doctors saw existing patients on the surgical wards.

- There was a 24-hour emergency service with dedicated theatres. This meant that any patients admitted out of hours or over the weekend could have emergency surgery if required.

- Microbiology, imaging (e.g. x-rays and scans), physiotherapy and pharmacy support was available outside of normal working hours.

Surgery

- Medical staff with the exception of vascular specialists told us that they had adequate access to urgent imaging outside of normal working hours. This means that patients could have scans and x-ray's urgently out of hours if required.

Access to information

- Medical records were easily accessible and readily available on an electronic records system.

- Staff told us that they found accessing records easy in most cases. However some medical staff told us that they sometimes had difficulty accessing specific sections of patients medical records, One example of this was within the ophthalmology speciality where we found that visual field tests required by doctors were not always available when the doctors required them at the time of surgery.

- We also found that consent forms were not always available on the date of surgery due to the electronic records system and this meant that consent forms would have to be completed again on the day of surgery. We observed that this happened on two occasions during the inspection. It is important that patients having elective surgery have time to think about their procedure are do not feel rushed to consent to a procedure on the date of their surgery.

- Medical staff produced discharge summaries from the electronic patient system and sent them to the patient's general practitioner (GP) in a timely way. This meant that the patient's GP would be aware of their treatment in hospital and could arrange any follow up appointments they might need. Staff provided patients with copies of their discharge summaries on discharge.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- Staff had the appropriate skills and knowledge to seek consent from patients. Staff were able to tell us clearly about how they sought informed verbal and written consent before providing care or treatment.

- Staff sought appropriate consent from patients prior to undertaking any treatment or procedures. In one case we found that complications were not always fully described to patients prior to the consent process. This was highlighted to staff who then arranged for further information to be provided to the patient.

- All patient records we looked at indicated that staff had sought and obtained verbal or written consent before treatment was delivered.

- Staff on the main theatre areas and all surgical wards except one were aware of the legal requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Staff on one surgical ward were not able to articulate the legal requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. We observed one patient on this a surgical ward who was suffering from confusion. This patient was requesting to leave the ward and staff confirmed to us that they would stop the patient if they tried to leave. We found that this patient did not have a mental capacity assessment detailed for any stage or decision of their treatment and there was no application for a deprivation of liberty safeguards to be applied. This was highlighted to the senior nursing team and arrangements were made to ensure that all appropriate assessments were undertaken.

- Three out of four staff in the day surgery unit did not understand the legal requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. These three staff were unable to articulate how they would apply the Mental Capacity Act 2005 and the DOL's in a practical situation. One example of this was a patient who presented for surgery to the unit and was displaying new confusion which had developed since they had signed their consent form some months earlier. Staff did not consider that this patient's mental capacity to consent to the surgery may have changed. This was highlighted to staff and they then arranged for the patients capacity and consent to be reassessed.

- Registered nurses and health care assistants in all areas of the surgical services did not routinely receive training on the application and responsibilities of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. All staff spoken to below band 6 and 7 level told us that they had not received this training. Senior staff within the service told us that this training was only provided to band 6 and 7 nurses.

- A trust-wide safeguarding team provided support and guidance for staff in relation to any issues regarding mental capacity assessments and deprivation of liberties safeguards.

Surgery

Are surgery services caring?

Good 🟢

Summary

We found that the surgical services at the Countess of Chester Hospital were providing a good service in relation to the caring domain because:

- Staff treated patients with kindness, dignity and respect.
- Staff provided care to patients while maintaining their privacy, dignity and confidentiality.
- . Patients spoke positively about the way staff treated them.
- Patients told us they were involved in decisions about their care and were informed about their plans of care.
- The NHS Friends and Family test showed that most patients were happy with the care they received in the surgical services. Staff displayed involved patients and their families in decisions about their care.

Compassionate care

- We observed staff treating patient with kindness, dignity, respect and compassion. Staff took time to interact with patients and communicated with patients in a considerate and compassionate manner.

- The areas we visited were compliant with same-sex accommodation guidelines. Patient's dignity was respected. We observed that curtains were closed around patient bed areas when staff were providing personal care. There were private areas available where staff could speak to patients privately if required, in order to maintain confidentiality.

- We spoke with 14 patients, who all gave us positive feedback about how staff treated and interacted with them.

- The NHS Friends and Family Test (NHS FFT) is a satisfaction survey that measures patient's satisfaction with the healthcare they have received. The results showed that the majority of the surgical wards consistently scored above the England average, indicating that most patients were positive about recommending the hospital's wards to friends and family.

- The average response rates for the surgical wards was 34% which was higher than the England average of 32%. This means that 34% of the patients who were discharged from surgical wards completed the test.

- Two staff member told us that they had observed completed friends and family tests results with negative results being intentionally destroyed by other staff members. However we found no evidence of this practice during the inspection.

Understanding and involvement of patients and those close to them

- Staff respected patients' rights to make choices about their care and communicated with patients in a way they could understand.

- Patients and their families told us that staff kept them informed about their treatment and care. They spoke positively about the information staff gave to them verbally and in the form of written materials, such as information leaflets specific to their condition and treatment.

- Patients told us the medical staff fully explained the treatment options to them and allowed them to make informed decisions.

- Staff identified when patients required additional support to be involved in their care and treatment, including translation services. Staff were able to tell us how they would access translation services including sign language interpreters.

- Pre-operative assessments took place and took into account individual preferences

Emotional support

- Staff demonstrated that they understood the importance of providing patients and their families with emotional support. We observed staff providing reassurance and comfort to patients and their relatives.

- Patients told us that staff supported them with their emotional needs.

Surgery

Are surgery services responsive?

Good 🟢

Summary

We found that the surgical services at the Countess of Chester Hospital were providing a good service in relation to the responsive domain because:

- The surgical services were responsive to the needs of patients and in most cases met individual patient needs.

- Staff kept patients well informed of their treatment and care.

- Information was readily available for patients in a variety of formats, which could be adapted to individual needs.

- Patients who were not placed on a ward best suited to meet their needs received daily medical review.

- Patients had timely access to consultant led care which although it did not meet the national target of 90% most of the time the trust did perform above the England average.

- Complaints were well managed and learning from these complaints was evident.

However:

- There were some issues with access and flow within the surgical services; however staff managed this effectively.

- Patients were not always placed in the appropriate ward setting and a number of wards had additional beds open to accommodate medical patients. This led to an increased workload for the staff in these areas.

- A consistently higher number of planned operations were cancelled than the England average.

- The length of time patients stayed in hospital was mostly the same or higher than the England average with some exceptions.

Planning and delivering services which meet people's needs

- Some aspects of the services had been planned effectively to meet the needs of the local population.

- One example of this that the senior management team had noted an increase in the number of patients who could have day case surgery. Surgical services had therefore increased their capacity to provide day case surgery by building a new theatre to meet this demand.

- There was also an emergency general surgery and trauma theatre that was staffed 24-hours, seven day per week so that operations could be performed for patients requiring emergency surgery at any time of the day.

- We found one example where the service was not planned to meet the needs of the people using them. This related to the provision of specialist dementia support on surgical wards. The service provided care and treatment to a large proportion of elderly patients who suffered from dementia. However we found that the specialist dementia nurse and team only provided support to patients outside the surgical services. Despite this we found that staff working on the surgical wards provided care which met the needs of patients suffering from dementia.

Meeting individual needs

- Information leaflets about services and treatments were readily available in all areas. Staff told us they could provide leaflets in different languages or other formats, such as braille, if requested. We saw examples of information leaflets in different languages available in the day case unit. Staff told us that they could access a language interpreter if needed and were able to show us how they would do this. They also had access to language line which is a translation facility.

- We found that patients who suffered from dementia were provided with care that met their needs on all surgical wards. However, Staff did not receive training in the care of patients with dementia and the surgical wards did not have dementia link nurses in place. There were no designated 'dementia friendly' wards areas within the surgical services.

- Staff could also contact a trust-wide safeguarding team for advice and support for dealing with patients living with dementia or a learning disability.

- Staff did use a 'this is me' document for patients admitted to the hospital with dementia. Patients or their representatives completed this document and included key information such as the patient's likes and dislikes.

Surgery

This document was also completed during the pre-operative stage of a patients care to ensure any reasonable adjustments which were needed were put in place.

- A reasonable adjustment pathway and flagging system was in place for patients living with a disability and in use in all areas. This pathway alerted staff to any reasonable adjustments that they needed to make to accommodate the patient living with a disability. We saw evidence that this pathway had been used in patient records and on boards behind patient's beds.

- Staff told us they gave patients who identified as transgender the option to be treated in a side room for privacy or in the main bay areas. Where possible staff accommodated these preferences. We saw evidence of staff planning care for patients who identified as transgender in a way that would meet their needs. This planning included specifying what preferred name patients would like to be called and the gender they identified with.

- Access to psychiatric support was readily available and staff told us they did not have any issues accessing this support for patients.

- Staff could access appropriate equipment such as specialist commodes, beds or chairs to support the moving and handling of bariatric patients (patients with obesity).

- The theatre recovery areas had designated paediatric recovery bays.

- Accessibility to all facilities and areas was good

Access and flow

- Patients were admitted for surgical treatment and care through a variety of routes, including pre-planned surgery, the emergency department and by GP referral.

- The admission, transfer or discharge of patients from the surgical wards was not well managed in all areas.

- Patient records showed discharge planning did not always take place at an early stage and there was multidisciplinary input (e.g. from physiotherapists and social workers). In four out of 18 records there was no evidence of early discharge planning.

- Trust data showed that medical patients were regularly outlied to surgical wards (moved to a ward which is not best suited to meet their needs due to bed availability issues). In August 2015 data showed that there were 34 patients outlied, which rose to 120 in September and further increased to 130 in October 2015.

- We reviewed nine records of medical patients who had been outlied to surgical wards. In all nine cases these patients had received a daily review by the medical team.

- The trust was able to track which ward accommodated outliers using an electronic system.

- The trusts access and flow policy stated that only patients with an expected date of discharge of 24-48 hours should be outlied.We found that in one case a patient had been outlied to a surgical ward with an acute medical problem and social problems which meant they were likely to be in hospital for an extended period of time.

- Data provided by the service showed that multiple surgical wards were consistently used to support medical patients. Staff told us surgical patients sometimes experienced delays in accessing the wards due to beds being filled with medical outliers.

- Data showed that the service was performing above the England average for the national 18 week referral to treatment target between September 2014 and August 2015. However, the service missed the target of 90% in the general surgery, trauma and orthopaedics and oral surgery specialties, with oral surgery performing at 64.4%, trauma and orthopaedics at 89.7% and general surgery at 86.4%. This means that most patients referred to the surgical specialities started consultant led treatment within 18 weeks of being referred. Managers within the service told us this was because the trust had taken on additional surgeries for pateints out of area to assist other providers and to ensure patients received the most timely care possible.

- NHS England data showed that the number of cancelled operations within the trust remained consistent between 2014 and 2015 but was above the England average for all four quarters of 2014-2015. This meant that a higher number of patients had their planned operations cancelled in this service compared to other services of a similar size in England.

Surgery

- Patients told us they had easy access to surgical services and had experienced minimal delays in accessing treatment.

- The average length of time that patients stayed in hospital after having surgical treatment was higher than the England average for three out of four non- elective (unplanned) specialities and was about the same as the England average in the general surgery speciality.

- The average length of time that patients stayed in hospital after having surgical treatment was around the same or lower than the England average for three out of four elective (planned) specialities and higher than the England average in vascular surgery.

Learning from complaints and concerns

- Notice boards within the clinical areas and outside ward areas included information including any comments for improvement.

- Patients told us they knew how to make a complaint. Posters were displayed around the hospital detailing how to make a complaint.

- Leaflets detailing how to make a complaint were readily available in all areas.

- The trust recorded complaints on the trust-wide system. The local ward managers and matrons were responsible for investigating complaints in their areas.

- We reviewed two complaints which had been raised in relation to surgical services and found that the investigations and responses were robust and undertaken appropriately.

- We saw evidence of learning from complaints and this learning was disseminated through newsletters, staff meetings and safety huddles.

Are surgery services well-led?

Good ●

Summary

We found that the surgical services at the Countess of Chester Hospital were providing a good service in relation to the well led domain because:

- The surgical services were well led at local line manager level and at divisional level.

- There were robust governance frameworks within division and managers were clear about their roles and responsibilities.

- Risks were appropriately identified, monitored and there was evidence of action taken where appropriate.

- There was clear leadership throughout the service and staff spoke positively about their managers and leaders.

- Senior managers were visible and known to staff and staff felt able to able approach them and raise concerns.

- Staff told us the culture within the service was open up to their head of nursing level.

- Senior staff told us that they felt the divisional clinical leaders were open to challenges and willing to make changes to improve patient care.

- We found that the board had made efforts to engage with staff through different mediums and had implemented a speak out safely campaign.

However:

- The trusts vision was not embedded throughout the division. Staff were unclear what this vision was and were not able to tell us what the trusts values were.

Services vision and strategy

- The trusts vision was to provide integrated care at its best. This was based on the trusts strategic vision and direction which included three work streams; the West Cheshire Way, integrated specialist services and Countess 20:20.

- All staff we spoke with were not able to articulate these values and vision to us; however the values they displayed reflected the trusts vision and values.

- The trust was also participating in the 'model hospital' project. This was an improvement program which focused on value, high reliability, operational transparency and accountability. The trust were undertaking this work with external individuals to become the blueprint for a model hospital. All staff we spoke with were aware of this programme and spoke positively about it.

Surgery

Governance, risk management and quality measurement

- There was a robust governance framework within the surgical services. Senior managers were clear on their roles in relation to governance and they identified, understood and effectively managed quality, performance and risk.

- Managers had risk registers in place for all areas of the surgical services. Managers regularly reviewed, updated and escalated the risks on these registers where appropriate. There was a system in place that allowed managers to escalate risks to trust board level through various meetings.

- There was a clear alignment of risks recorded and what staff told us was concerning them. This showed that managers were in touch with the opinions and concerns of their staff and showed that they acted on these concerns.

- Audit and monitoring of key processes took place across the ward and theatre areas to monitor performance against objectives. Senior managers monitored information relating to performance against key quality, safety and performance objectives and they cascaded this to ward and theatre managers through monthly reports.

- There was regular clinical governance and risk meeting held within the surgical services and we saw minutes from this meeting.

- Concerns had been raised formally with the trust board by staff in relation to the use of additional beds on surgical wards during times of pressure and associated staffing shortages as a result of this. We saw evidence of this in email and letter form. Staff told us that they had not received a full response to these concerns and they felt that their concerns had not been taken seriously.

Leadership of this services

- The leadership within the surgical services at local and divisional level reflected the vision and values set out by the trust. Staff spoke positively about local leaders within the services. Local leaders were visible, respected and competent in their roles.

- All staff told us that they valued and respected their local line managers and divisional leaders.

- The head of nursing for the division had a large workload and an area of responsibility which included multiple services. Despite this staff told us that she was visible and approachable and they felt that she respected and valued them.

- Medical staff told us their senior clinicians supported them well and they had access to senior clinicians when they required. All medical staff were aware of who the medical director was and spoke positively about them.

- We observed that there were regular emails and updates from the trust board team to all staff. We also found that the chief executive and other trust board members made efforts to connect with staff and keep them updated. One example of this was the chief executives blog which was available for all staff to read.

- The chief executive and director of nursing had also held open door sessions and meetings with staff and ward managers.

Culture within this services

- Staff we spoke with told us they felt respected and valued by their local and divisional leaders.

- We found that there was an open culture within the surgical services and staff felt able to raise conecrsn with their local line managers.

- We found that concerns were raised staff and the trust board were responded to.

- The trust had also implemented a speak out safely campaign which encourages staff to raise concerns about patient safety.

- The trusts also had whistle blowing policy which was readily available on the trust intranet site.

Public engagement

- Staff told us they routinely engaged with patients and their relatives to gain feedback from them. Information on the number of incidents, complaints and the results of the NHS Friends and Family test were displayed on notice boards in the ward and theatre areas.

- The surgical services participated in the NHS friends and family test, which gives people the opportunity to provide feedback about care and treatment they received.

Surgery

Staff engagement

- Staff told us they received support and regular communication from their line managers.

- Staff participated in regular team meetings across the surgical services.

- The Chief executive and other board member regularly wrote blogs and published these on the trusts website for staff to access. These blogs included pertinent themes and also developments within the trust.

- We saw evidence that the trust board regularly sent out emails and communications to staff across the trust, informing staff of progress with various projects and conveying important messages.

- The Chief executive and director of nursing had held a number of open door sessions and meetings with ward managers and staff.

- Staff told us that the head of nursing and matrons for the division had an open door policy and were available to all staff.

Innovation, improvement and sustainability

- Staff and managers within the division were striving to improve the care and treatment patients received and were working to continually improve services. One example of this was the development of a new theatre and day case area to increase the number of elective patient operations.

- The service had a robust business plan for the year in place with clear objectives and progress towards these objectives monitored.

Critical care

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

Information about the service

The critical care unit at the Countess of Chester hospital provided a service to patients who required advance care, in a purpose built critical care unit. In April 2014 a new, two-storey wing was opened on the first floor of the hospital, replacing the old High dependency unit (HDU) and Intensive therapy unit (ITU).

The facility is a 21-bedded unit with 15 beds in use, where care is provided to all patients in single rooms. This includes three additional beds to support emergency vascular patients receiving care from the South Mersey arterial centre hub that is now based at hospital. The unit has a purpose built 100% side room facility. This allows the critical care team to overcome a number of challenges with infection prevention and control, maintain privacy and dignity as well as prevent sleep deprivation and the associated effects this has on prolonging recovery following critical illness.

There are also two relatives' suites providing overnight facilities. The room is prioritised for short-term use only.

The unit admits around 763 patients a year and between the 1 July 2015 and 30th September 2015, the critical care unit admitted 213 patients.

The unit is an active member of the Cheshire and Mersey adult critical care operational delivery network.

During the course of the inspection visit, we spoke with 9 relatives and over 35 staff of all grades, nursing, medical and allied health professionals.

Summary of findings

We have rated critical care services as good because:

- Incidents were reported and acted upon and used continuously as a service improvement tool
- Safety thermometer data was collected and displayed in public areas for patients and relatives to view.
- Performance results were also shared with staff in critical care in a monthly unit newsletter, together with results from relative's surveys.

- There were sufficient numbers of suitably skilled nursing and medical staff to care for the patients.
- The service took part in the intensive care national audit and research (ICNARC) data so we were able to bench mark its performance and effectiveness alongside other similar specialist trusts.
- The trust performed well, however data indicated some concerns regarding delayed discharges.
- The trust had an outreach team with five critical care trained, dedicated members of staff who supported wards in the early detection and treatment of acutely unwell patients.

- There was evidence if a multidisciplinary approach to caring for the patients. Ward rounds included consultants, a physiotherapist, a pharmacist, a junior doctor, a nurse, SHO and a member of the outreach team.

- There was adequate number of nursing and medical staff to provide a seven-day service.

Critical care

- Staff were aware of the vision for the service and had strategy's in place for innovation and improvement.

However,

- We did find that that the unit fell below the intensive care society's recommended level of staff who held a post registration award in critical care nursing.

Are critical care services safe?

Good 🟢

We rated caring as good because:

- There were systems in place for reporting and learning from incidents.
- There were sufficient numbers of suitably skilled nursing and medical staff to care for the patients.
- We found a recruitment drive in place and the unit had permission to over recruit to compensate for sickness and maternity leave.
- We found a good ratio of one consultant to seven patients. A designated consultant was on call at weekends who did not have on call responsibilities elsewhere in the hospital.
- The critical care service had an outreach team with five dedicated members of staff, all critical care trained, to recognise and care for an acutely unwell patient on the wards around the hospital.
- On occasions, the outreach team would support theatre recovery staff, to care for a Level three patient, due to access and flow problems within the critical care unit.

However,

There was no major incident awareness at local level. All staff we spoke to did not how to respond if there was a major incident, or what was expected of them.

Incidents

- Staff in critical care were aware and were encouraged to report incidents and learning was shared from findings. Staff used an electronic system to report incidents, which were sent automatically to senior staff as an alert.

- Data from the National learning and reporting system between October 2013 and September 2015 indicated that no never events associated with critical care had been reported. .

- Two serious incidents had been reported by the unit between October 2014 to 2015.Both were investigated and actions identified from learning through route cause analysis investigations and action planning.

Critical care

- Critical care reported 66 incidents between October 2015 and January 2016 through the national learning reporting system (NLRS). All were reported as no or low harm.

- We reviewed documentary evidence of regular and detailed mortality and morbidity meetings, which were held monthly. These meetings had a multidisciplinary approach, events were reviewed and any learning points were identified and cascaded to relevant teams.

- Regional bariatric mortality and morbidity meetings were attended regularly by a representative from the critical care unit and any issues were fed back to the parent team for learning.

- Senior staff attended the Cheshire and Mersey adult critical care operational delivery network meetings quarterly. Findings from this forum, including serious incident investigations including learning was cascaded to all staff to improve safety.

- We saw evidence of regular critical care delivery group meetings, which had a multidisciplinary approach, attended by pharmacy, outreach team and practice educators, amongst others. Quality and safety in critical care were discussed at these meetings and the recent intensive care national audit research centre (ICNARC) data.

- Senior staff were aware of the principles of 'duty of candour' (the regulation introduced for all NHS bodies in November 2014, meaning they should act in an open and transparent way in relation to care and treatment provided), However, whilst senior nurses were able to explain what was meant by the term, junior medical and nursing staff, were not familiar with what was meant by 'duty of candour' and couldn't recall having had any training on the subject. However, they did understand the responsibilities about being open and transparent.

Safety thermometer

- The NHS safety thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. Safety thermometer data was submitted from the unit and reported at trust level. This included data on patient falls, pressure ulcers, urinary catheter related infections and episodes of venous thromboembolism. Results showed that it had been five days since the unit had last reported a pressure ulcer and 102 days since the last patient fall.

- Safety thermometer data was collected and displayed in public areas for patients and relatives to view.

Mandatory Training

- Mandatory training figures for critical care were reported at business group level, and data reported in February 2016 showed that over-all compliance was in line with trust targets.

- In February 2016, the business unit reported mandatory training core subject compliance as; fire training 86.5%, conflict resolution 85.4%, equality and diversity 97.8%, information governance 91%, safeguarding children 83.1%, local induction 100% and medical devices 76.3%. The trust target was 80 % for safeguarding children and 95% for local induction, so they were above the trust target.

- As part of Mandatory training, staff had undertaken mental capacity act (MCA) and Deprivation of liberty (DOLs) training. Staff knew where to find information online and knew how to contact the safeguarding team for advice.

- Staff who had not yet undertaken training in conflict resolution and safeguarding children were all booked onto training at the time of our visit.

- There was no major incident training.

- There was no specific duty of candour training.

Safeguarding

- Staff were aware of safeguarding policies and procedures, and could verbalise the process used to escalate a concern. Low level concerns of safe guarding were raised electronically and then the safeguarding team were alerted. For all mental capacity incidents, DOLs and Independent mental capacity act (IMCA) referrals, a band 6 completed the documents.

- Safeguarding training was part of the trust mandatory training programme. The trust target was 80% for all safeguarding. In February 2016, critical care compliance was; 100% of administration and clerical staff had completed level one adult safeguarding and 67% had completed level one child safeguarding. 78% of nursing and midwifery staff had completed level 2 adult safeguarding and 82% of nursing and midwifery staff had completed level two child safeguarding.

Critical care

Cleanliness, infection control and hygiene

- All clinical areas, staff areas and relative's accommodation were clean and fit for purpose.

- All equipment was clean and in a good state of repair. We observed that some equipment had been labelled as clean by using a green sticker system; however, this system was not used for all equipment.

- All beds on the unit were single rooms, which meant that patients who had an acquired infection would be isolated. Rooms and equipment were cleaned in between use, using hydrogen peroxide steam cleaning to minimize the risk of cross infection. This was a seven-day service.

- On entry to the unit was a hand washing system with temperature control and timing device to support hand washing by staff and visitors before entering the unit, which people used.

- There were sufficient supply of hand gel, hand soap and personal protective clothing (PPE) at the point of care. We observed staff appropriately washing their hands, using hand gels and wearing personal protective equipment (PPE) when delivering personal and clinical care. We also spoke to relatives, who had all observed this practice.

- The most recent validated ICNARC data for 1 July to 30 September 2015 showed that the unit had no cases of unit acquired (MRSA) or Clostridium difficile infections (C dif). This applied to the presence of MRSA in any sample taken for microbiological examination forty-eight hours after admission to the unit.

- The unit had two negative pressure isolation rooms, which could be used to support patients where there were specific infection prevention requirements. These had a separate lobby and one directional airflow in order to isolate the patient from the rest of the unit.

- The critical care unit was subject to monthly audits of hand hygiene. The results for hand hygiene data showed 100% compliance from May to September 2015; however, compliance had dropped to 87% in October 2015. The trust aim was for all areas to routinely demonstrated 95% hand hygiene compliance.

- We observed that staff followed policies and procedures in the safe handling and disposal of sharps. Results of a trust wide sharps audit September 2015, showed

improvement in compliance with use of the temporary closure mechanism had improved from 64% compliance in 2014 to 89% compliance in September 2015, which reflected what we saw.

Environment and Equipment

- The critical care unit is a purpose built unit, which opened in 2014 and complies fully with health building guidance, HBN 04-02, which is best practice guidance on the design and planning of new or reconfigured healthcare buildings.

- The sluice, equipment and utility rooms all had coded access doors, but were found to be unlocked.

- We reviewed the resuscitation equipment; including defibrillators and difficult airway management trolleys and all were in date. All emergency equipment, which was checked daily, signed and dated.

- There was a rolling equipment replacement programme supported by the medical engineering team (EMBE), which ensured that the unit had a sufficient equipment to meet patient's needs. This reflected what we saw on the unit.

- Some ventilators were due to be replaced as part on a rolling programme. In the interim procedures were in place to loan this equipment and service arrangements were in place from the company.

- Four dialysis machines were on a loan contract, however not all of them had heaters. We were told that a procurement process was underway to purchase new machines.

- We saw evidence on the risk register that both issues with the ventilator machines and dialysis machines had been raised at trust level.

- The blood gas machine was overseen by the point of care testing co-ordinator. Nursing staff were all trained in using the machine and interpreting results. If the equipment did fail, a second machine was available in the main laboratory.

- All equipment on the unit was listed on the hospital intranet in order for staff to access instructions, manuals and cleaning instructions.

Medicines

Critical care

- We found that the unit had appropriate systems in place to ensure that medicines were handled safely and stored securely. Medicines were stored in the drugs room on the unit and access was required with individual swipe cards.

- There were three secure control drugs cabinets, accessed by key, which was kept with the team leader. We observed that when a control drugs cabinets was opened, an alert was sent to the nursing stations outside the room, by the way of a red light indicator.

- In addition to the secure control drugs cabinets, a secure coded cabinet was in use for storage of other drugs, equipment and syringes. The staff required a personal code for entry and the requested drugs location was highlighted to staff. This made the withdrawal of medication and equipment safe, quick and efficient for the staff. The system then automatically re-ordered the equipment from the stores, or the medicine from the pharmacy.

- There were two drugs fridges within the drugs room, the first was a secure fridge containing controlled drugs, including morphine. The keys for this fridge were kept with the team leader. A second fridge was not secure; this contained medicines for emergency incubation, where quick access was required.

- The drugs fridges displayed the internal fridge temperature, which was monitored daily and recorded by the unit housekeeper, we observed that this was maintained daily and was signed and dated accordingly.

- There were registers in use for the controlled drugs and a separate register for patient's own drugs. We carried out random controlled drugs checks, which demonstrated that actual stock matched the stock accounted for in the registers. The pharmacist carried out a three monthly audit of the controlled drugs, to check that the medicines were being recorded correctly, the stock was appropriate and in date.

- There were two dedicated specialist pharmacists for critical care and a pharmacist attended on the ward daily and as part of the multidisciplinary morning ward round.

- The pharmacist regularly reviewed medications and returned any that were no longer required to the pharmacy

- The unit used an electronic prescribing system and prescriptions could be ordered at any time of the day and night.

- The Trust does not use red allergy bands; however an alert is printed onto the allergy bands. Allergies were recorded on the opening screen of the electronic nursing notes at the patient's bedside and were highlighted in red.

- There was pharmacy cover five days a week and the pharmacist was available out of hours for advice by telephone.

Records

- The critical care unit used a mix of paper and computerised records; the nursing notes were recorded on computer at the patient's bedside, but patient notes were paper based.

- We looked at five patient care records. These were paper based and comprised of a range of clinical records, assessments and plans. These included; venous thromboembolism (VTE) risk, delirium, nutritional risks, pain scores and skin care bundles. Although entries were comprehensive, two out of the five records displayed the time of decision to admit the patient to critical care and three out of the five records were signed and dated by the consultant. No records showed the author's professional registration number. For example, General medical council (GMC) or Nursing and midwifery Council (NMC) registration numbers.

- We saw evidence of a 'Do not attempt Cardiopulmonary Resuscitation' (DNACPR) form accurately completed and an associated Mental Capacity Act (MCA) assessment, which was within a patients paper records.

- Physiotherapy notes were kept on paper and not available at the patient's bed side, however physiotherapy plans were verbalised with nursing staff.

- We saw some patient records left insecure on trolleys outside patient's rooms, which could have been accessed by visitors to the unit.

- The unit was using electronic prescribing; this has been shown to have positive impact on patient safety by reducing medication and transcription errors.

Assessing and responding to patient risk

Critical care

- All patients were monitored appropriately according to policies and procedures. Staff were able to access specialist medical support promptly to support patients who condition had changed and required review and intervention.

- The unit had a twice daily, multidisciplinary ward round, which included a pharmacist. A pharmacy was available 24/7 and was on call after 4.30 pm.

- We found that the trust used the national early warning scoring system (NEWS) to identify patients who may be at risk of their condition deteriorating. Early warning scoring systems are widely used in hospitals to track patient deterioration and to trigger escalations in clinical monitoring and response. National adoption of the National early warning system (NEWS) system is advocated.

- The critical care service had an outreach team with five dedicated members of staff, all who were critical care trained. The team supported staff to recognise and care for acutely unwell patients in the ward setting and provide expert advice and act as a point of escalation. The outreach team covered from 8.30am to 9.30pm, seven days a week. . The outreach team saw on average five patients per day. The team could not refer directly to the critical care unit.

- The clinical site co-ordinator responded to the acutely deteriorating patients at night.

- The outreach team were integral in the care of patients with Acute Kidney Injury (AKI) and ensuring compliance with NICE CG 169 (2013) and in helping to raise the profile, recognition and treatment of SEPSIS (NICE CG due 2016).

- On occasions, the outreach team would support staff in theatre recovery, to care for a Level 3 patient who waiting to be transferred to critical care there due to access and flow problems within the critical care unit. This was not usual and was based upon a risk assessment. This was reported as an incident and monitored by the trust.

Nursing staffing

- Staffing levels were monitored regularly with an appropriate staffing tool and we found adequate staffing to meet peoples care need and which were in line with national standards.

- The unit had 71.5 whole time equivalent nurses in post as of October 2015.

- Over the previous year the unit had recruited 18 new nursing staff, however they lost 15 due to promotion and progression to other areas. In order to support safe staffing levels, the unit recruited above establishment to compensate for sickness and maternity leave.

- The unit had been using bank staff and agency staff, but were within the required range and were not utilising greater than 20% on any one shift.

- An Induction was carried out for any agency staff who worked on the unit.

- A new focus group for band 7 nurses had been set up in order for information and data from management meetings to be shared with nurses.

- A service improvement lead was in post on the unit, for one day a week, funded by the critical care network, which aimed to support nursing skills and competency on the unit.

- The unit employed 6.25 whole time equivalent (WTE) health care assistants (HCA), there was one HCA on duty each shift.

- Each shift on the unit had a member of staff identified in a supernumerary capacity, however due to staffing levels this was not always possible.

Medical staffing

- The unit had nine whole time equivalent (WTE) consultants, 50% of their time was spent in anaesthesia. There were 3.6 WTE funded trainees, 2nd on tier and 6 junior tier WTE, 4 of the junior fellow's work 50% in critical care and 50% in vascular surgery.

- We found appropriate medical cover both in and out of hours on the critical care unit. Two consultants were present on the intensive care unit in the day and one consultant was on call overnight. The consultants remained on the unit as required, were contactable by telephone, and would attend at the unit within 30 minutes. The consultants did not have on call responsibilities elsewhere in the hospital.

Critical care

- A second on call anaesthetist was assigned to critical care at all times and was onsite to respond immediately to medical emergencies and airway management support.

- The consultant/patient ratios were good for a hospital of this size with a ratio of one consultant to seven patients.

- An Induction was carried out for any agency staff who worked on the unit.

Major incident awareness and training

- There were major incident policies and procedures in place, however all staff we spoke with on the unit were not clear on their roles and responsibilities regarding major incident.

- We spoke to the critical leads with regards to critical care policy for a major incident and they stated that it was currently being reviewed at a trust level and would be cascaded to staff.

- Staff we spoke to knew what to do if there was a fire, as it was covered in their mandatory training.

Are critical care services effective?

Good ●

We rated effective as good because:

- A range of local policies and procedures based on up-to-date evidence and best practice were followed, including guidance from the National Institute for Health and Care Excellence (NICE), relevant royal colleges and core standards for intensive care units. These were up to date and were easily accessible to staff.
- The unit took part in local and national audits, including the intensive care national audit and research centre (ICNARC). This meant that the care delivered and outcomes for patients were benchmarked against similar units nationally.

- We found that the staff were competent and there was a good skill base mix on the unit.
- We saw strong evidence of multidisciplinary and multi-professional working in critical care.

- Ward rounds included consultants, a physiotherapist, a pharmacist, a junior doctor, a nurse, SHO and a member of the outreach team.
- Patients had access to dieticians, pain teams and the physiotherapists took the lead in tracheostomy management in the hospital setting.
- Physiotherapists also held courses to teach patients, relatives and staff on how to care for patients requiring long-term tracheostomy care.

However,

- The unit did fall below the acquired level of staff recommended by the intensive care society who held a post registration award in critical care nursing, however patient's needs were being met.

Evidence-based care and treatment

- A range of local policies and procedures based on up-to-date evidence and best practice were followed, including guidance from the National Institute for Health and Care Excellence (NICE), relevant royal colleges and core standards for intensive care units. These were up to date and were easily accessible to staff.

- The unit took part in local and national audits, including the intensive care national audit and research centre (ICNARC). This meant that the care delivered and outcomes for patients could be benchmarked against similar units nationally.

- The unit were part of the Cheshire and Merseyside Critical Care Network

- The unit employed a research nurse, who was involved in screening for ventilator-acquired pneumonia (VAP) RAPID 2.

- The unit were auditing ventilation-acquired pneumonia (VAP) and in September 2015, they reported 89% compliance with the VAP bundle. The unit monitored VAP bundles and reported on the level of compliance, any short falls were recorded via their safety briefing and action taken.

- Guidelines for delirium were followed and whilst patients were not screened routinely on admission to critical care for delirium, all patients were screened daily once admitted.

Critical care

- There was a range of local policies, procedures and standard operating protocols in place, which were easily accessible via the trust wide intranet.

Pain relief

- We reviewed five patients' records and noted pain scores were recorded appropriately and pain was discussed at ward rounds.

- The unit had a dedicated pain team available to support patients on the critical care unit. The pain team did not routinely visit the unit, but would attend on referrals made to them.

- There were processes in place to access patient's pain and the pain scores were recorded on the patients care records and monitored. A recent patient survey highlighted that pain may not be as well managed as the patients would like, however all family members that we spoke to stated that pain was well managed for their loved ones.

- Most of the critical care consultants have specialist training in management of acute pain.

Nutrition and hydration

- We found that there were policies and procedures in place to support patients nutritional and hydration needs. Patients nutritional needs were risk assessed and results were acted upon appropriately.

- There were no protected meal times for the high dependency patients on the ward. The purpose of protected meal times is to allow patients to eat their meals without unnecessary interruption and to focus on providing assistance to those patients unable to eat independently.

- Staff and patients had access to specialist nutritional advice from the dietician team. The dietician reviewed all patients requiring specialist feeding including nasogastric support and attended afternoon ward rounds daily as part of the multidisciplinary process.

- During our visit we observed that nutritional and hydration needs of patients were being met, however, one relative told us that there had been communication problems between themselves and staff when there loved one was stepping down from nasal gastric feeding to oral feeding.

- Patients fluid requirements were assessed regularly and we reviewed patient records which showed this.

Patient outcomes

- The unit demonstrated submission of continuous patient data contributions to INARC. This meant that the care delivered and mortality outcomes were being monitored against the performance of similar units nationally.

- The latest published ICNARC data for the period July to September 2015 showed that for ventilated admissions, mortality was comparable with similar units, although the mean length of stay was longer.

- Data showed that for admissions with severe sepsis or pneumonia, the unit mortality was generally higher than for comparable units.

- In terms of elective surgery, the mortality data was in line with comparable units and for emergency surgical and trauma admissions, unit mortality was generally better than comparable units were.

- In terms of outcomes for patients, the worse performing area shown in the latest ICNARC data was for delayed discharges, of which 20% of discharges were delayed. Over 30% of the recorded delays were greater than 4 hours, but less than 24 hours and approximately 12% of patients waited between one and two days to be discharged once they had been judged clinically fit to do so.

- Approximately 1% of patients from the unit were readmitted to the unit within 48 hours of discharge, which was better than the national average.

Competent staff

- 40% of nursing staff on the unit held a post registration award in critical care nursing. 8% of nursing staff were currently undertaking the course. This meant that the unit was 2% below the acquired level of staff recommended by the intensive care society. The trust were aware of this and plans were in place to become fully compliant within the new financial year.

- The critical care unit had two designated full time clinical practice nurse educator in post that supported staff appraisals annually. Data from February 2016 showed that 97.8% of critical care nursing staff had received their appraisal.

Critical care

- One member of staff told us that they had not had an appraisal for several years, but this had been booked the week after our inspection.

- All nursing staff appointed to critical care were allocated a period of eight to 12 weeks supernumerary to allow time for registered nurses to develop basic skills and competencies to safely care for critically ill patients.

- The unit regularly used agency staff, all of which carried out an induction to the unit.

- Agency staff had partial access to electronic systems, which had improved accessibility to key information; however, agency staff were limited in what they can input on the computer system, they could write notes, but could not order prescriptions electronically.

- Nursing staff completed a set of core competencies as part of induction to the unit and then they were responsible to demonstrate their competency in practice going forward.

- The unit followed the national competence framework for adult critical care nurses. The matron for the unit signed off all competencies.

- There were 11 staff consisting of band 7 nurses and five outreach team staff, who were qualified in advanced life support.

- Nurses were assessed as competent to carry out key duties in preparing ventilators and respiratory equipment in preparation for use and decontamination of equipment.

- Staff said that whilst there was no formal training for continuous positive airways pressure (CPAP) safety checks, nurses learnt as they carried out their duties but there was no formal competency assessment.

Multidisciplinary working

- A physiotherapist in critical care saw all patients. Patients who had been ventilated for three days or more were assessed and if appropriate, routinely had 40 minutes of physiotherapy as per National institute for health and care excellence (NICE) 83 Guidance.
- The physiotherapy team took the lead in tracheostomy support for staff, patients and families in the hospital. One physiotherapist we spoke to ran courses to teach patients, relatives and staff on how to care for patients requiring long-term tracheostomy support.

- Patients had access to speech and language therapist (SALT) for swallowing assessments and the physiotherapists were able to make referrals to SALT and the dietician if necessary.
- A dietician was always available for the critical care unit and all patients who required naso gastric feeding support were seen by the dietician.
- The outreach team reviewed all patients on wards who had been discharged from the critical care unit.
- Consultant lead multidisciplinary rounds took place each day, which consisted of; two consultants, a physiotherapist, a pharmacist, a junior doctor, a nurse, senior house member (SHO) and a member of the outreach team. New referrals to the unit were discussed, together with staffing levels and bed availability.

Seven-day services

- A consultant was present at the unit from 8.30am to 6.30pm, Monday to Friday and one consultant is on-call overnight and weekends. A second on-call anaesthetist was assigned to intensive care at all times.

- The unit had one consultant on call at weekends, they undertook full ward rounds in the morning and then again in the afternoon, or evening prior to leaving. They remained contactable by telephone and would attend the unit within 30 minutes; they did not have responsibilities anywhere else in the hospital.

- The pharmacist covered a five day week, with an on-call pharmacist available out of hours and on bank holidays

- Physiotherapy services were provided daily, including the weekend and were on-call after 4.30pm.

Access to information

- Risk assessments, care plans and test results were completed at appropriate times during a patient's care and were accessible to staff.

- Guidelines, policies and procedures were easily accessible to staff on the trust intranet site

- The unit used a blend of electronic patient systems and paper records to record and report patient information including electronic prescribing and electronic pathology and radiology reporting. Prescriptions for intravenous infusions and patients notes were all recorded on paper.

Critical care

- Agency staff had partial access to electronic systems, which had improved accessibility to key information; however, agency staff were limited in what they can input on the computer system, they could write notes, but could not prescribe medication electronically.

Consent and Mental Capacity Act (include Deprivation of Liberty Safeguards if appropriate)

- Staff were competent and aware of the mental capacity act and deprivation of liberty safeguarding protocols. We saw an example of staff supporting a patient who was identified as lacking capacity using the mental capacity act principles and two-stage capacity test. Clinical staff included family who knew the patient best in decision-making related to tracheostomy insertion and emergency treatment.
- Staff were aware of policies and procedures relating to obtaining consent and the processes related to best interest decision making.

Are critical care services caring?

Good ●

We rated caring as good because:

- Patients, relatives and their friends were listened to and processes were in place for their feedback to be reviewed and acted upon.
- 100% of relatives in the relative satisfaction survey said that they felt their relative's privacy and dignity were maintained on the unit.
- We spoke to nine patient's relatives during our visit, who all gave positive feedback about the staff and told us that they were caring and respectful.
- Patient diaries were in use at the unit which helped patients fill gaps in the memory after a stay in critical care and helped patients to understand what had happened to them.

Compassionate care

- We spoke to nine relatives who all told us that the staff in critical care were caring and respectful to them and the patients.

- One relative we spoke to told us that staff had took the time to play music to her daughter whilst she was in the unit, taking into consideration that she was the youngest patient on the ward at that time.

- Patient diaries were in use in the unit, but not routinely. Intensive care patient diaries are a simple but valuable tool in helping patients come to terms with their critical illness experience. Research has shown that diaries enable patients to make sense of their intensive care experiences and they reduce the risk of developing depression, anxiety and post-traumatic stress disorder (PTSD) for both patients and relatives.

- The patient diaries were only used for level three patients and were not given out routinely. We noted that no diaries had been given out from 26 December 2015 to 8 February 2016.

- We reviewed the relative satisfaction survey for intensive care for the period of April to June 2015, 92% of relatives said that staff had approached them at the bedside whilst they were visiting, introduced themselves and explained what they were doing.

- 100% of relatives in the same survey said that they felt their relative's privacy and dignity were maintained on the unit.

- Single rooms ensured that patient's privacy and dignity was continually maintained during episodes of physical or intimate care. The windows to the adjoining rooms had blinds and the doors to the rooms could be closed.

- On entrance to the unit, we saw a large, wall mounted, electronic screen in the corridor, and we saw further screens along the unit. The screens displayed the room numbers and patient's name and due to the position of the screens, a patient's name was in full view to any visitors to the unit, however staff found this technology supportive in ensuring patients were seen promptly by visiting staff.

Understanding and involvement of patients and those close to them

- Patient information leaflets were available in the relative's waiting rooms, which provided information on a variety of subjects including; MRSA, infection prevention, C dif, pressure ulcers, and VTE.

Critical care

- On admission to the critical care unit, patients and relatives were given a 'Visitors guide to the intensive care unit' booklet, which covered all aspects of the intensive care unit, including information about visiting times, relative accommodation, parking, patient dairies, research and rehabilitation.

- The 'Visitors guide to the intensive care unit' was also available on request in large print, braille, on compact disc and in other languages.

- We spoke to relatives who had been given the 'Visitors guide to the intensive care unit', information on infection prevention and an 'Intensive care unit relative satisfaction survey', on admission of their relative.

- The unit provided an information booklet for patients, relatives and carers about DNACPR decisions, the booklet explained what CPR is, how it can be carried out and the possible outcomes. There was also information about talking to counsellors, a Patient Advice and Liaison Service (PALS) and the Chaplin, at the back of the booklet.

- We observed delays for families and non-critical care staff entering the unit due to the shortage of reception staff and observed the ward phone not being answered. One relative told us that they had attempted to contact the unit by telephone for over a day and eventually another relative had to attend the unit in person for a patient update.

- The unit had a dedicated specialist nurse in organ donation who spoke to relatives when treatment was being withdrawn. The information in the ICU booklet also prepared relatives for the questions that may be asked.

Emotional support

- The critical care staff arranged and led a memorial service once every three months in the hospital chapel, for relatives who had lost loved ones in the unit.

- Direct feedback was given to us from a relative whose spouse was receiving palliative care at the unit. Relatives told us that their child had some learning difficulties and two senior doctors took time to listen and explained everything; the care was described as 'Fantastic'.

Are critical care services responsive?

Requires improvement 🟠

We rated responsive as requires improvement because:

- Challenges for the unit were related to delayed patient discharges which had been reported on the risk register; over 20% of discharges were delayed. 30% of discharges were delayed for 4 to 24 hrs and approximately 12% were delayed for 24 to 48 hrs, however the results were still in the expected range for a hospital of this size.

- We found that on ten occasion's patients had to stay in theatre recovery, due to staffing and bed issues within the critical care unit and during our visit we were made a aware of a patient being nursed in the theatre recovery until a bed came available. Patients stayed between 40 minutes and 11 hours.

- This also had an effect on elective surgery cases which are regularly being cancelled due to the staff/bed shortage in critical care.

However,

- The unit offered overnight accommodation to patient's family and friends, for short-term use. The rooms were immaculately kept and well equipped and had been funded by a local charity.

Service planning and delivery to meet the needs of local people

- The trust planned and built the new unit in 2014 after identifying that the previous unit did not meet patient's needs due to a poor environment and small bed space areas. The design of the new unit considered this and the risks associated with transmission of infection. In addition to this, the unit was planned in preparation for the transfer of vascular services.

- The unit did not offer a follow up clinic for patients who had been discharged from the unit; however, patients were seen on the ward by the outreach team.

- The unit were aware of their need to improve access to a clinical psychologist for the patients and it had been noted as a recommended action in the

- The unit had two overnight en-suite bedrooms available to family and friends, for short-term use. The rooms

Critical care

were well equipped and had been funded by a local charity. During our visit, we saw a relative who had travelled a considerable distance being offered the room to sleep in, prior to driving again.

- Staff told us that they were able to access cold snacks for patients who had missed meals due to being away from the unit.

- There were facilities for visitors to make hot drinks in a small kitchen area and in the waiting room outside the critical care, entrance had a water machine.

- The critical care physiotherapists held a follow up clinic for rehabilitation after discharge. The patients received six sessions of rehabilitation.

Meeting people's individual needs

- Decisions made to withdraw care were discussed with relatives and this involved a multidisciplinary team. We saw evidence of this in patient's notes.

- Learning disability passports were in use on the unit, which worked on a traffic light system, for example indicating what the patient preferred to be called, and what their likes and dislikes were which supported their individual needs.

- Relatives who were visiting a patient who had been in critical care for more than 48 hours were given a car park pass free of charge, which could be used for up to four weeks.

- The latest available ICNARC data showed that the unit was performing the same as comparable units for early readmissions and post unit hospital deaths and during the last quarter performed better on post unit deaths than other units. Early readmissions are classified as being unit survivors that are subsequently readmitted to the critical care unit within 48 hours of discharge and post unit deaths are classified as being unit survivors that die before ultimate discharge from acute hospital, (excluding those discharged for palliative care).

Access and flow

- Challenges for the unit were with delayed discharges, which had been reported on the risk register. Data from ICNARC for the period of 1 July 2015 to 30 September 2015 showed that over 20% of discharges were delayed.

30% of discharges were delayed for 4 to 24 hrs and approximately 12% were delayed for 24 to 48 hrs, however the results are still in the expected range for a hospital of this size.

- We were told that on occasions patients have to stay in the theatre recovery, due to staffing and bed issues within the critical care unit. The trust provided us with the monthly audit for recovery occupancy for April to May 2015, for both level 2 and level 3 patients; 10 patients remained in theatre recovery due to lack of critical care beds. The waiting time ranged from 40 mins to 11 hours; eight of the patients waited over four hours before being transferred. The outreach team, or critical care trained theatre staff would care for the patient whilst they remained in recovery.

- During our visit, it was discussed at the critical care morning handover that they would be unable to take admissions to the unit that day and level two emergency cases had to be held in theatre recovery until a bed became available. One elective surgery case was also cancelled due to staff/bed shortage in critical care.

- Access and flow pressures had an impact on operational effectiveness. For the year 2015/2016 there had been 51 cancelled elective surgery cases. These had been for a variety of reasons, not just the lack of critical care bed. For example, when an emergency patient would take priority over an elective case.

- Access and flow difficulties within critical care was due to a number of combined issues; staffing, layout of the unit and the hospital being a centre for vascular surgery. The unit was a 21 bed single rooms unit, dealing with a mix of level two and 3 patients. The beds are flexible to meet demand, though not more than eight level three patients can be accommodated at any one time. A nurse supporting level two patients would be 1:2; however, the patients being cared for may be anywhere in the unit and not necessarily in adjacent rooms, therefore staffing needs were risk assessed.

- The critical care leads told us that they kept a vacant bed in critical care whenever access and flow allowed, accommodating for any emergencies and this reflected what we saw.

- Patients were reviewed in person by a consultant in intensive care within 12 hours of admission to the unit.

Critical care

Out of hours, discharges were closely monitored. For the period 01 July to 30 September 2015 the ICNARC data shows that there were 213 admissions to critical care and 10 night time discharges, 5 of those being to the wards. These had been for a variety of reasons, not just the lack of critical care beds. The last quarter shows an improvement in this data and the out of hours discharges are better than comparable units.

Learning from complaints and concerns

The trust's website contained information on how to raise a concern both informally and as a formal complaint, which included contact numbers and email address for PALS. We also saw PALS information and reporting cards in the relative's waiting room on the unit.

- Staff learnt from complaints or concerns by completing a self-reflection form and the content would be discussed with the matron and then filed in their personal file.

- The matron reviewed any complaints and incidents reported and information was displayed on the staff notice board for staff to review.

- Results from the safety thermometer data and relatives surveys were included in a monthly unit newsletter for all staff in critical care to review.

- Generic feedback themes are included in the daily safety briefs, for example, a pressure sore incident was recently discussed and a case study carried out for staff to learn from.

- The unit was active in the Cheshire and Merseyside adult critical care operational delivery network and shared learning from complaints across this network.

- The critical care matron attended the planned care divisional meetings and a critical care delivery group, which were held twice a month, where complaints, incident trends and patient/ relative feedback are discussed.

- Once a month, a band 7 nurse staff meeting is held and a band 6 nurse staff meeting bi-monthly to learn from complaints and concerns.

Are critical care services well-led?

Good ●

We rated well-led as good because:

- Staff were aware of the vision for the service and had strategy's in place for innovation and improvement.
- There was an effective governance structure in place, which ensured that all risks to the unit were discussed within the trust and through regional networks.
- The critical care unit had a designated consultant clinical lead and a team of experienced senior nurses led the nursing team. There was strong leadership in the unit with many new ideas, which had been implemented for improving communication amongst the staff.
- The service took part in the intensive care national audit and research (ICNARC) data so we were able to bench mark its performance and effectiveness alongside other similar specialist trusts. The trust performed well, however data indicated some concerns regarding delayed discharges.
- Staff told us they felt supported by senior leaders on the unit.
- Incidents were reported and acted upon and used continuously as a service improvement tool Safety thermometer data was collected and displayed in public areas for patients and relatives to view. Results were shared with staff in critical care in a monthly unit newsletter, together with results from relative's surveys.
- The staff we spoke to felt respected and valued and were all passionate about working in critical care**.** All staff we spoke to said that they felt supported and confident to raise any issues or ask for support.

Vision and strategy for this service

- The unit had a business case in progress to expand the service to be able to support 12 ventilated patients as part of a wider vision and strategy. This meant they will require three additional ventilators and appropriately trained staff.

- Staff were aware of the vision for the service and had strategies in place for innovation and improvement. The trust-wide critical care delivery group, highlighted a number of priority recommended actions as part of this, for example; Improvement of patient flow, reduce delayed discharges and discharges out of hours and

Critical care

Increase percentage of qualified nursing staff with a post-registration qualification in critical care, all of which were being addressed as part of the strategy going forward.

Governance, risk management and quality measurement

- There was an effective governance structure in place, which ensured that all risks to the unit were discussed within the trust and through regional networks.

- The lead nurse in critical care attended planned care governance meetings and cascaded key information in the unit.

- There was a multidisciplinary attendance at the critical care network meeting which were held quarterly.

- Critical delivery group meetings were held regularly and attended by multi professional representatives from pharmacy, outreach and education. ICNARC data was reviewed and discussed.

- There was a risk register for the unit, which were up to date included controls and measures to mitigate risks. The risk register was updated regularly and risks reviewed and acted upon.

- One high-risk issue that was highlighted on the units risk register referred to blood heaters not being supplied with hired hemofiltration machines. Four of the dialysis machines were on loan; we were told that the procurement process was under way to purchase new machines, which will mean the unit will have the ability to carry out calcium citrate dialysis.

Leadership of service

- The critical care unit had a designated consultant clinical lead and a team of experienced senior nurses led the nursing team. There was strong leadership in the unit with many new ideas, which had been implemented for improving communication amongst the staff.

- Staff told us they felt supported by senior leaders on the unit.

- We spoke to the practice educators about the percentage of staff on the unit who had not yet attained a post registration award in critical care nursing; they told us that this was due to financial difficulties. The unit

had been refused funding for training, due to over spending the previous year, which was confirmed when we spoke to the critical care leads and was identified on the March 2016 risk register.

- The unit was aware of ICNARC data and their position in the network in comparison to other similar critical care units and the critical care leads told us they put a lot of effort into improving their performance from the data.

Culture within the service

- The staff we spoke to felt respected and valued and were all passionate about working in critical care. All staff we spoke to said that they felt supported and confident to raise any issues or ask for support. Communication was an area within critical care that we were told had not always been effective. Recently new monthly band 7 nurse staff meeting and bi-monthly band 6 nurse staff meetings had greatly improved this.

- The staff in the unit felt supported in undertaking further training, however, the outreach team told us that they felt they needed more guidance in their roles and they did not always feel as supported as the rest of the team. They were due to set up a specific subgroup within the Cheshire & Merseyside critical care network for outreach staff, with the view for them to receive more guidance and support in this area.

- The practice educators told us that each nurse is part of a support group whom they can go to with any problems or issues. There is also an occupational health service that the nurses can refer themselves to.

- The current matron had recently arranged an away day with nurses to improve communication, relations and sharing of information. This had been welcomed by the staff who felt that there was a supportive culture on the unit.

- Staff told us that they felt actively engaged and their views were considered. A junior doctor told us of an incident where he was dealing with an emergency and he found it difficult to communicate with the 10-team members of nursing staff around the bedside due to numbers and noise levels. He completed an incident report raising his concerns; his views were listened to and actions were then taken to prevent this situation from reoccurring.

Public and staff engagement

Critical care

- The critical care unit's matron produced an informative newsletter for staff, which had key information and news. Staff said they found this supportive.

- Within each 'Visitors guide to the intensive care unit' booklet handed out, was an intensive care unit relative satisfaction survey. Relatives can anonymously complete the survey if they wish to do so and patients have the option if they are well enough to complete it. There were 16 questions in total, with simple 'tick' box multiple choice answers. The results from these surveys were analysed weekly and shared with the staff, patients and relatives. The results for the relatives were displayed on the notice board in the waiting room and the results for the staff were shared in the monthly newsletter.

- One issue raised from the relative's survey was that the lighting in the relative's waiting room was too bright in the evenings, a number of surveys relayed this feedback and the unit addressed this, changing the light switch in the waiting room to a dimmer switch, so that in the evening the relatives could dim the lights.

- In a recent survey relatives were asked when they came to visit if they were kept up to date on the condition of the patient, 88% answered 'yes'.

Innovation, improvement and sustainability

- The unit was participating in the provision of psychological support to people in intensive care (POPPI). The study is being led by a Professor from ICNARC and a Dr from University College Hospital, London. POPPI is a research study which aims to improve patients' well-being after a stay in the intensive care unit by teaching nurses how to; provide a calm, therapeutic environment for critically ill patients, detect psychological distress in critically ill patients and provide stress support sessions to their more distressed patients.

- The Critical Care building is less than two years old and HBN04-02 was used in developing the design for the new unit. The 100% single rooms eliminated a number of previous problems in the unit for example bed spacing too close together, only curtains to restrict view and maintain dignity and confidentially during care and procedures, no confidential space to discuss sensitive issues with patients, or relatives. Staff told us the environment had improved staff morale, it is light and airy and staff have commented that they feel more valued by the Trust.

Maternity and gynaecology

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

Information about the service

The Countess of Chester maternity services provided care to women in Chester and Ellesmere Port and the surrounding areas including North Wales.

The service provided midwife and consultant led maternity care.

The trust provided antenatal care at different venues including children's centres, GP surgeries or the woman's own home. The trust provided medical input at the hospital antenatal clinic. Qualified ultra-sonographers completed ultrasound scans at the antenatal unit.

The service included the obstetric day unit, fetal medicine department, medical disorders clinic and a high-risk clinic. There was also a clinic for women who had experienced a previous caesarean section.

The inspection team visited the central labour suite (CLS), Cestrian ward the antenatal and post-natal ward and ward 40 the gynaecology ward. We visited the antenatal day unit and the obstetric theatre on the labour suite.

We talked with 10 women and three family members receiving a service from the maternity service. We recorded contact with 41 members of staff from the areas we visited including lead consultants, business manager, head of midwifery services and gynaecology lead nurse; junior doctors, ward sisters, shift leaders, a range of midwives and trained nurses, health care assistants and ward clerks. This number also included students.

We reviewed the care pathway from antenatal to postnatal care for eight women and their babies

Maternity and gynaecology

Summary of findings

We rated Maternity and gynaecology as good because:

- The trust had systems in place to review midwifery staffing levels using latest national guidance (National Institute of Clinical Excellence : Safe Midwifery staffing for Maternity units 2015 NG4) and were in the process of employing addition midwives following the most recent review in January 2016.
- Clinical areas at the point of care were clean.
- The trust provided clear procedures for reporting incidents and the electronic reporting system was accessible to the majority of staff. The trust treated incidents seriously and ensured completed investigations using staff external to the service including external peer review.
- Multiagency and disciplinary working was established and promoted the best outcome for mothers and their babies.
- The record keeping systems were effective ensured accurate and up-to-date information about patients was readily available.
- Women were cared for with kindness and compassion and were positive about the standard of care and treatment provided by the maternity and gynaecology services.
- The service encouraged and supported learning and development. The ratio of supervisors of midwives to midwives was 1:14 which better than the recommended 1:15.
- The trust ensured staff followed best practice guidance and participated in national and local audits in relation to care and treatment.
- The majority of staff felt communication between ward staff and senior managers was effective.
- Midwives subscribed to the philosophy of the nursing and midwifery council six of compassionate care and we saw this in practice". There was limited involvement of stakeholders or the general-public in the trusts long-term plans for the service.
- The gynaecology ward and clinics were well run by the gynaecology service and ward managers.

However,

- The number of midwives employed did not meet best practice Birthrate Plus recommendations. This resulted on the closure of the unit and delays in procedures for women using the service on rare occasions.
- The layout and security detection arrangements meant mothers and babies weren't always monitored, however access to the unit was monitored by close circuit television at key points across the unit, and access was restricted either by a staffed reception or swipe access door.
- General cleanliness in non clinical areas on the central labour suite and Cestrian ward needed to improve.
- We did not find evidence that emergency response training included drills for dealing with common obstetric emergencies was in place during inspection, however the trust advised us that this was covered on induction and also using innovative skills and drills training.
- The trust did not provide maternity midwives, health care assistants and midwife assistants with individualised appraisals.
- The trust did not employ a specialist bereavement midwife; however, there were two link bereavement midwives.
- The management system for audits needed to be improved and sharing the lessons learnt from incidents, audits and complaints was not well established.
- There were not enough opportunities for midwives to meet and review the safety of the ward or unit during each shift.

Maternity and gynaecology

Are maternity and gynaecology services safe?

Good 🟢

We rated safe as good because:

- Systems were in place for reporting incidents and these were reviewed and investigated
- Medication management and record keeping were robust.
- There was appropriate consultant, middle grade and junior grade obstetric cover.
- Infection control measures were in place and used by midwives and doctors.
- Processes including methods for alerting staff to ongoing concerns and multi-agency working, promoted adult safety and child protection.
- The trust had systems in place to review midwifery staffing levels using national guidance (National Institute of Clinical Excellence : Safe Midwifery staffing for Maternity units 2015 NG4) and were in the process of employing addition midwives following the most recent review in January 2016.

However,

- Feedback about learning from incidents was not always disseminated to all staff effectively.
- The environment and facilities needed to improve because there was one single obstetric theatre.
- The layout and security detection arrangements meant mothers and babies weren't always monitored, however access to the unit was monitored by close circuit television at key points across the unit, and access was restricted either by a staffed reception or swipe access door. A swipe access system was also being introduced on exit of the labour unit.
- The number of midwives employed did not meet best practice guidance.

Incidents

- In the period 01/12/2014 to 30/11/2015 the trust reported one never event in maternity services. Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures had been implemented.
- The root cause analysis report indicated that in this case a robust investigation had been completed and action taken to strengthen processes and protect against a repeat incident. Action included a robust final counting regime for equipment used during surgical procedures and additional failsafe if a doctor was disturbed at the end of a procedure.
- There was a clear process for reporting incidents through an electronic incident recording system. The policy was available through the trusts intranet site. Nurses, midwives and doctors told us the system was easy to use. Detailed guidance was available to support staff using the system.
- Staff stated they felt comfortable filing incident reports and the trust scored above average compared to the England average. Midwives and maternity shift leaders were able to articulate changes resulting from incidents, for example investment in specialist cardiotocography training had been introduced in response to incident patterns.
- The trust recorded 843 maternity and gynaecology incidents in the period December 2014 to November 2015. Most were reported as no or low harm. 18 required further investigation.
- We reviewed five obstetric secondary reviews and two root-cause analysis completed in 2015. There were processes in place to monitor incident investigation at both departmental governance meetings and at trust level.
- The trusts plans indicated that individual staff or teams were to reflect on incidents. However, reports did not always include detailed information about new or revised instructions were shared with the wider service. Action plans did not include timescales by which reflections and the impact of new learning were evaluated or assessed. We did observe however, that there was a rolling ½ day programme of learning from incidents which was in place which included dissemination of shared learning across surgical, obstetric and gynaecology services.

Maternity and gynaecology

- We noted that some action plans did not have measurable outcomes and timescales, and did not always focus on all findings. For example, one investigation found that access to information from all services involved in providing antenatal care may have improved the outcome, however addressing this was not one of the actions. This meant the trust may miss or delay opportunity for improvements.

- Four of the seven investigations reviewed did not include information about contacting the patients or keeping updated about the progress of the investigation, however this was information was recorded and monitored at trust governance level, however it was unclear on how information on completion of fulfilling duty of candour responsibilities in a timely way was cascaded to staff.

- The processes of peer review to provide impartial scrutiny following a significance event was not evident. For example, one investigation identified a series of omissions and delays in care. The findings were not reviewed independently to ensure the actions taken were robust and appropriate.

- The trust reported that safety briefings before handover, monthly mortality meetings and updates on the intranet was used to share the lessons learnt from investigations with staff.

- Handovers occurred at the beginning of shifts these occurred twice a day. A safety check through staff 'safety huddles' (very small quick meetings) did not occur and so opportunities to update staff about changes in risk factors on the units more frequently than every 12 hours were not built into the day.

- Gynaecology services presented evidence such as a training presentation detailing the lessons learnt from a serious incident and staff were able to articulate lessons learnt.

Safety thermometer

- The NHS safety thermometer is a national improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. There are different topics to review depending on the specialism.

- The trust had developed a spread sheet which provided monthly data about obstetric and neonatal outcomes compared against national averages.

- Information about some safety topics for example the proportion of women with infections within 10 days of labour and the proportion of term babies who needed to transfer to special baby care unit was measured.

- Between December 2014 and November 2015 the maternity services scored above (better) than the average England score of 63.% combined measure for harm free care five times and equal to the average score three times.

- The information about safety was not available or displayed in a format which was accessible to patients and the public.

Cleanliness, infection control and hygiene

- Clinical areas were clean and tidy. Cleaning schedules were in place and reports indicated these kept.

- The area behind the adult resuscitation equipment on the central labour suite was dirty. There was a visible build up of dirt in the vents in the doors on the labour suite and room corners.

- The placenta fridge in the dirty sluice on the central labour suite was stained inside and out. This fridge contained a bucket with unlabelled contents. The temperature readings for this fridge were not recorded. This was identified to staff during our visit.

- The maternity service had been identified as an outlier for puerperal sepsis in 2014. The trusts investigations found that the issues concerned the reporting of puerperal sepsis and the trust concluded in April 2015 that actual infection rates for that period had been within acceptable ranges.

- Between December 2014 and January 2016 safety thermometer data showed that the maternity services scored below (better) than the average England score of 7% for infection within 10 days of labour.

- The maternity services reported no cases of hospital-acquired Methicillin-Resistant Staphylococcus Aureus (MRSA) or Clostridium difficile (C. difficile) between May and October 2015 prior to the inspection.

- Hand hygiene audits on the labour unit between May and October 2015 showed staff achieved 100% compliance. The results on Cestrian ward indicated the audit had been omitted on one occasion; however staff had achieved 88% to 100% for the same period.

Maternity and gynaecology

- We saw that midwives and doctors used hand cleansing gel, liquid soap, hand towels and personal protective equipment appropriately.

- Clear guidance was in place and equipment available to protect staff and the public from cross contamination and infection risks including respiratory illnesses.. The trust provided midwives with tailor fitted masks for use when required.

- We observed visitors using hand-cleansing gel as they entered the wards.

- However we observed domestic staff handling waste materials without proper use of gloves or aprons, this was brought to the attention of senior staff.

- Records indicated that the trust ensured antenatal and admission blood tests to screen for infection were completed as appropriate.

Environment and equipment

- There was one theatre available for maternity services. The trust used room 15 on the labour suite as a second theatre when needed. This had occurred 10 times in the 3 months prior to the inspection. We saw checklists and observed that appropriate safety equipment and checks took place, however best practice guidance identified that all but the smallest consultant-led units (CLUs) should have two theatres.

- The need for a second theatre was on the speciality risk register and the senior management team indicated this was on the agenda for reconfiguration of the estate including the women and children's building. However notes from governance meetings did not provide insight into future plans in relation to this.

- Entrance to the CLS was controlled by the receptionist situated in the main foyer to the maternity building. Babies were not security tagged and there were no controls to exiting the maternity units, however access to the unit was monitored by close circuit television at key points across the unit, and access was restricted either by a staffed reception or swipe access door. A swipe access system was also being introduced on exit of the labour unit.

- Some staff were not clear on procedures of what to outlined in the trust missing babies policy, however there were established policies and risk assessments in place.

- The trust had not conducted missing infant drills and so staff, including security staff had not practiced what to do if a baby went missing. .

- Service level agreements were in place to ensure equipment was maintained and serviced.

- The neonatal unit was close to the labour ward so babies could receive specialist treatment quickly.

- There was one side room situated away from the main ward areas for women who needed more privacy.

- Adult resuscitation equipment was available in each clinical area and records indicated that daily checks of the equipment had taken place on the wards we visited.

- There was a baby resuscitaire in each room and labels indicated checks occurred as required.

- Cardiotocography (CTG) equipment used by midwives to monitor the baby's heart rate and contractions of the uterus during labour was available. Records indicated to ensure accurate readings machines were correctly monitored and calibrated.

- There were two birthing rooms with birthing pools. We were informed that staff had not tested evacuation from the pool to bed in the event of maternal collapse and an adjustable bed was not available in the room.

Medicines

- We reviewed the medication records of eight patients. These records were completed appropriately including information about allergies.

- There was a detailed policy for storing and administering medication. We saw that medicines, including intravenous fluids, were stored appropriately.

- Medicines requiring refrigeration were stored within the correct temperature, and daily checks were made.

- Controlled medication was stored securely and had appropriate checks in place. The controlled drug entry log on the antenatal unit indicated that this medication was checked by two qualified staff at the change-over of each shift and before administration.

- Medication protocols were changed in line with best practice guidance for example in June 2015 the timing

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of measles mumps and rubella (MMR) vaccination in certain women was reviewed to meet Department of Health guidance, 'Immunisation against infectious disease' (2013) (the Green Book) guidance.

Records

- We reviewed eight sets of records these were complete, dated and timed. The signatures were legible and names identifiable in most instances.

- We reviewed the complete care pathways for antenatal, delivery and postnatal information for three women. Records were complete and showed that each woman had individualised care plans for pregnancy and labour, each had received appropriate antenatal screening and assessment of risk to promote safe treatment. The trust ensured the allocation of named midwives or consultants to women..

- Records were up to date and completed at the time of contact.

- The trust was in the process of consolidating the electronic record keeping system in use.

- Discharge reports and referrals were made to health professionals through the electronic recording system. Women were given a copy of the information sent to their Gp; this included the date of birth, sex and weight of the baby and whether mother was breast or bottle feeding.

- We read the pregnancy communication books carried by two women and entries indicated that midwives and other health professionals used these to record visits and tests as appropriate.

Safeguarding

- The maternity service worked closely with the safeguarding nurse specialist. The safeguarding nurse specialist and midwives interviewed worked in keeping with robust safeguarding and child protection policies.

- The policy and guidance about female genital mutilation was been updated and staff indicated they had attended training about how to report and respond to this safeguarding concern.

- There was a single system for communicating safeguarding concerns between the safeguarding team, midwives and medical staff. Concerns were flagged on the electronic reporting system. This information was highlighted in code on a whiteboard in the clinical room.

- The mandatory training data provided by the trust confirmed 89% of maternity and gynaecology midwives and nurses had completed level three children's safeguarding training.

Mandatory training

- The trusts maternity education and training report December 2015 indicated 98% of midwives and support workers were up to date with mandatory training.

- 78% of doctors were up to date, the trust had reviewed the reason for low figure and a plan was in place to ensure staff completed this training.

Assessing and responding to patient risk

- The trust ensured women received screening at the required milestones and the results shared with women and their GP appropriately.

- Processes were in place to ensure comprehensive risk assessments and maternal screening protocols were completed in line with best practice guidance.

- In keeping with antenatal and new born screening programmes best practice the trust had commissioned three screening co-ordinators. Each had specialist responsibilities for example sickle cell and thalassaemia screening, fetal anomaly and Downs syndrome screening and infectious diseases.

- The coordinators were also responsible for counselling, education, training and audit. They worked from Cestrian ward and the fetal medicine unit.

- The 2014/15 screening results indicated the trust performed better than the England average in key performance indicators for all areas of antenatal screening.

- The trust ensured risk assessments completed during birth, protected women from harm because the service used the modified early obstetric warning score (MEOWs) to check the vital signs of women during labour. This ensured deterioration was quickly recognised and treated.

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- The result of the April to September 2015 audit which was reported in November 2015, indicated MEOWs was correctly used almost 100% of the time between April and August 2015 but dipped to 66% in September due to all entries not being dated and signed and no escalation when the scored triggered a response. Results were monitored and processes were in place to act upon results.

- The World Health Organisation (WHO) surgical checklists for maternity surgery were in place and monitored. The five steps to safer surgery checklist for maternity were in use. This is a set list of safety questions that ask and answer before, during and after a caesarean section to make sure women and babies are kept safe during the procedure.

- WHO checklist audits cpmpleted in March, July and September 2015 indicated overall 87% compliance; this was below the trust target of 100%. The results were discussed at key governance meetings and in October 2015 and monitoring arrangements increase increased to monthly from January 2016.

- Midwives used a handheld doppler instrument or a cardiotocography (CTG) monitor, as appropriate, to listen to the baby's heart rate during labour. This meant action was taken to provide urgent or emergency treatment.

- There were four transitional care cots' for babies who did not need to admission to the neonatal unit but needed some nursing input. Nursery nurses from the neonatal unit performed isolated care tasks for these babies, however transition arrangements were unclear.

- The issue had been highlighted at governance meetings however plans to resolve the issue were not identified neither was the risk placed on the divisional risk register to ensure senior staff were involved in reviewing the concern.

Midwifery staffing

- The trust had systems in place to review midwifery staffing levels using national guidance (National Institute of Clinical Excellence : Safe Midwifery staffing for Maternity units 2015 NG4) and were in the process of employing addition midwives following the most recent review in January 2016.

- The staff was below (worse than) the current national benchmark for midwifery staffing set out in the royal college of obstetricians and gynaecologists guidance (RCOG) (Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour) which is 1:28 across both community and hospital staff. The ratio for the service was 1:31 midwives to babies born.

- The unit had identified this and had put plans in place to recruit 3.5 additional midwives. 3.5 midwives. We noted, however, that this would bring the staffing ratio to 1:29 that would not comply with RCOG guidelines, but would achieve birthrate plus national guidance of 1.29.

- In December 2015 the service completed a baseline assessment of maternity staffing needs using NICE safe staffing guidelines N64 and staff were instructed to complete a 'red flag' log to record in keeping with this guidance. This was to record all events caused by staff shortages such as delays in inductions or planned caesareans sections, midwives been transferred from one unit to another, midwives working longer shifts or missing breaks. This had been put in place to evaluate midwifery staffing needs going forward.

- The red flag log summary reported 25 instances of delayed procedures between August 2015 and January 2016. The information identified delays in induction of labour in excess 24 hours when best practice guidance stipulated women should have their induction of labour started within 2 hours of admission for the procedure.

- Women we talked with commented on a shortage of staff at night and indicated they call bells took a while to answer during the night. Women receiving antenatal care said they rarely saw their named midwife or the same midwife.

Medical staffing

- The trusts medical staffing information confirmed 60 hours consultant cover for the delivery suite. This meant the service met the recommendation in the safer childbirth best practice guidelines.

- There was a robust process of recruitment and induction for locum doctors.

- The trust ensured detailed clinical handovers.

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- Feedback and staff rosters indicted that out of hour's maternity anaesthetic cover often included locum anaesthetists. The consultant anaesthetists had developed a detailed induction protocol and guidance manual. The head of midwifery services stated this issue had been discussed at governance meetings.

Major incident awareness and training

- There was a major incident policy however this was not tested within maternity and gynaecology.

- There was a clear business continuity plan and action flow chart for managing patients in adverse situations such as closure of the unit. The plan included liaising with ambulance services and the maternity units in the North West network to make sure women were redirected to an alternative service.

Are maternity and gynaecology services effective?

Good ●

We rated effective as good because:

- The trust provided women's care and treatment in line with current evidence-based guidance, standards and legislation.
- There were arrangements in place to audit the care and treatment provided.
- Women received pain relief as required.
- There were opportunities for professional development for midwives and nurses in women's services.
- Multidisciplinary team working was well planned and effective.
- Newly employed and qualified midwifery staff had received appropriate training for them to carry out their role effectively.

However,

- a number of planned audits had not been completed. Outcomes for women using the maternity service were in line with England average but local targets for improvements were not always set.

Evidence-based care and treatment

- The trusts care pathways for antenatal; intra partum and postnatal care were in keeping with best practice guidance. For example we saw that NICE pathway 64 was followed in the event of a congenital anomaly being identified during screening and (NICE) antenatal care guidance 62 was followed for low risk women.

- Policies, procedures and pathways were based on national guidance. We observed that the service self assessed against national guidance and were fully compliant.

- The obstetrics and gynaecology division provided a forward audit programme. This identified 32 audits the majority of which had commenced in 2015. Three items were coded 'green' indicating completion. The remainder were coded 'red'. Data provided did not highlight the progress towards completing the other audits and it was difficult to identify which were overdue and which were on target. We observed that these were being monitored though the wider trust audit committee.

- Minutes between June – January 2016 for management meetings, ward meetings and community midwifery meetings indicated that outcomes of audits were not discussed and it was unclear at the time of inspection how findings were disseminated. The trust advised us that this done by the practice development midwife.

- Maternity services had identified the need for additional support to co-ordinate clinical audit and a lead person was identified in November 2015.

Pain relief

- Care plans showed all the women had received pain assessments and appropriate pain control was provided. We talked with 10 women about pain control all confirmed appropriate pain relief had been discussed.

- Women who were post-natal stated pain control had met their needs during and after delivery.

- Pain management was timely and effective. Epidural, entonox, pethidine and codeine analgesia were readily available.

- For women with special needs or safeguarding concerns, liaison and discussion about pain control with

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the person and their social worker, support worker or birthing partner always occurred. Midwives described scenarios and action taken when they had attended vulnerable women during labour.

Nutrition and hydration

- The trust met the UNICEF baby friendly criteria for reaccreditation in April 2013. At that time it was found that there was effective antenatal discussion about breast feeding, the service valued donor breast milk and skin to skin contact for mother and new-born baby were embedded into practice. They had completed an audit and had set targets and update the findings from the 2013 reaccreditation as suggested in the UNICEF Bliss guidance in 2015 which demonstrated compliance.

- There was an infant feeding team and 'Bosom buddy' volunteers to provide breast feeding support. Mothers with babies on the neonatal unit were encouraged and supported to express milk for their babies.

- Women on the maternity and gynaecology units were provided with snacks, meals and drinks while on the unit, fluid balance charts were completed so that oral intake could be monitored when required and when intravenous fluids were administered.

Patient outcomes

- The maternity and gynaecology units used plans of care in line with best practice provided by the Royal colleges and national institute for health and care excellence (NICE). Systems were in place to monitor whether women received the care and treatment expected.

- The trust reported 1,841 births between June and October 2015. There were nine stillbirths reported during this period, which was in keeping with the average of 1:200 births (Nhs Choice).

- The trust contributed data to the Royal College of Obstetricians and Gynaecologists (RCOG) clinical indicators reported in August 2015. RCOG results indicated the trust performed in line with the national average for:- normal vaginal deliveries; overall numbers of induced labours; numbers of planned and emergency caesarean sections; numbers of deliveries involving instruments and numbers of 3rd and 4th degree tears.

- The trusts internal performance measures data June 2014 to October 2015, however, stated the percentage of

inductions of labour ranged between 27% and 36% and scored 'red' in terms of internal compliance ratings. The caesarean section rate scored between 25% (green) and 34% (red). We discussed these findings with the senior staff who indicated that maternal choice was an important factor in the figures.

- The number of woman having a serious haemorrhage after birth scored green, indicating effective care, for each month during this period.

- The score for maternal readmissions within 42 days of caesarean sections was in line with the England average.

- The trusts score for maternal readmissions within 42 days of delivery for women with normal deliveries was 2.8% and worse than the England average of 1.9%.

- The midwifery service completed a local audit report. The 'Summary report April-September 2015 inclusive midwifery care matrix' dated November 2015 provided information about the outcomes of eight audits.

- This included information about the audit of medical records, care of women in labour, Cardiatocography (CTG), induction of labour, Modified observation (Meows) and neonatal observations.

- The results were at times unclear for example all audits scored 'green' in all areas and yet compliance for staff completing Meows assessment ranged between 100% and 66% over the time of audit.

- The action plan for this report was to email staff about the omissions identified and discuss with the individual midwife if the issues were identified in a single case. The actions did not include sharing the results and learning service or trust wide.

Competent staff

- We interviewed 41 midwives and doctors of all grades and seniority and all indicated that the trust provided a wide range of opportunities for developing expertise in maternity practice and obstetrics. Learning opportunities included funding for external study days; support to attend conferences; training and seminars provided by consultants linked to mortality and morbidity reviews; in-house on-line training developed in response to updated policies and external on-line workshops provided by the royal colleges.

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- Midwives were particularly complementary about an interactive cardiotocography (CTG) training package.

- New starter induction programme was provided for clinicians who completed the examination of the new-born.

- Midwives were able to maintain their full range of skills because they rotated into the community, day unit, labour suite and Cestrian ward.

- The 2015 training report indicated 98-99% of staff attended allocated study days; those who did not attend were followed up.

- The trust achieved approximately one supervisor of midwives to every 14 midwives this was better than the required numbers.

- The trust was not able to confirm the number of midwives provided with individual appraisals. The trust provided group appraisal and staff who felt they required individual expected to approach their line manager to arrange individual appraisal.

- Staffing also included breast care nurses who provided breast feeding support and guidance and specially trained midwives who ran specialist clinics such as diabetic clinic, there was also a research midwife.

Multidisciplinary working

- Midwives rotated between the different midwifery services this promoted multidisciplinary working. There were good working relationships between doctors and midwives.

- The trust enabled effective and seamless multidisciplinary joint working between the units, allied health professionals, the community midwives, including an independent maternity service provider.

- We witnessed positive interactions and liaison with general practitioners and pharmacy this resulted in positive outcomes for patients ready for discharge.

- Paediatricians were on call for the maternity unit and midwives were aware of which paediatrician was on call out of hours. This meant new-born babies received appropriate care and treatment.

- There were clear guidelines that midwives used to access clinicians outside the maternity service. This information included contact details and bleep numbers.

Seven-day services

- Consultant cover and antenatal assessment was available seven days a week.

- A consultant obstetrician was on call out of hours. If a consultant lived more than 20 minutes away they slept at the hospital.

- Imaging and radiotherapy was available out of hours.

- Pharmacy was available seven days a week.

Access to information

- Staff had access to information through an electronic report keeping system, paper records held by the patient and on the units. Information was readily available for all staff including locum doctors.

- We noted that key policies and procedures such as the emergency escalation policy were available in print format on the wards and in the reception area.

- Networked computers were available in all key areas and staff could access the internet and the trust intranet web pages.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We spoke to 10 women who said midwives provided enough information to help make informed decisions about their care and treatment.

- Staff described the different types of consent and we witnessed staff giving choice and waiting for verbal and implicit consent when supporting women.

- Doctors and midwives had received training in gaining informed consent.

- We saw consent forms signed and dated for women who had undergone planned or emergency caesareans sections.

- The correct termination of pregnancy notification forms were completed and sent to the chief medical officer as required by the department of health.

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- Staff had received appropriate training in mental capacity and deprivation of liberty safeguards.

Are maternity and gynaecology services caring?

Good ●

We rated caring as good because:

- Women said midwifery and nursing staff were caring and information about choices was provided in a way they understood.

- We observed woman-centred care and saw staff responding respectfully to requests for support.

- The service did not have a dedicated bereavement midwife however, some staff had received specialist bereavement training and so the trust could be assured that bereaved parents were supported in a caring way.

- Facilities had been provided to enable midwives to support grieving families sympathetically.

Compassionate care

- The national 2014 maternity survey completed by patients showed that this trust achieved better ratings than average for antenatal care; care in hospital after the birth; support while feeding baby and care at home after the birth.

- The maternity friends and family test (FFT) data return for January 2016 scores was low (1.9%) however all respondents indicated they were likely to recommend the service. The trust had introduced new FFT collation methods to try and increase the number of respondents.

- Gynaecology FFT outpatient response was 31% and 90% were likely to recommend this service.

- Ten women and three family members were interviewed. They were in the antenatal clinic, delivery suite, triage, antenatal/postnatal ward and gynaecology unit.

- Women described positive experiences and felt doctors, nurses, health care assistants and allied health care professionals were kind and helpful. They felt their family was looked after and felt they had been given enough information about results and what to expect during their time on the unit.

- One woman on the Cestrian ward commented that at night they had to wait for assistance however staff were always pleasant and helpful.

- During our inspection we observed caring, respectful and compassionate interactions between staff and women and their families.

- There were systems and processes in place to make sure women and families who had experienced a still birth or a miscarriage were treated with compassion and sensitivity. Examples included admission to a separate area away from mothers with their babies. The trust offered photographs of babies who had died and mothers could decide when these were taken home.

- Midwives were not especially involved with supporting parents to make funeral arrangements as this was managed by the bereavement service.

- Curtains were used in bay areas which ensured dignity and privacy was maintained.

Understanding and involvement of patients and those close to them

- Processes were in place to involve women and their birth partners.

- Birth partners were supported to remain with women in labour. There was a reclining chair in each room for partners to use.

- Birth partners told us they felt involved in care and treatment. We observed staff involving and supporting family members appropriately.

- Staff recorded the choices made by women in relation to pain control, breast feeding and preparedness for being discharged.

- We witnessed staff explaining care, treatment and processes in easy to understand terms.

- The tone and language used in records to describe care and treatment indicated midwives and doctors had a respectful and caring attitude towards patients.

Maternity and gynaecology

- Visiting hours on Cestrian were extensive 9am to 9pm for partners and 11am to 9pm for others. This meant women and babies did not have protected time for rest. The service was planning to survey women about visiting hours.

Emotional support

- Staff considered the emotional needs of women and their partners during the handover of shifts.

- The advanced midwife practitioner and fetal medicine manager had completed counselling module NM205 and a bereavement counselling course.

- All midwives received training on induction to enable them to provide appropriate counselling to antenatal patients in relation to screening for fetal abnormalities so that parents can make an informed choice regarding whether or not to have the screening. Reports indicated this training was updated annually on the mandatory training programme.

- An external workshop in November 2014 delivered by the charity SANDS (Stillbirth & neonatal death) was attended by 20 midwives. The aim of the course was to enable participants to develop the knowledge, insight and skills to provide high quality, sensitive care to parents who experience the death of a baby, before, during or shortly after birth.

- Assessments for anxiety and depression were completed, and women were referred to an external mental health team if perinatal mental health care was required.

- Mothers were supported to spend time with their baby if admitted to the neonatal unit to enable bonding.

- The head of midwifery stated 100% of bereaved parents attended the pregnancy risk clinic which was consultant led. The fetal medicine midwife also reviewed each case and counselled women and their partner about their experience.

- Babies who needed antibiotic screening or medication had to be taken down to the neonatal unit for treatment and so mothers who were not well enough to escort their babies were separated from their babies for a procedure that could be completed at the bedside.

Are maternity and gynaecology services responsive?

Good 🟢

We rated responsive as good because:

- The service was open to suggestions from people who used the service other maternity services, commissioning agencies and outside auditors.
- Action was taken to resolve access and flow concerns when new issues were identified.
- Specialist midwives were employed and systems were in place to ensure the individual needs of women and babies were met.
- Individual staff were supported to learn from complaints and concerns however processes for wider learning were not evident.

Service planning and delivery to meet the needs of local people

- The maternity services used information from patient surveys to plan service delivery provided to local people. For example the 2015 antenatal satisfaction screening survey showed an increase in the number of women reporting that they had received their results or feedback about scans and tests on the same day as the test and additional counselling had been provided. This meant women had more time with the midwives and sonographers.

- The trust worked collaboratively with Healthwatch England and used independent feedback to assist with planning services for example the service had refitted a small office so this could be used when discharging mothers.

- The trust worked regionally and members of obstetric and maternity services attended the "Saving babies in North England" meeting which uses best practice to plan services aimed at reducing the number of intra partum stillbirths in the region.

Access and flow

Maternity and gynaecology

- The maternity service had closed six times during 2015 due to activity. This had been managed through the escalation policy which involved working with other local maternity services and emergency ambulance services.

- The trust took action to try and prevent delays in the service. For example meeting notes and discussion with the senior managers indicated that the trust had reviewed planned inductions of labour (IOL) to prevent a backlog caused by unforeseen changes on the labour suite. Verbal feedback at meetings indicated the change was having a positive effect; however on the day of inspection we found two women who had experienced significant delays in their procedures, however no women were sent home without the procedure being undertaken.

- All the midwives were talked with stated delays in IOL's was a regular occurrence.

- The admission process was clear and women rang the day unit, however, if out of hour's woman were able to contact for help directly.

Meeting people's individual needs

- Specialist midwives and processes were in place for supporting patients with complex needs such as diabetes, teenage pregnancy, learning disabilities and mental health needs. However a drugs and alcohol specialist midwife weas not in place, but processes were in place to support patients and families.

- Interpreter request forms and invoices showed patients had access to these services. The policy was clear and there were no barriers to accessing translation services.

- If patents could read English, clearly written and easy to understand patient information leaflets about gynaecological and obstetric procedures were available in waiting areas.

- The trust was introducing a specialist system for checking how well a baby was growing during the antenatal period. This specialist 'growth chart' would help midwives to identify if a baby was small or large for dates. This would help women, midwives and obstetrician decide on how to manage the delivery of the baby.

- Individualised growth charts were introduced for new antenatal bookings in October 2015. The first measurement was not due to be taken until 24 weeks gestation and so more time was needed to confirm positive improvements.

- Specialist advice was available to support people with bariatric needs.

Learning from complaints and concerns

- The complaints report indicated that maternity and gynaecology services had received 22 formal complaints about the service. An individual report about themes and management of complaints had not been compiled, however information from individual reports indicated complaints were reviewed and in-depth investigations completed when required.

- The outcome usually involved speaking with the individual member of staff involved.

Are maternity and gynaecology services well-led?

Good ●

We rated well-led as good because:

- The vision for maternity services was based on the 6 C's, care, compassion, competence, commitment, courage and communication, outlined in the chief nursing officer for England's national nursing strategy 2012. Midwives were able to articulate this.
- The senior managers were active members of Cheshire and Merseyside maternity, children and young people strategic clinical network steering group and so involved in influencing maternity services for a catchment area wider than Cheshire
- Whilst there were some gaps in systems for sharing information from learning from incidents and monitoring of audit performance at a departmental level, however there were over-arching governance arrangements in place within maternity and gynaecology services which monitored risk, quality and performance which ensured that information was shared.
- The senior management team described early plans to review the layout, use of the facilities on the maternity

unit, and improve liaison with local community groups. Plans also included a closer working relationship with other maternity services so that effective ways of working could be shared.

- The immediate leadership of the maternity and the gynaecology services was visible to staff and were aware of the day to day challenges of the service.
- An open, transparent culture was evident where the emphasis was on the quality of care delivered to women. The service encouraged a 'no blame' culture where staff could report when errors or omissions of care had occurred.
- The trust worked to promote innovation, improvement and sustainability. The trust had employed a research midwife with a remit to prioritise obstetric studies. Her role included working with obstetricians, midwives, women and centres of excellence to develop projects which would influence best practice guidance in the future.
- The service had recently introduced hypnobirthing for women using the service.

However,

- Ward staff were aware of the short and long-term goals for the service but did not feel involved in the plans to bring about the changes.
- Action plans for governance and improvement were in place, however they did not always include specific, measurable, achievable and time-limited goals.

Vision and strategy for this service

- The trust had a strategic plan for the future and strategy through the model hospital concept hospital'. This is a new strategy for measuring quality focussed on wider concepts of value, reliability, operational transparency and accountability.
- The 'summary strategic plan document for 2014-19' indicated that the site strategy and capital priorities included refurbishing the women and children's building in two phases.
- At the time of our inspection, the local maternity services strategy 2014-2019 'Delivering excellence in maternity care' we were not provided with a framework for future development. The document described the current services and provided a list of intentions, however the trust advised us that forward plans and actions were monitored monthly.

- The vision for maternity services was based on the 6 C's, care, compassion, competence, commitment, courage and communication, outlined in the chief nursing officer for England's national nursing strategy 2012. Midwives were able to articulate this.
- The senior managers were active members of Cheshire and Merseyside maternity, children and young people strategic clinical network steering group and so involved in influencing maternity services for a catchment area wider than Cheshire.

Governance, risk management and quality measurement

- There were governance arrangements in place monitored key risk and quality measurements though obstetric and gynaecology services, for example the risk register, all incidents and investigations, clinical audit and research.
- At the time of inspection, we found that the risk register included three items rated moderate or above which were the interface between the maternity services and an independent provider, lack of a second theatre which had been entered on to the register in January 2015 and the need to be compliant with cardiotocography (CTG) best practice guidance placed on the register in 2013. The risk register was reviewed was part of governance meetings as a standard agenda item and minutes showed discussions that supported risk register entry and escalation to trust board.
- The speciality risk register did not include low staffing levels, however staffing levels were part of the trust wide executive risk register and we saw details actions that had been taken and monitoring arrangements that were in place.
- Action plans for governance and improvement were in place, however they did not always include specific, measurable, achievable and time-limited goals.
- The speciality risk register had been updated in February 2016 and included the need for more robust management of audits and outcomes.

Leadership of service

- Maternity and gynaecology formed part of the planned care business unit. The leadership of the maternity

Maternity and gynaecology

services was stable however the service was being reviewed at board level to make sure future developments met the needs of the population, was sustainable and based on best practice.

- The immediate leadership of the maternity and the gynaecology services was visible to staff and were aware of the day to day challenges of the service.

- Senior staff were seen in clinical areas and had a good awareness of activity within the service during the inspection. Staff we spoke with informed us the matron would be work clinically if needed. Staff were clear about who their manager was and who the senior consultant and head of midwifery were.

Culture within the service

- An open, transparent culture was evident where the emphasis was on the quality of care delivered to women. The service encouraged a 'no blame' culture where staff could report when errors or omissions of care had occurred.

- We observed strong team working, with medical staff. Maternity, obstetrics and gynaecology staff said they worked well together as a team.

- The gynaecology and maternity services had an effective working relationship and worked flexible to promote the best outcome for women receiving care.

Public engagement

- There was an active local maternity network which involved stakeholders and service users in place to help inform maternity services going forward.

- The trusts strategy plan for 2014-2019 for maternity services did not include information about how the trust would inform and involve the general public about the plans, however we were advised that actions were in place and this was monitored monthly.

Staff engagement

- Staff were engaged in making plans for the development of the maternity services. The results of the CQC staff survey showed that Countess of Chester midwives involvement with future development was neither worse nor better than the national average.

- Evidence confirmed staff involvement in the future strategy through surveys and consultation. Within maternity and gynaecology senior staff were able to articulate the 'model hospital' strategy and minutes from meetings indicated some elements such as value and accountability had been introduced to midwives at team meetings.

- The women and children's division senior management team told us they were developing on unit level staff surveys. This was at the early planning stage and so not yet evident in meeting notes and reports provided by the trust.

Innovation, improvement and sustainability

- The trust worked to promote innovation, improvement and sustainability. The trust had employed a research midwife with a remit to prioritise obstetric studies. Her role included working with obstetricians, midwives, women and centres of excellence to develop projects which would influence best practice guidance in the future.

- The service had recently introduced hypno birthing for women using the service.

- The maternity service at the Countess of Chester was under review.

Services for children and young people

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

Information about the service

Countess of Chester Hospital provides a range of paediatric and neonatal services within its Women and Children's building. Both the neonatal unit and children's unit are situated on the ground floor. The neonatal unit has 20 cots and provides critical care, high dependency care, special care and transitional care for newborn babies. The children's unit has 34 beds, which include a 22-bed ward area incorporating two high dependency beds and six adolescent beds. There is also a six-bed paediatric day surgery area and a six-bed acute assessment unit. A dedicated paediatric outpatient clinic is located next to the ward.

Hospital episode statistics data (HES) showed there were 4,343 children and young people seen between September 2014 and August 2015, 95.3.% of cases were emergency admissions, 17% were day case admissions and 1.1% were elective admissions.

We visited the Countess of Chester Hospital between the 16 and 19 of February 2016 and performed an unannounced visit on the 4 March 2016. We inspected a range of paediatric services including the children's unit, the neonatal unit, surgical theatres and the paediatric outpatients department.

We spoke with ten patients and/or carers, observed care and treatment and inspected nine sets of records and seven prescription charts. We also spoke with 44 staff of different grades including nurses, doctors, consultants, medical students, ward managers, specialist nurses, and play specialists. 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:

- We saw evidence that incidents were being reported and that information following clinical incidents was fed back to staff in daily safety briefings.
- Cleanliness and hygiene was of a high standard in areas we visited and staff followed good practice guidance in relation to the control and prevention of infection.
- Care was delivered by caring and compassionate staff and the differing needs of children and young people were considered when delivering care.
- Facilities were available for parents to stay with their children.
- 97.6% of children and young people were seen within the 18 week target time and correspondence with GPs following admission or treatment was sent in a timely fashion.
- The hospital at home service enabled children to be treated in their own home or reduced their stay in hospital.
- Managers had a good knowledge of performance and were aware of the risks and challenges to their service.

However,

- Nurse staffing levels on the children's unit did not reflect Royal College of Nursing (RCN) standards (August 2013) and nurse staffing levels on the neonatal unit did not meet standards recommended by the British Association of Perinatal Medicine (BAPM).
- The neonatal unit lacked storage space and resources for barrier nursing.
- There was not always a member of nursing staff on duty with Advanced Paediatric Life Support (APLS) on the children's unit. The unit ensures APLS trained staff are included for day duty and gaps at night-time are mitigated by nursing staff being PILS trained and medical staff being APLS trained.

Are services for children and young people safe?

Requires improvement ●

We rated safe as requires improvement because:

- Nurse staffing levels on the children's unit did not reflect Royal College of Nursing (RCN) standards (August 2013) and had resulted in eight incidents between January 2015 and January 2016, of which two detailed direct impact to patients.
- We found nurse staffing levels on the neonatal unit did not meet standards recommended by the British Association of Perinatal Medicine (BAPM). Between January 2015 and January 2016, 11 incidents were recorded that related to the acuity of patients and staffing breaching BAPM standards and on seven occasions in that period the neonatal unit had been closed to admissions.
- Nurse staffing was recorded as a risk on the divisional risk register for both the children's unit and the neonatal unit however, the risk to the neonatal unit was first recorded in 2010.
- The neonatal unit lacked storage space and resources for the care of patients who required strict infection control measures.
- Patient's medical records were not securely stored on the children's unit.
- Emergency resuscitation equipment was in place but records indicated that daily checks of the oxygen, suction and the defibrillator were not consistently completed.
- Controlled medicines were stored correctly however not consistently checked as per the trusts policy.
- There was not always a member of nursing staff on duty with Advanced Paediatric Life Support (APLS) on the children's unit however, the unit was funded for four training places per year and plans were in place to train all nurses at band 5 and above. Most registered nursing staff on the neonatal unit were qualified in New born Life Support training (NLS) and plans were in place for the remaining staff to attend the course.

Services for children and young people

- The trust target for safeguarding adults training was not met by all staff however safeguarding policies and procedures were in place, staff were aware of their roles and responsibilities and knew how to raise matters of concern appropriately.

However,

- Incidents were reported appropriately with the majority being low or no harm to the patient and lessons learned were shared with staff by the daily safety brief or group email.
- The wards and clinical areas were visibly clean. Staff were aware of and adhered to current infection prevention and control guidelines.
- We reviewed nine sets records, which were generally completed to a good standard.
- Staff were aware of the trusts Major Incident Policy and where to locate it.

Incidents

- Incidents were reported using an electronic reporting system. Staff could demonstrate the process and received feedback both individually and via the daily safety brief or group email sent to all staff within the children's unit.

- There were no never events or Serious Incidents reported by the trust between November 2014 and January 2016 within children's services. Never events are very serious, wholly preventable, patient safety incidents that should not occur if the relevant preventative measures have been put in place.

- One serious incident was recorded by urgent and emergency care between November 2014 and January 2016 that involved failure to obtain a bed for a child. Staff within the children's unit told us there had been a high demand for beds during the recent winter regionally and nationally as well as locally. During the incident medical staff cared for the patient in the accident and emergency department until a bed could be found.

- Between January 2015 and January 2016, 254 incidents were recorded by the children's unit, neonatal unit and paediatric outpatient's clinic. Of these, 252 were reported as low or no harm.

- Nineteen of the incidents classified as no harm related to staffing levels and acuity of patients within the units.

- Between December 2014 and November 2015, 11 incidents were reported that required further investigation. We reviewed documentation relating to three of the incidents and found actions identified because of an incident review.

- Safety thermometer was in use on the neonatal unit to monitor device related pressure ulcers and results as at January 2016 showed 100% harm free care. The NHS Safety Thermometer is a local improvement tool for measuring and monitoring 'harm free' care.

- Staff we spoke to were unfamiliar with the term 'Duty of Candour' (the regulation introduced for all NHS bodies in 2014, meaning they should act in an open and transparent way in relation to care and treatment provided) however they could describe the principle and the circumstances it was used.

- Perinatal and neonatal mortality and morbidity meetings were held separately to allow time for discussion and numbered five and two respectively in the last year. Key messages and learning points were then given to staff.

- Two paediatric mortality and morbidity meetings had been held in the last year and governance meetings were held monthly. Meeting minutes were produced and sent electronically to staff.

- All child deaths were reviewed by a named paediatrician from the Child Death Overview Panel (CDOP). This was a community paediatrician who sat with the Local Safeguarding Children's Board (LSCB).

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. We observed staff using personal protective equipment such as aprons when delivering care.

- The had been no cases of MRSA blood stream infection on the children's or neo-natal unit.

- Hand washing facilities, including hand gel were readily available in prominent positions in each clinical area.

- There were arrangements in place for the handling, storage and disposal of clinical waste, including sharps.

Services for children and young people

- Hand hygiene monitoring between May 2015 and October 2015 showed that the neonatal unit scored 100% with the exception of June when this fell to 98%. The childrens unit also achieved 100% with the exception of September when the results were 96%.

- Patient-led assessments of the care environment (PLACE) audit for 2015 showed the trust scored higher than the national average for cleanliness across the trust.

- Patients transferred to the childrens unit from another hospital were routinely screened for Methicillin Resistant Staphylococcus Aureus (MRSA) and isolated until results were available. Patients who had previously tested positive for MRSA were also screened on admission.

- Cleaning checklists were present in the milk room however we noted five dates between the 22nd January 2016 and our inspection when the chart was not completed.

- Staff on the neonatal unit told us they encouraged parents to question nurses and doctors about handwashing, if they felt able.

Environment and equipment

- The neonatal unit lacked storage space resulting in equipment such as cots and incubators being stored on the corridor. Lack of space and resources for barrier nursing was recorded as a risk on the departmental risk register on the 1st March 2015 and a major fundraising appeal was ongoing during our inspection to raise funds to build a new neonatal unit.

- A door from a staff resource room on the neonatal unit that led to an internal courtyard was unable to be secured. This had been reported however, staff could not tell us how long this had been broken. We looked at this again at our unannounced inspection and found that this situation had not been resolved.

- Doors to storage rooms were left open on the neonatal unit despite have clear signs that indicated they were fire doors. We raised this with staff during our inspection and were told that if the doors were kept shut the storage areas became too hot. No thermometer was evident in any of the storage rooms.

- Emergency resuscitation equipment was in place on the ward, but records indicated that daily checks of the oxygen, suction and the defibrillator were not consistently completed. Between the 1st January 2016 and 17th February 2016, checks on the equipment kept on the corridor in the children's unit were not recorded on four occasions. A more detailed check was undertaken weekly and records showed this was completed however, we did observe blood culture bottles in the treatment room resuscitation trolley on the children's unit that were out of date. Staff were made aware of this and took immediate action to replace them.

- The clinical areas we visited had controlled access and the children's unit was colourfully decorated with different coloured paw prints on the floor to guide patients and visitors to various areas of the unit. However, the kitchen door on the children's unit was unlocked allowing access to patients despite being designated a staff only area.

- Equipment we observed that had portable appliance testing stickers (PAT) were in date and most equipment had electro-biomedical engineering stickers (EBME) however; staff were unaware when equipment had been serviced.

- Clinical waste storerooms on the main access corridor to the neonatal unit and paediatric outpatients' clinic were found to be unlocked and a container of used batteries was observed. We informed staff who removed the container and doors were subsequently locked.

Medicines

- Medicines, including controlled drugs were stored securely in line with legislation.

- Records indicated that there were eight occasions between the 1st January 2016 and our inspection when the controlled drugs had not been checkeddaily on the childrens unit as per trust policy.

- Fridge temperatures were checked and recorded daily and included the minimum and maximum range.

- We observed medicines being given to patients by nursing staff on the childrens unit. Standard operating procedures (SOP) were followed, medication was given in accordance with the prescription and patient details were checked.

Services for children and young people

- The trust had implemented electronic prescription charts. Of the seven prescription charts reviewed all were signed, dated and had allergies and the age of the child documented. Six of the seven had the weight of the child recorded and the one record where it was appropriate, had a documented reason for not giving medication.

- Processes were in place to ensure the safe issue of medicines at the point of a patients discharge.

Records

- The trust used a combination of paper and electronic records. Nursing records and prescription charts were electronic, medical notes remained in paper format.

- We reviewed nine sets of records on the children's unit, which were generally completed to a good standard. Eight records were signed and dated, all had a plan of care, an assessment of pain was recorded if appropriate, however only two records had evidence that nutritional needs had been addressed.

- Medical records for patients for patients due to be admitted or that had been discharged were placed in a storeroom opposite the ward reception desk on the children's unit. This was not locked despite having a keypad lock and was therefore accessible to patients and visitors.

- Records of inpatients were stored in an unlocked trolley behind the ward reception desk. This was also accessible to patients and visitors particularly between the hours of 6pm and 8am when the reception desk was not staffed.

Safeguarding

- A safeguarding screen was part of the admission process using the electronic patient record. These ensured enquiries were made about any allergies or involvement in drug trials as well as child protection issues including contact with children's services or social worker involvement.

- Safeguarding policies and procedures were in place across the trust and these were available electronically for staff to refer to.

- Staff were aware of their roles and responsibilities and knew how to raise matters of concern appropriately. Safeguarding training formed part of the trusts

mandatory training programme and the children's unit organised three study days a year to enable staff to attend an annual update. This was reported to include topics such as Female Genital Mutilation.

- The trust target for safeguarding training was 80%. Data provided by the trust for the children's unit indicated 100% of administrative and clerical staff and 60% of estates and ancillary staff had completed level 1 training. Nursing and midwifery registered staff, medical and dental staff and additional clinical services required level 3 training and attendance rates were 88.3% for nurses, 93.8% for medical staff and 94.8% for clinical services staff. Some medical and dental staff also required Level 4 and 5 training and attendance for this was 100%.

- The trust safeguarding adults training target was 80%. Level 1 training was required by staff in additional clinical services, administrative and clerical staff, estates, and ancillary staff. However only additional clinical services staff achieved this with an attendance rate of 82.9%. The lowest attendance rate was by administrative and clerical staff at 50%. Medical and dental staff, nursing, and midwifery registered staff required level two training and attendance rates were 59% and 79% respectively.

- A named midwife for safeguarding children and a safeguarding lead doctor where identified within the trust.

- Serious case reviews (SCR) were discussed at a safeguarding peer review meeting and given to staff in the daily safety brief, ward meeting or by group email. A serious case review takes place after a child dies or is seriously injured and abuse or neglect are thought to be involved.

- Electronic and paper referrals were made to paediatric liaison 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.

- Qualitative information was provided to the Local Safeguarding Children's Board (LSCB) quarterly regarding the number of attendances at A&E for under

18 year olds for self-harm related issues, attempted suicide or for drug or alcohol related issues that were reported to the liaison health visitor. This highlighted any key trends, risks or issues and as well as any training or resource issues.

- Figures for quarter one to three 2015-2016 indicated that 292 attendances were recorded for self-harm related issues and/or attempted suicide and 52 for drug or alcohol related issues. All children and young people who attended with self-harm or suicidal ideation were admitted to the children's ward; 16-18 year olds were assessed in A & E and referred on as appropriate.

Mandatory training

- All staff attended trust induction when they started work at the hospital and new nursing staff within the children's unit received support from the practice development lead to achieve competencies with medical equipment.

- Staff received training in areas such as infection prevention, medicines management, information governance and fire training. Training was delivered online as well as face to face.

- The trust target for mandatory training was 95%. Records showed that training completion rates among staff in the reporting unit for children were 100% for medical and dental staff and 98% for nursing and midwifery registered staff.Additional clinical services attended either full or half day and attendance rates were 98% and 50% respectively. Administrative and clerical staff and estates and ancillary staff required half-day training and attendance rates were 100%.

- Staff reported receiving an email reminder when training was due and the practice development lead within the children's unit kept a database and supported staff attendance.

- Conflict resolution was not identified as mandatory for all staff on the children's unit however all neonatal staff were scheduled to attend. We were told the decision was based on manager's discretion.

Assessing and responding to patient risk

- The trust used Paediatric Early Warning Scores (PEWS) to monitor a child's condition. This included observation of the patient such as pulse and respiratory rate. If a child's condition deteriorated, the score for the observations increased and gave an indication that intervention maybe required.

- Monthly monitoring of care metrics took place on the children's unit. This is a standard of measurement for nursing care, which can be monitored against agreed standards. Appropriate escalation of patients using the PEWS was one of the standards and total scores for November 2015 was 100%, December 2015 was 90% and January 2016 was 100%.

- Of the records reviewed, a PEWS charts was not present in one case and one record did not have documented action taken when appropriate.

- Care metrics recorded monthly on the neonatal unit included infection control and privacy and dignity, pain management and patient observations and total scores for November 2015 was 100%, December 2015 was 99% and January 2016 was 100%.

- Managers told us that there was not always a member of nursing staff on duty with Advanced Paediatric Life Support (APLS) on the children's unit. Howeverall Advanced Paediatric Nurse Practitioners (APNP) had completed APLS training and one APNP was on duty in the Assessment unit between 8am-9pm, seven days per week.

- Data from the trust showed that in October 2015 65% of shifts had APLS trained nurses on duty, in November 2015 this was 62% and in December 2015 the figure was 64%. This meant that there was no member of nursing staff on night duty with APLS on a regular basis however; managers told us onsite medical staff provided support.

- All hospital consultants are APLS trained (7); all registrar level doctors (7wte) and also a number of the SHOs are trained. Seven nursing and midwifery registered staff had completed APLS training, however there was funding for four nurses to be trained per year and plans were in place for all band 5 staff and above to attend.

- All staff band four and above were trained in Paediatric Immediate Life Support (PILS) and new staff attended this course within six months of commencing with the trust.

Services for children and young people

- All but three registered nursing staff on the neonatal unit were qualified in Newborn Life Support training (NLS) and plans were in place for the remaining staff to attend this course which was available as a rolling programme, renewable three yearly.

- Transfers of infants between hospitals were completed by the Cheshire and Merseyside Neonatal Network Transport service.

- Children and young people up to the age of 16 years who required child and adolescent mental health services (CAMHS) were admitted to the ward from the A and E department and were seen by the CAMHS team when medically fit.

Nursing staffing

- The expected and actual staffing levels were displayed on a notice board were displayed within the children's unit.

- 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. Staff informed us that the System to Escalate and Monitor (STEAM) acuity tool had been trialled however, this was no longer used and no other acuity tool had replaced it. Staffing issues were escalated through bed meetings. Staffing was being addressed going forward as part of service redesign which was due to be in place by June 2016, looking at more flexible ways of working.

- A skill mix review of the nursing establishment had been completed in June 2014 with a subsequent update in December 2015 where it was recognised that the trust did not meet all of the RCN recommendations, particularly concerning HDU patients. North West Regional guidance on HDU patients in a district general hospital stated a 1:1 ratio.

- Staff and managers reported that the demand for beds and the acuity of patients throughout the winter had been high. Trained staff numbers on the children's unit were eight for the morning shift, seven for the afternoon shift but only three trained staff for 22 beds on a night shift however the six bedded assessment bay and six surgical day case beds were closed overnight.

- At night a fourth nurse was requested from the nurse bank if both high dependency beds were in use

however, this had not always been achieved during December 2015. Managers reported that staff from the children's unit worked on the nurse bank and so additional shifts were usually covered by staff familiar with the ward.

- Data from the trust showed that staff levels for December 2015 were reviewed and on six occasions staffing met the RCN standard, however on 11 days up to 1.5 additional staff were required and on 14 days a further two or more additional staff were required when bed occupancy and acuity of patients was taken into account.

- Care at night on the children's unit was recorded as a risk on the divisional risk register from 29/1/16 and managers told us that a business case had been submitted to increase the nursing establishment to four trained members of staff at night.

- The children's unit also had four band 5 nurse vacancies recorded as a risk on the divisional risk register however we were advised that two posts had been filled and recruitment was ongoing.

- A Patient Flow policy was in place that detailed the circumstances when the children's unit would be closed.

- Between January 2015 and January 2016, eight incidents were recorded relating to staffing on the children's unit. Three detailed that staff had missed breaks due to the workload on the ward, two detailed direct impact to patients due to medicines being administered late and patients not receiving 1:1 care as required and one related to parental concern regarding staffing levels with particular reference to nights.

- Data from the trust showed that the children's unit had been closed on two occasions in November 2015 and three occasions in December 2015 due to the number and acuity of patients, and staff sickness. The unit had also closed on a number of occasions in December 2015 for a few hours to facilitate discharges.

- Day case surgery was also cancelled on the 4th December for the day, 7th December Monday – Friday for the week and on the 14th December for the day due to dependency of patients and staff numbers.

Services for children and young people

- Staff told us that during particularly busy times additional staff would be drawn from the assessment unit, the hospital at home service and the clinical development nurse and ward manager would take on clinical duties.

- Staffing within the neonatal unit did not meet standards of staffing recommended by the British Association of Perinatal Medicine (BAPM).

- Staffing on the neonatal unit was recorded as a high risk on the divisional risk register however this had been in place since 1/6/2010 and both staff and managers told us this remained a concern. A business case had been prepared for submission for additional staff. Data from the trust showed that, as at 4/1/16 the ratio of qualified to unqualified staff on the neonatal unit was 73% to 27% compared to 80:20 as recommended by BAPM.

- We reviewed staff rotas on the neonatal unit between the 1st and 10th of December 2015 and found that out of 20 shifts covering days and nights BAPM standards were not met on any occasion. Further review of staff rotas between 1st and 10th of January 2016 showed that BAPM standards were met on 15 occasions covering 20 day and night shifts.

- Between 29/1/15 and 26/1/16 11 incidents were recorded that related to acuity of patients and staffing breaching BAPM standards and on seven occasions in that period the neonatal unit had been closed to admissions.

- Staff on the neonatal unit also administered intravenous antibiotics to babies on the maternity unit. Parents would attend the neonatal unit with their child and during our inspection; five children required this service, which added to the workload within the neonatal unit.

- The neonatal unit had four cots designated for babies that required transitional care. These were described as 'floating' cots and were based within the maternity unit but cared for by neonatal staff. Staff would be allocated to care for the infants however if they also had patients on the neonatal unit this would involve working between the neonatal unit and the postnatalward during their shift meaning that there would be times some patients were not observed. Staff told us that if space was available, mothers and infants were brought to the neonatal unit to be cared for. Transitional Care had been recorded on the risk register since 01/09/12.

- We observed a nursing handover that was completed using a tape recorder. Staff pre-recorded the nursing handover, which was subsequently played to the staff at change over at the start of their shift. This provided information such as the name, age, diagnosis, observations, medications and treatment plan of patients on the ward. This approach meant that staff could not ask questions or seek clarification however; we observed staff obtaining additional information from colleagues as required following the handover.

Medical staffing

- The percentage of consultants working in paediatrics within the trust was 30% which was lower than the England average of 35%.The percentage of registrars was 51%, which is the same as the England average, and 6% of the medical staff

- Consultant paediatric and neonatal cover was provided 24 hours per day.

- The trust had 6.8 whole time equivalent consultants (WTE) who took part in 'paediatrician of the week' rota. A shortage of a paediatric consultant was recorded on the divisional risk register on 21/10/15 however; managers informed us that approval had been obtained to increase the complement to 8.8 wte.

- Consultant shortage had led to the trust not meeting the Royal College of Paediatrics and Child Health (RCPCH) 'facing the future' standards 2015 of providing two consultant led medical handovers per day and every child being reviewed by a consultant paediatrician within 14 hours of admission.

- We observed a clinical handover, which included discussion of clear management plans and review of x-rays. Opportunistic teaching of junior staff took place, staffing issues were identified and proposals made for adequate deployment of staff.

- The trust also employed Advanced Paediatric Nurse Practitioners (APNP) who worked in the children's assessment unit seven days per week 8am to 9pm.

Major incident awareness and training

- The trust had a documented major incident plan which listed key risks that could affect the delivery of services and a Corporate Business Continuity Plan.

Services for children and young people

- Staff were aware of the trusts major incident policy and where to locate it.

- Managers told us there was no winter management plan specifically for the children's unit.

Are services for children and young people effective?

Good ●

We rated effective as good because:

- Care and treatment was delivered in line with evidence-based guidance. Policies and procedures were in place and staff knew how to access them.
- Tools were available to assess pain in children and young people and pain relief was available.
- Induction processes were in place for new staff and documentation was in place on the children's unit to orientate temporary staff to the ward.
- Good multidisciplinary (MDT) working was noted in areas we visited and policies were in place for the transition of patients from paediatric to adult services.
- Staff were aware of the principles when obtaining consent from a child and we observed staff tailoring their approach appropriately to the age of a child.

However,

- The trust had no nutritional assessment tool used routinely for patients admitted to the children's unit.

- Appraisal rates did not achieve the trust target of 95%.

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 the management of babies with suspected or early onset neonatal infection and when to suspect child maltreatment.

- There were a number of evidence-based pathways in place that staff were familiar with such as care of oncology patients with febrile neutropenia.

- The neonatal unit belonged to the North West Neonatal Operational Delivery Network and was working with the eight other units in the area to standardise practice and equipment. This was to assist with the transfer of patients between units.

- Policies and procedures were in place and could be accessed via the trust's intranet. Staff were aware of how to access them.

- The neonatal unit had achieved level 3 Baby Friendly accreditation and were signed up to the Bliss Baby Charter, which is a practical guide to help hospitals provide the family-centred care for premature and sick babies.

Pain relief

- The neonatal unit had an integrated pain management and observation chart and used a procedural pain assessment tool to improve pain management for sick and premature babies. This used methods such as used swaddling and containment for procedures. An audit was completed after the introduction of the pain assessment tool and an action plan put in place to promote continued use and evaluation.

- Analgesia and topical anaesthetics were available to children who required them in the ward and outpatients department.

- Patients we spoke with described how staff assessed their pain using a number scoring system both before and after providing pain relief and we saw assessment of pain documented in records as appropriate.

- The trust had no nutritional assessment tool used routinely for patients admitted to the children's unit however; paediatric dietetic referrals were initiated for patients admitted with a feeding problem or eating disorder.

- Patients told us that there were 'reasonable' food choices and staff could provide additional options if mealtimes were missed for any reason.

- A dietician was available to support infants in the neonatal unit who required assessment due to slow weight gain.

- Infants on the neonatal unit were weighed twice weekly and fluid balance was monitored.

Services for children and young people

- Designated breast milk fridges were kept on the neonatal unit and children's unit and mothers were encouraged to express breastmilk. Adonor milk bank facility was also available

- The trust provided data for the National Neonatal Audit Project. The latest published report was 2015 using 2014 data and showed there was a documented consultation with 100% of parents within 24 hours of admission; this ensures that parents have a timely explanation of their baby's condition and treatment. Thirty two per cent of eligible babies were discharged feeding only mother's milk and 24% taking some mothers milk. Results also showed 98% of children were screened on time for Retinopathy of Prematurity (ROP). ROP is an eye condition that can affect babies born weighing under 1501g or 32 weeks gestation and action plans were developed to address areas of improvement.

- The rate of multiple (two or more) emergency admissions within 12 months (July 2014 to June 2015) among children and young people aged 1-17 years with asthma was 16.5% compared to the England average of 16.8%.

- Children and young people aged 1-17 years admitted on two or more occasions with diabetes was 18.8% compared to the England average of 13.6% between July 2014 and June 2015. However, data from the diabetes specialist nurse indicated that between October 2015 and January 2016 only two patients had been admitted to the children's unit with diabetic ketoacidosis (DKA).

- The hospital took part in the National Paediatric Diabetes Audit. This identified that in the period 2013/14 the percentage of children with controlled diabetes was 22.2% compared to the England average of 18.5%.

- A child health audit programme was in place to monitor compliance to clinical care pathways for example the guidelines for the management of patients with deliberate self-harm.

- Admission of term infants to the neonatal unit was audited monthly and discussed at the Clinical Incident group to identify any trends.

Competent staff

- Staff identified their learning needs through the trusts appraisal process and the trust target was 95%.Trust

data showed that between April 2015 and November 2015 87% of staff in the children's reporting unit had received an appraisal. Junior medical staff and medical students said teaching was good and they felt supported.

- Induction processes were in place for new staff, which included competency assessments for medical devices for both registered and unregistered nursing staff.

- New staff to the neonatal unit was allocated a mentor and we observed completed documentation on the children's unit used to orientate temporary staff to the ward.

- All trained staff on the children's unit had completed competencies for medical devices used in HDU.

- Managers in the children's unit reported that it had been difficult for staff to maintain competencies to care for patients with tracheostomies due to the low number of children admitted to the unit. However, staff had received clinical updates from both internal and external sources including training provision from physiotherapy staff and the complex care team.

- The number of neonatal staff Qualified in Speciality (QIS) was 81.3% and a rolling programme was in place for new staff to complete this training. This is a standard level of knowledge and skills for nurses within neonatal care.

- Managers described how they managed poor staff performance including holding discussions with staff, support for retraining and use of human resource policies and procedures.

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 and paediatric pharmacy support was available Monday to Friday.

- Children referred to child and adolescent mental health services (CAMHS) were usually seen the next day

Services for children and young people

between Monday and Friday and a Service Level Agreement was in place for the trust to provide medical care to patients as part of the Childrens Eating Disorders Service (CHEDS).

- Psychologist support was available to provide support for CHEDS and CAMHS patients.

- Monthly MDT meetings were held on the children's unit for oncology patients and senior clinicians meetings were held weekly in the neonatal unit.

- Meetings were held with social care and community professionals as required for example in cases involving safeguarding or that required discharge planning.

- Play specialists were available 8am-4.30pm Monday to Friday in the children's unit and attended theatre with patients as required.

- Summary letters were sent to a patients GP following discharge and GPs were also advised by telephone when a baby was discharged from the neonatal unit. Health Visitor liaison informed community professionals when a baby was admitted to the neonatal unit.

- Policies were in place for the transition of patients from paediatric to adult services and audit data indicated that service users and professionals were satisfied with the process however, it was noted that respondent numbers were small.

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 ED, however outpatient appointments were only scheduled Monday to Friday.

- Play specialists only worked Monday to Friday and no cover was provided during the weekend.

- Consultant on-call cover was provided out of hours.

Access to information

- Policies and procedures were kept on the trusts intranet and staff were familiar with how to access them.

- There were mobile computers around the wards to enable nursing documentation and prescription charts to be viewed and completed as well as to support ward rounds.

- Vaccinations given were recorded in the child's Personal Child Health Record (PHCR).

- GP discharge letters were sent following discharge from the children's unit to ensure continuity of care in the community.

- Discharge summaries were provided to parents and GPs when babies were discharged from the neonatal unit.

Consent

- Play specialists frequently supported children and young people for all procedures undertaken.

  This ensured that information was provided at an appropriate level and that patients understood what was happening

- Staff described how they worked on the principle of verbal consent for some procedures such as taking observations of temperature and pulse and we observed staff tailoring their approach appropriately to the age of a child.

- 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.

- We observed the procedure of obtaining written consent for a child going to theatre and accompanied them to the anaesthetic room to see how this was reviewed.

- Staff on the neonatal unit described how support was requested from extended family and the safeguarding team when dealing with parents who may lack capacity.

Are services for children and young people caring?

Good ●

We rated caring as good because:

- Parents and children were positive about the care they had received. They felt supported and involved in their child's healthcare and received information that was easy to understand.

Services for children and young people

- Care was provided by committed and compassionate staff that treated patients and their relatives with kindness and respect.
- Services were available for families that experienced the loss of a child.

However,

- Privacy on the neonatal unit was limited.

Compassionate care

- The children's unit presented as a calm environment during our inspection and call bells were observed to be answered in a timely fashion.

- Care was provided by committed, compassionate staff that 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 on the neonatal unit were described as ' amazing' and 'reassuring' and boosted parents confidence while staff on the children's unit got to know patients as people.

- Privacy on the neonatal unit was reported as an issue by parents due to the lack of space and limitations of the environment. Portable screens were used if mothers wished to express breast milk or breastfeed their baby but the unit was reported to be 'crowded' and our observation supported this.

- The children's unit scored the same as other trust for 23 questions in the Children's survey in 2015; however, it scored better than others for parents feeling like the hospital staff took good care of their children.

- Friends and family results were displayed on the wall by the reception desk in the children's unit and indicated that in January 2016 100% of respondents would recommend the service to friends and family. Data had been collected for the first time in January 2016 as the trust had moved to a new company in an effort to make this process more child friendly and posters and cards observed had a monkey logo to encourage participation. Managers told us they were working with the company and linking with local partners to engage children in a competition to name the monkey.

- Parental experience surveys from families who had received care in the neonatal unit were collected through Bliss and results received by the unit offered opportunities to identify areas where they were performing well and areas that required improvement. Staff told us that action plans were written as a result of feedback and actions we reviewed that were rated amber included the requirement for a specific guideline for social interaction and touch which is regularly referred and adhered to by staff and identifying a dedicated individual to coordinate a baby's discharge plan from the moment of admission.

Understanding and involvement of patients and those close to them

- Patients and parents told us they felt fully informed about their care planning, that staff spent time explaining what was happening and provided information that was easy to understand. Parents stated 'they will explain as many times as needed until you understand'.

- Patients and parents felt involved with their future care and were confident that they were taught skills required before discharge, for example parents on the neonatal unit had been taught how to administer medicines and received a resuscitation demonstration.

- A variety of leaflets were available for parents on the neonatal unit covering a variety of topics including discharge from hospital.

- Parents were encouraged to stay with their children on the children's ward and there were chairs at the bedside that converted to beds and parents had access to Christopher Wing. This was a residential facility next to the children's unit that had bedrooms, a kitchen, sitting room and shower room and was originally opened with donations from a family whose child had passed away

Emotional support

- Parents felt confident about leaving their baby in the neonatal unit and stated they could always telephone to ask about the baby overnight. On return, a report was also given to them telling how their baby had been since their last visit.

- Play specialists accompanied children and parents to theatre. Children admitted requiring Child and

Services for children and young people

Adolescent Mental Health Services (CAMHS) were supported by ward staff who received guidance from CAMHS and paediatric medical staff, however, there was no registered mental health nurse on the ward.

- Parents were provided with the contact number for the ward on discharge to allow them to telephone for advice if they had any problems and in some cases were given open access to the ward for 24-48 hours.

- The children's unit had a quiet room away from the ward. This was a designated area to allow professionals to hold private or sensitive conversations with patients and relatives.

- A designated specialist cot was available on the neonatal unit so that in the event of a baby passing away parents and family members could spend time with their infant.

- Parents had the choice of transferring their baby or child to a local hospice after they had passed away where bereavement and sibling counselling could be arranged.

Are services for children and young people responsive?

Good ●

We rated responsive as good because:

- Paediatric services met the needs of children, young people and their families. Most areas were children were treated were child friendly and facilities on the children's unit catered for the needs of children of different ages.
- Facilities were available for parents to be with their child at all times.
- Interpreting services were available as required.
- 98% of children and young people were seen within the 18-week target time and correspondence with GPs following admission or treatment was sent in a timely fashion.
- The Hospital at Home service enabled children to be treated in their own home or reduced their stay in hospital.
- The service received few complaints but lessons learned from the complaints were shared with staff.

However,

- The environment within the neonatal unit was welcoming but lacked space and privacy for mothers who wished to breastfeed and parents who wanted to spend time with their baby.

Service planning and delivery to meet the needs of local people

- The environment on the children's unit including the paediatric outpatient's clinic was child friendly. A playroom and an adolescent lounge was available on the ward so that children and young people had activities appropriate to their age. The adolescent lounge had games consoles and televisions as well as an outside area. We saw leaflets in this area appropriate to the needs of teenagers.

- Every bed in the ward and day case area had an overhead television that was free to use until 8pm and cards were given to patients on arrival to access Wi-Fi. This enabled patients to access social media via telephone or laptop so they could keep in contact with friends and family.

- The six adolescent beds on the ward were separated into two three bedded bays, one for male patients and one for female patients, each with bathroom facilities and connected by the adolescent lounge.

- Children were also seen in some adult outpatient clinics, the x-ray department and emergency department within the hospital. Facilities for children were observed but limited within the adult outpatient and diagnostic waiting areas however, Audiology had a children's area and paediatric room and A & E had a dedicated children's treatment and assessment area called 'Kids Zone'.

- Children attending for day case surgery could be accompanied by their parents into the anaesthetic room and an appropriately decorated section was set aside in the recovery area however, this was only separated by curtains.

- Parents were encouraged to stay with their child on the ward. There were chairs at the bedside that converted to beds and Parents had access to Christopher Wing. This was a residential facility next to the children's unit that

had bedrooms, a kitchen, sitting room and shower room and was originally opened with donations from a family whose child had passed away. Parents told us this gave "the chance to get 5 minutes to recapture yourself".

- There were no facilities for parents to make hot drinks on the children's ward however, drinks could be brought in and put in thermos flasks.

- The environment in the neonatal unit was welcoming but lacked space and privacy for mothers who wished to breastfeed and parents who wanted to spend time with their baby.

- There were two rooms with en-suite facilities that could be used by parents on the neonatal unit who wished to stay overnight as well as access to Christopher Wing.

- Open visiting was available to parents with infants on the neonatal and children's unit and support was available with parking charges.

Access and flow

- Admission to the children's unit was either via A & E, GP referral to the assessment unit however, patients with known conditions had direct ward access with a patient passport.

- The assessment unit was open 8am-9pm every day and any patients requiring care after 9pm were admitted to the ward.

- Babies admitted to the neonatal unit that required intensive care for longer than 48 hours were transferred to a specialist unit.

- Data from the trust indicated that 98% of patients referred to paediatric services were seen within the 18-week target however figures from January 2016 indicated that outpatient clinic Did Not Attend rates (DNA) were 9.4% compared to the trust target of 5%.

- Bed occupancy rates were reviewed at the paediatric speciality meetings. Data from the trust showed that bed occupancy rates between February 2015 and January 2016 ranged from 37% to 64% on the neonatal unit and 35% and 69% on the children's unit however this was a snapshot at 08.00 and staff told us that this did not take into account the number of patients who may have been admitted and discharged home within the time frames. Specific dependency and acuity data from the children's unit showed that occupancy rates for

the children's ward was 31% to 100% in November 2015 and 45% to 95% in December 2015. During this period day case surgery was cancelled for eight days and the never event occurred that involved failure to obtain a bed for a child.

- The median length of stay in the trust is lower than the England average.

- Care summaries were sent to the GP on discharge to ensure continuity of care in the community. Figures from January 2016 showed that 96% of e-discharge letters were sent within 48hours against a trust target of 92% and 81.3% of outpatient letters were sent within 14 days against a trust target of 50% in Paediatrics.

- Urgent clinic appointments were available within the paediatric outpatient department.

- Child and adolescent mental health services (CAMHS) were available Monday to Friday. Children referred to CAMHS were usually seen the next day if admitted Sunday to Thursday. Staff told us there had been a pilot of providing weekend cover however, this had not continued.

- The trust had set up a Hospital at Home service in 2012 to reduce the time children spent in hospital and prevent re admissions. The Hospital at Home service was available Monday to Friday 8am-9pm and 8am-6pm Saturday and Sunday and allowed children requiring treatment such as intravenous antibiotics or suffering with infections or respiratory problems where appropriate, to be cared for at home. This meant children did not have to experience an unfamiliar ward environment and families did not have the disruption to family life associated with a hospital admission.

- Ward staff rotated into the community to provide this service and it had been extended in 2015 to accommodate referrals from GPs to reduce the number of children admitted to hospital. Feedback from both children and families was reported to be positive.

- Data provided by the trust showed that January 2015 to December 2015, 708 children had care delivered by the Hospital at Home service and between July 2015 and December 2015 49 admissions to hospital had been avoided. Data was provided by staff delivering the service, however further data analysis was in progress.

Services for children and young people

- At the time of our inspection, the Hospital at Home service was only available to patients who resided in the West Cheshire area. Patients in North Wales did not have access to the service and figures showed that between January 2015 and December 2015 109 referrals were declined from the North Wales area. This meant that 109 children who lived in North Wales were either admitted to hospital or stayed in hospital longer than children who lived in Cheshire in that period.

Meeting people's individual needs

- 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.

- Children who were inpatients on the children's unit for more than seven days had a play specialist assessment completed and a play plan drawn up to ensure their developmental progress was supported during their admission.

- We observed additional information on the list of patients to be admitted to the ward for day case surgery that indicated preferences such as to come in to hospital in the school holidays or a preference to be placed on the morning theatre list.

- Paediatric outpatient appointments were co-ordinated for patients with multiple attendances where possible to minimise the number of visits to the hospital required.

- Leaflets were available within the areas we visited on subjects such as breastfeeding and information about the ward. Information was also available in paediatric outpatient's clinic regarding the paediatric clinic support line. This provided additional support and information to parents and children on a variety of issues such as arranging blood tests, the use of local anaesthetic cream before blood tests and advice about managing a child's condition.

- Parents with children going to theatre were given pagers so that they could leave the ward and be promptly informed when their child was out of theatre.

- Formal transition processes were in place for children moving to adult services including children diagnosed with diabetes.

- We were told a pathway for children at the end of life was being written during our inspection however, a specialist nurse for oncology and palliative care was in post to support children and their families.

Learning from complaints and concerns

- Information leaflets were available within the areas we visited advising patients about Patient Advice and Liaison Service (PALS) and the trusts procedures if the wished to make a complaint.

- Staff were aware of the complaints process. Staff told us they would try to resolve issues immediately and if this were unsuccessful would direct the patient and family to the ward manager and PALS.

- Between December 2014 and December 2015, six complaints were recorded by the trust relating to paediatrics.

- Managers shared lessons learned from clinical incidents and complaints during the daily safety brief and by group email to staff within the children's unit.

Are services for children and young people well-led?

Good 🟢

We rated well-led as good because:

- Managers had a good knowledge of performance in their areas of responsibility and they understood the risks and challenges to the service.
- Quality and performance were monitored through paediatric and divisional dashboards.
- Staff were aware of the trusts vision and values and daily safety briefings were held to inform staff of current issues.
- Managers were visible and approachable and staff received a weekly email, which contained updates on relevant trust information.
- There was an open and honest culture in the service and the views of patients and their relatives were actively sought.
- Paediatric speciality meetings and clinical incident meetings were held monthly however there was not a named executive at board level for Children and Young People's Services at the time of our inspection.

Services for children and young people

Vision and strategy for this service

- Staff were aware of the trusts vision and values to deliver safe, kind, effective care.

- A lead nurse supported by managers in the neonatal unit and children's unit led Paediatric services. A care packages service manager was also in post.

- The trusts strategic plan included the refurbishment of the woman's and children's unit which was to be part funded by charitable donations and the Babygrow fundraising appeal was in progress during our inspection.

Governance, risk management and quality measurement

- Quality and performance were monitored through paediatric and divisional dashboards. This covered data such as, number of referrals, length of inpatient stay and waiting times for outpatient appointments.

- Monthly paediatric speciality meetings were held which ward unit managers attended, the lead nurse for children's services and doctors. These meetings were chaired by the clinical lead consultant paediatrician and discussed relevant governance issues including the divisional risk register, finance and staffing as well as reviewing activity against key performance indicators to identify emerging trends.

- Corporate and divisional risk registers were in place, managers knew the risks and mitigating actions within their departments.

- Safety briefings were held daily and provided information on topics such as safeguarding and clinical issues including implementing and monitoring care plans for high-risk patients.

- Clinical incident meetings took place monthly and feedback was provided to staff via group email.

- Managers told us that there was not a named executive at board level for children and young people's services at the time of our inspection. However close links with divisional management ensured any issues were raised that required board scrutiny.

Leadership of service

- Nursing staff told us managers were visible and approachable.

- Doctors told us that senior medical staff were helpful and supportive and teaching provision was good.

- Most staff reported the trust board were not visible however; they were supportive of events held for the Babygrow appeal, which was raising funds to provide a new neonatal unit.

- Staff received a weekly email, which contained updates on relevant trust information.

Culture within the service

- Staff were passionate about their work and were committed to providing high quality care in sometimes difficult circumstances because of busy periods or low staff numbers.

- 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 morale fluctuated and was dependant on how busy the units were however all staff reported their colleagues were supportive of each other and felt there was effective team working.

- Managers of both the neonatal and children's unit spoke highly of the hard work and commitment shown by their staff.

- NHS staff friends and family test results in September 2015 indicated that 94% of staff

- would recommend this Trust to friends and family in need of care or treatment and 88% of staff would recommend the Trust to friends and family as a place to work.

- Results of the 2015 NHS Staff Survey from across the trust showed that 82% of staff was satisfied with the quality of work and patient care they were able to deliver compared to the average of 83% for acute trusts.

Public engagement

- The children's unit actively sought the views of patients and their relatives and had recently changed to a more child friendly approach to obtain the views of children and young people.

Services for children and young people

- A 'book of thank you' was present on the reception desk in both the inpatient and outpatient areas of the children's unit for parents and children to add comments.

- Information was gathered regarding parents experiences on the neonatal unit by Bliss and given to the trust.

- Parents and patients were involved with the Baby grow fundraising appeal and parents were represented on the neonatal project board, which meant they could review designs and plans for the planned neonatal unit and provide their views and ideas.

- Displayed above every cot on the neonatal unit was the Cheshire and Merseyside Neonatal Network Partnership parents' agreement. This was described as a parent and staff promise and included commitments such as staff would introduce themselves and answer questions honestly. It also requested certain promises from parents for example that they asked whatever they wanted to know or if they did not understand something and to make sure the unit had their contact details.

Staff engagement

- Team meetings were planned quarterly within the children's unit and a suggestion box was available during the month prior to the meeting for staff to submit any topics for discussion.

- The children's unit had won the outstanding achievement award in June 2015.

Innovation, improvement and sustainability

- The neonatal unit had achieved level three baby friendly accreditation.

- The neonatal unit were nominated for an AQuA (Advancing Quality Alliance) award following the development of a procedural pain assessment chart.

- The Hospital at Home service was introduced in 2012 to reduce the length of inpatient stay for children and to provide acute care at home. This meant that children were able return to their normal activities despite the need for on-going care such as intravenous antibiotics. This extended in 2015 to take direct referrals from G.P's in West Cheshire in an attempt to avoid some hospital admissions.

- The Paediatric Diabetes team had developed a tool for educating newly diagnosed children and their families. In addition, an annual education programme has been devised for different age groups to ensure children, young people and their families receive updates through multi-disciplinary education.

End of life care

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

Information about the service

The trust provides a consultant led specialist palliative care nurse team [SPCT]. The SPCT team support all clinical areas in the Countess of Chester Hospital and Ellesmere Port Hospital, providing specialist palliative care, advice and support for adult inpatients who are affected by cancer and other life limiting illnesses.

The SPCT provide an advisory and supportive service, whilst the medical and nursing management of the patient remains the responsibility of the ward teams. The SPCT provide ward support, and facilitate the transfer of the patient from the curative to the palliative approach for their incurable illness. The trust has a bereavement team that provide support to relatives following the death of those close to them. There are established links with charitable and voluntary organisations providing hospice care, counselling and bereavement support.

We visited Countess of Chester Hospital as part of our announced inspection on 16 - 19 February 2016. During this inspection, we visited inpatient wards including ward 43 (Elderly care ward), 44, 49,33 and 52 where the trust had identified patients that were receiving palliative or end of life care. In addition, we visited the spiritual centre, bereavement office, hospital mortuary and the deceased viewing room.

We observed care and spoke with 26 members of staff across all disciplines including, bereavement services, mortuary staff, chaplaincy, nursing staff, medical staff, allied health professionals and porters. We spoke with the lead specialist nurse, palliative medicine consultant

(clinical lead), executive lead for palliative care and the business performance manager. We spoke with two people receiving support from the SPCT and their relatives, and we spoke with five relatives of people who were identified as close to the end of life. We interviewed an SPCT nurse, following which there was limited observation of her work as she provided advice and support for a patient and their family.

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

End of life care

Summary of findings

We rated end of life services as requires improvement over-all because :

- There was an insufficient number of general nursing staff who had received appropriate training regarding end of life care and the replacement for the LCP, the care and communication record. The trust informed us that training had been undertaken, however staff we spoke to were not aware of this.

- The trust performed worse than the England average in five of the seven organisational key performance indicators for the National Care of the Dying Audit 2014. However an action plan is currently in place to address the issues identified in the 2014 audit.

However,

- There was a three-year strategic work plan developed by the Trust Supportive and End of Life Care Group. We found this had been communicated to most general ward teams. We found evidence of an overarching monitoring of the quality of the service across the trust. Complaints were responded to appropriately.
- Staff were able to describe safeguarding procedures and provided us with examples of how these would be used.
- All of the general nursing staff we spoke with were aware of how to report an incident or raise a concern.
- Appropriate equipment was available to patients at the end of their life; the equipment at the hospital was adequately maintained.
- Medicines were managed appropriately.
- Patients were involved in care planning and decision making. Staff were respectful and treated patients with compassion.
- Specialist nurses were visible, competent, and knowledgeable.
- The trust had a dedicated specialist palliative care team [SPCT] who provided good support to patients at the end of life. Care and support was given in a sensitive and compassionate way.
- On the wards staff worked hard to meet and plan for patient's individual needs and wishes.

- Staff within the [SPCT] team were very motivated and committed to meeting patients' different needs at the end of life and were actively developing their own systems and projects to help achieve this.

End of life care

Are end of life care services safe?

Good ●

We have rated safe as good because:

- Staff were able to describe safeguarding procedures and provided us with examples of how these would be used.
- All of the staff we spoke with were aware of how to report an incident or raise a concern.
- Staff were observed to be using personal hand sanitising equipment when entering wards to visit patients and personal protective equipment was available for the SPCT if required.
- Appropriate equipment was available to patients at the end of their life; the equipment at the hospital was adequately maintained.
- Medicines relating to symptom and pain control for people at the end of their lives were managed appropriately.
- Records were clear, legible and up to date. Records we reviewed included completed risk assessments for example, falls, nutrition and pressure relief.
- The specialist palliative care team provided records of mandatory training completed by the nurses in the team. The records showed all members of the SPCT were up to date with all of their mandatory training.
- Nursing staff on all of the wards we visited could articulate what to do if a patient deteriorated. Ward staff were aware of the escalation processes to seek senior medical and nursing support and were able to define what they would do in an emergency.

However,

- There was an insufficient number of general nursing staff who had received appropriate training regarding end of life care and the replacement for the LCP, the care and communication record. The trust informed us that training had been undertaken, however staff we spoke to were not aware of this.

- The palliative care consultant staffing levels across the trust were not in line with the recommended national guidelines.

- Information in relation to the care and treatment of patients at the end of their lives, was not consistently available to ward staff, however records when available, were adequately completed.

Incidents

- There were no never events or serious incidents relating to end of life care reported between November 2014 and October 2015.

- There had been 23 incidents related to end of life and mortuary services between December 2014 and November 2015. All incidents were identified as no or low risk, and procedures were followed to investigate and act upon findings appropriately.

- Staff were aware of how to report an incident or a concern and gave examples of the types of things they would report. For example, staff we spoke with were able to tell us about the process they would use to complete an incident form if they had any concerns regarding the care and treatment of patients at the end of their life.

- Incidents relating to patients were investigated and serious incidents were escalated to the serious incident panel. We found formal mechanisms were in place to share learning regarding end of life patients across other teams, for example, bereavement services and general ward teams, which supported patients and their families at the end of life.

- We reviewed records and documentation, which confirmed that the trust maintained an updated list of incidents and issues relating to patients. For example, we saw records, which confirmed that issues relating to patients at the end of their life, such as preferred place of death, had been reported on the trust wide system.

- When patients were re-admitted through the accident and emergency department, information was readily available. We reviewed the trusts paper and electronic patient management systems at the time of the inspection and found that DNACPR details were there and immediately accessible to staff.

- Medical and nursing staff demonstrated an understanding of their individual responsibilities in relation to the duty of candour.

Cleanliness, infection control and hygiene

End of life care

- The trust had policies for the prevention and control of infection and hand hygiene. Both were available on the trust's intranet and staff could show us how to access them.

- Staff were observed to be using personal hand sanitising equipment when entering wards to visit patients and personal protective equipment was available for the SPCT if required.

- The mortuary was visibly clean, well ventilated and free from odours. A member of staff told us that it was cleaned Monday to Friday and we saw documentary evidence, which confirmed the cleaning had taken place.

- The Human Tissue Authority (HTA) licensed mortuary services. The service had undergone a HTA inspection in April 2015 and HTA certification was visible in the mortuary.

Medicines

- We reviewed the trust's policy for the management of controlled drugs and anticipatory medications for patients at the end of their life, found these were current, and reflected guidance.

- The senior nurse on each of the wards we visited was able to describe the process used in relation to the administration of controlled drugs for people at the end of their life.

- Anticipatory medication was prescribed appropriately. We reviewed two medication administration record charts on two of the wards we visited and saw appropriate prescribing.

- Written prescribing guidelines were available for doctors to prescribe appropriate end of life medicines to manage patient's pain, anxiety and other symptoms.

- Records showed that patients referred to the specialist palliative care team had their medicines reviewed by the team. This was done in consultation with other medical staff involved in the patients care.

Records

- We looked at four care plans used to assess and record patients' care needs and found that they reflected

national guidance. These records were clear, legible and up to date. Records included completed risk assessments for example, falls, nutrition and pressure relief.

- We reviewed five DNA CPR forms held in patient records on three different wards. These were fully completed. They contained information including who had approved the final decision, and who was consulted in the process of a decision being made. We noted that DNA CPR forms were filed in patients' notes in such a way that there were easily accessible to staff.

- We reviewed the trust electronic patient data management system. Staff recorded decisions related to DNA CPR and completed documentation. This information was readily available to staff on the electronic system.

- Risk assessment forms completed by ward the nursing teams on the wards we visited, were complete, legible and easily accessible.

- We were told the trust carried out an annual audit of do not attempt cardio-pulmonary resuscitation (DNA CPR) forms.Information received from the trust prior to our inspection confirmed this.

- Recording systems were in place in the mortuary to ensure patients were admitted and kept appropriately. The mortuary records we reviewed, which included body release forms, were accurate, complete, legible and up to date.

Safeguarding

- There were trust wide safeguarding policies and procedures in place, which were accessible via the trust's intranet site.

- Staff knew how to report and escalate concerns regarding patients who were at risk of neglect and abuse.

- Records supplied by the trust indicated that all staff in the specialist palliative care team had completed level two safeguarding training for adults and children.

- Staff were able to describe safeguarding procedures and provided us with examples of how these would be

applied. Staff were able to tell us about safeguarding concerns they had raised previously and said they had always been supported by their line manager in raising concerns.

Mandatory training

- The specialist palliative care team provided records of mandatory training completed by the nurses in the team. The records showed all members of the SPCT were up to date with all of their mandatory training.

- Overall, the trust failed to meet the organisational key performance indicator [KPI] for continuing education, training and audit for all staff involved in the care of the dying patient. Information we received from the trust prior to our inspection, confirmed that the trust had plans in place to address this by employing a new end of life facilitator and had a training programme in place. This role is expected to have a substantive input relating to a programme of mandatory education and training for general ward staff. Areas covered by the proposed training are to include communication skills, advance care planning & end of life care, incorporating such aspects as hydration and nutrition. However, at the time of our inspection the post had not been filled, and staff we spoke to had not received training.

- Senior managers confirmed this training had not been kept up to date for nursing/clinical support workers but confirmed that this was an area, which would be addressed when the vacant post for an end of life facilitator was filled.

Assessing and responding to patient risk

- The SPCT monitored the trust's performance in line with established best practice for patients who required palliative or end of life care.

- Nursing staff on all of the wards we visited could articulate what to do if a patient deteriorated. Ward staff were aware of the escalation processes to seek senior medical and nursing support and were able to define what they would do in an emergency. Ward staff had contact details for the SPCT and confirmed the team responded promptly when needed.

- In the eight patient records we reviewed, we noted that there was evidence of risk assessments being completed appropriately. Risk assessments for venous thromboembolism (VTE), pressure ulcers, nutritional needs, falls and infection control risks for patients receiving palliative/end of life care were conducted by the nursing teams on the wards where patients were being cared for.

- A system was in place to identify patients individual needs, such as those patients at the end of life by use of a discreet symbol on the patient detail 'white boards' visible at the nursing station on each of the wards we visited. Staff showed an understanding of these symbols on the wards we visited.

- Patients on the general wards who had been given a palliative diagnosis had easy access to call bells and we observed their calls were responded to promptly. This was supported by relatives that we spoke to.

Nurse staffing

- Staffing for end of life care was the responsibility of all staff across the wards and not restricted to the specialist palliative care (SPCT) team.

- The trust's SPCT consisted of a lead nurse for palliative care (0.4 WTE) and three palliative care clinical nurse specialists (3.4 WTE).

- The team responded to all referrals from clinicians throughout the trust for adult patients who had complex support and/or complex symptom management needs during end of life care. This included support to families of patients referred.

- The specialist palliative care team screened and allocated all new referrals on a daily basis. Current work and new allocations were reviewed every morning by the team and work was allocated based on patient need and urgency.

- The SPCT worked across the trust, as part of a multi-disciplinary team, which also included the rapid discharge team, consultants, general ward nursing teams and medics.

Medical staffing

- The trust currently had one WTE consultant and 1.0 WTE for the emergency department and AMU. This was below the recommended staffing levels outlined by the Association for Palliative Medicine of Great Britain and Ireland, and the National Council for Palliative Care

End of life care

guidance, which states there should be a minimum of one WTE consultant per 250 beds. This trust has 680 beds, which equates to a consultant requirement in excess of three WTE consultants.

- Weekend and out-of-hours on-call advice for general ward staff was provided by the local hospice using an advice line, staffed by nurses with medical support.. Staff could use this facility to access specialist advice and support for symptom control or holistic advice.

Major incident awareness and training

- The trust had a major incident policy in place, but not all ward staff we spoke with were aware of it. Patient needs were prioritised and staff assisted on the wards to keep patients safe.

- In the event of a major incident, the mortuary had a policy for staff to consult. Mortuary staff described these arrangements.

- Staff we spoke with within both the mortuary and SPCT teams were aware of the plans and described the action they would take in the event of a major incident.

Are end of life care services effective?

Requires improvement ●

We rated effective as requires improvement because:

- The trust performed worse than the England average in five out of seven of the organisational key performance indicators of the National Care of the Dying Audit 2014.
- These included continuing education and training for staff, the development of clinical provision/protocols promoting patient privacy and access to specialist support.
- The specialist palliative care team [SPCT] was available Monday to Friday, from 9am to 5pm. Out-of-hours; telephone support for general ward staff was provided by nursing staff or medical staff if required using the local hospice advice line. This meant that End of Life services provided by the trust were not fully available to patients and their families outside of normal working hours.

However,

- 7 out of the 10 clinical key performance indicators were higher than the England average, in particular; medication prescribed for the five key symptoms that may occur during the dying phase.
- Specialist palliative/end of life care team members were competent and knowledgeable and there were examples of multidisciplinary team working.
- The specialist end of life team was valued by ward staff. The team were reported to be accessible, responsive and effective in supporting patients with complex end of life care needs and staff training needs.
- Patients had appropriate access to pain relief.
- Staff within the specialist team were suitably qualified to perform their roles and had the opportunity to enhance their skills through additional specialist training.

Evidence based care and treatment

- The specialist care (SPC) team worked in line with best practice and national guidelines such as National Institute for Health and Clinical Excellence (NICE) quality standard 13 relating to end of life care for adults. Clinical audits included monitoring of NICE compliance and other professional guidelines.

- Staff within the SPCT were highly trained and had a good understanding of existing end of life care guidelines.

- The trust's end of life care plan had previously been based on the Liverpool Care Pathway (LCP) for the dying patient. The SPCT was in the process of developing a new personalised care plan. The SPCT lead nurse told us that, following the withdrawal of the Liverpool Care Pathway (LCP) in 2014, an individual care and communication record had been introduced on all wards except critical care and AMU. However, we saw the care and communication record in situ on only one of the wards we visited. This incorporated the national document 'One chance to get it right' (2014), and aimed to support staff with identifying patients' preferences and wishes earlier in illness, in order for improved advance care planning to take place. We were not assured that all staff had access to the document or appropriate training in using it, however plans were in place to formalise training going forward.

- Patients received effective support from a multidisciplinary team, which included specialist palliative care nurses and consultants. However, data

received from the trust prior to inspection confirmed that the trust had not achieved the NCDA organisational target relating to patient access to specialist support for care in the last hours or days of life.

Pain relief

- Staff were able to access clear guidance on the prescription of medications to be given 'as required' for symptoms that may occur in patients during the last hours or days of life, such as pain, anxiety, nausea, vomiting and breathlessness. Patients identified as requiring end of life care were prescribed anticipatory medicines. These 'when required' medicines were prescribed in advance to promptly manage any changes in patients' pain or symptoms.

- Pain was reviewed for efficacy, and changes were made as appropriate to meet the needs of individual patients. We spoke with the relatives of two patients who told us pain relief had been provided in a timely manner.

- Staff confirmed that syringe drivers were accessible if a patient receiving end of life care required subcutaneous medication for pain relief. We were told this service was available seven days a week and during out of hours periods. However prior to our inspection we were made aware of two incidents where patients had required subcutaneous pain relief and there had been a delay in receiving the medication they required. This meant that on occasion patients at the end of their life may not have their pain managed effectively. This was confirmed by patient's relatives we spoke with and by incident data provided by the trust prior to our inspection.

Nutrition and hydration

- The trust participated in the National Care of the Dying Audit, which found that 26% of patients had undergone a review of their nutritional needs, which was below than the national average of 48%.Data received from the trust prior to inspection confirmed that reviews of patients hydration requirements were below the national average.

- Patients' records we reviewed for those identified as being in the last hours or days of life showed inconsistencies in relation to whether patient's nutrition and hydration needs had been evaluated and appropriate actions followed. These records documented subsequent discussions with relatives.

Three relatives of patients we spoke with told us that ward staff had not clearly explained what steps were being taken to ensure their relatives were receiving appropriate hydration.

- Nutritional assessments were completed and nursing records, such as nutrition and fluid charts were completed accurately on some of the wards we visited. However, due to the partial implemented of the trusts we saw that menus catered for cultural preferences.

Patient outcomes

- The trust performed worse than the England average in five out of seven of the organisational key performance indicators of the National Care of the Dying Audit 2014. These included continuing education and training for staff, the development of clinical provision/protocols promoting patient privacy and access to specialist support.

- The results of the National Care of the Dying Audit (NCDA), published in May 2014, showed that 7 out of the 10 clinical key performance indicators were better than the England average, in particular; medication prescribed for the five key symptoms that may occur during the dying phase. In addition, 96% of patients had undergone a review in the last 24 hours of life, which was higher than the England average of 82%.

- The trust failed to achieve organisational key performance indicators relating to patient access to specialist support for care in the last hours or days of life. However, the NCDA also reported 96% of patients had been recognised as dying and at the end of their lives, which was higher than the England average of 61%.

- Patients received care in line with national guidelines. Clinical audits included monitoring of NICE and other professional guidelines were in place, we noted that of 13 audits one had been completed and nine were active..

Competent staff

- Appraisals for staff were completed appropriately and staff spoke positively about the process. The trust provided appraisal data for 2015, which showed that all staff had undergone a yearly appraisal.

End of life care

- The SPCT confirmed they received monthly clinical supervision to support them in their role and they had received an appraisal in the last 12 months.

- Records showed that the SPCT had regular one to one meetings. Staff told us they received clinical supervision monthly with a level four psychologist, and were meeting their mandatory training requirements. This was supported by information we had received from the trust, this assured us that staff working within the SPCT were competent in their roles.

Multi-disciplinary working

- Multi-disciplinary meetings were held on the wards to discuss and co-ordinate patient care. Patients at the end of life were included in this discussion, so all staff involved could contribute to effective and consistent care for these patients.

- Staff discussed patients with a palliative/end of life prognosis and SPC team involvement, at the multidisciplinary meeting. This helped to ensure that information regarding patients at the end of their life was effectively shared among the different nursing/ medical teams working with them.

- The SPCT lead told us that members of the team, attended SPCT multidisciplinary team meetings and this was monitored to ensure attendance of 66% was achieved. This was undertaken to help identify and coordinate care for an individual approaching the end of life or requiring supportive care. Records confirmed that members of the team regularly attended multidisciplinary team meetings.

- The SPCT said they supported other health professionals to recognise and consider when patients may be approaching the need for palliative or end of life care.

- Records confirmed that staff met as a clinical review group weekly, during which SPCT staff had the opportunity to discuss relevant issues.

Seven-day services

- The hospital consultant and the SPCT offered a five-day Monday-Friday 8am - 5pm service across the trust's hospital sites. Out of hours cover/support for staff, was provided by a hospice covered by nursing staff with medical support via telephone. This meant that End of Life services provided by the trust were not fully available to patients out of normal working hours.

- All ward staff we spoke with said the SPCT responded promptly to referrals, with many patients being seen the same day or within 24 to 48 hours. However, all the general ward staff we spoke with said that if a patient came in after 5pm on a Friday or over the weekend, there was a delay of at least 48 hours in accessing specialist end of life services.

- Diagnostic services were available to staff 24 hours a day, seven days a week.

Access to information

- General ward staff we spoke with were not able to tell us about the new guidance which supports care of the dying person and those important to them, or training they had received regarding improved advance care planning. This meant that we were not assured that staff were aware of where to access information following the withdrawal of the Liverpool Care Pathway. We noted that some training had been provided and there was plans in place going forward, however this did not reflect what staff told us.

- Nurses and doctors on all the wards we visited told us they felt they did not always have sufficient access to information in order to support clinical decision-making, specifically relating to patients at the end of their lives. Staff we spoke with told us this was a particular issue out of hours and at weekends.

- We saw examples of patients being supported to move between services and teams, for example, from the hospital to their own home. We reviewed records, which confirmed information to support their care was available to staff in a timely way.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- The trust had a consent policy in place. The policy included advance decisions, lasting power of attorney, mental capacity guidance and the use of Independent Mental Capacity Advocates where necessary.

End of life care

- Staff received mandatory training in safeguarding children and vulnerable adults, which included aspects of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberties Safeguards (DOLS).

- Both specialist nurses and general nursing staff were able to describe their duties and responsibilities under MCA. SPCT nurses and general ward staff were able to define procedures to us and provided us with examples of how these would be applied.

- Staff within the SPC team understood the legal requirements of the MCA. Records we received from the trust prior to our inspection confirmed high levels of staff training.

- In all cases we reviewed, do not attempt cardio-pulmonary resuscitation (DNA CPR) an appropriate senior clinician signed forms. Patients' views relating to resuscitation were clearly recorded in their notes and on the form. It was clearly noted when the DNACPR should be reviewed once in place.

Are end of life care services caring?

Good 🟢

We rated caring as good because:

- Palliative and end of life services were delivered by highly trained, caring and compassionate staff.
- We observed that staff treated patients with dignity and respect and planned and delivered care in a way that took into account the wishes of the patients.
- Staff within the specialist team were highly sensitive to the needs of patients who were seriously ill and recognised the impact this had on the individual patient and those close to them.
- The patients and relatives we spoke to told us they felt involved with care and were treated with dignity and respect.
- Staff provided a caring service and people told us that they generally felt happy with the care and support both they and their families received.
- Interactions between staff and patients demonstrated a kind and compassionate approach. Staff within the

specialist team were highly sensitive to the needs of patients who were seriously ill and recognised the impact this had on the individual patient and those close to them.

- Patients received compassionate care and their privacy and dignity were generally maintained. A minority of people felt their experience could have been better with improved communication between medical and nursing staff and relatives.
- Patients felt staff on the wards were, "always really busy" and that more staff were needed. Despite that, staff came quickly when they were called and were "respectful and kind" when they were delivering care.

Compassionate care

- Patients were treated with compassion and empathy, by both the SPCT and general ward nursing staff. We observed staff speaking with patients and providing care and support in a kind, calm, friendly and patient manner.

- Patients said the staff had been nice and kind and they had no complaints about care they had received. We observed patients and relatives were treated with compassion.

- Ward staff told us where possible, end of life patients were accommodated in side rooms to increase dignity and privacy for them and those visiting.

- The patients and relatives we spoke with were mostly complementary about staff attitude and engagement. Comments received from patients demonstrated that staff cared about meeting patients' individual needs. For example one person, whose relative received care and support commented; "All the staff have been kind." Another relative commented; "They [staff] are good really…. It just hard having to sit in a ward full of people. They do their best and keep the curtains pulled, but a private room would have made things easier." Staff we spoke with confirmed that there were no side rooms available at this time, however they were doing their best to ensure the dignity and privacy of both the patient and their relatives were protected.

- Porters told us staff in clinical areas and mortuary staff handled patient's bodies in a respectful way. This was confirmed by relative's feedback via thank you cards, which we reviewed.

End of life care

- Ward staff reported to us how respectful hospital porters were when caring for deceased patients before they were transferred to the mortuary.

Understanding and involvement of patients and those close to them

- We witnessed staff awareness of people's beliefs and observed how they changed their approach accordingly by communicating with patients and relatives using terminology and language that people could understand.

- Patients and their relatives described how staff had worked to establish a good rapport with patients, their relatives and close friends. All of the people we spoke with were highly complementary regarding the way staff had cared for and supported them.

- Staff provided patients with information on how to contact the SPCT. People we spoke with told us that the specialist team were able to advise them on where to obtain additional support and information. Relatives said they felt nursing staff involved in their loved one's treatment and explained each of the optional treatments available.

- On the wards, we saw examples where families were encouraged to participate in aspects of care of their loved one, for example, mouth care.

- A minority of people felt their experience could have been better with improved communication between medical staff and relatives. One person commented;" I know it's a job to them and that they are always so busy….. but if the Dr doesn't explain what's going on, everything is just harder to cope with."

- Patients reported that they felt staff on the wards were, "always so busy" and that more staff were needed. However all of the patients we spoke with said that despite being so busy, staff came quickly when they were called and were "kind and calm" when they were delivering care.

Emotional support

- Although specific information leaflets or booklets were available on the wards we visited, people told us that staff had not always informed them about local services such as counselling services and services providing assistance with anxiety and depression. One person

commented; "It depends who is on really, some of the staff are lovely and really take time to see how I am doing. Others just seem to rush about and don't really tell you anything. It makes it difficult to know who to ask if I have any questions."

- There was a quiet space on most wards where sensitive conversations could be held and staff confirmed these were used to talk with relatives and patients. However, not all of the patients' records we reviewed confirmed that discussions of sensitive conversations that had been held with patients and/or relatives.

- There was a bereavement office, which issued death certificates and provided relatives with information on support services available to them, and what to do following a death. Prior to our inspection, we had received positive feedback from families regarding the bereavement service. This feedback detailed the kindness and support people had received from the bereavement team.

- Chaplaincy services were available on request. The chaplaincy team were able to offer spiritual support to patients of all or no faiths as they had developed close links with local churches and members of various congregations.

Are end of life care services responsive?

Requires improvement 🟠

We rated responsive as requires improvement because:

- We found people's diverse needs were not fully met and that there was not always appropriate provision of care for patients and their families in line with their personal or religious wishes.
- Chaplaincy service a multi-faith prayer room, however during our inspection of the service, we saw an individual of a faith other than Christian, having to pray in the middle of the open service room. As this room is adjacent to the chaplaincy office, we were not assured that support was fully available to everyone who may require it.
- Relatives' access to deceased patients within the mortuary was restricted and did not provide assurance

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that the service was run to meet the needs of people who use the service and their families. This meant that End of life care services were not always responsive to the needs of the local population they served.

However,

- Patients had adequate access to the SPCT during normal working hours, (9am until 5pm Monday to Friday) and staff were able to identify those who needed the service.
- Specialist palliative care team members were visible and staff knew how to contact them to secure appropriate advice and support for patients.
- The trust had a new draft strategic plan that aimed to improve and connect services to prevent patients having their care compromised with admissions and readmissions to hospital.
- The SPCT had a flexible referral process. Ward staff told us the SPC team responded promptly to referrals, usually within 24 to 48 hours.

Service planning and delivery to meet the needs of local people

- SPCT staff had a good understanding of the needs of the local population. Staff worked as part of multidisciplinary teams and routinely engaged with local hospices, the trust discharge team, adult social care providers and other professionals involved in the care of patients.

- The SPCT had established links with community palliative care services and the community services, such as district nurses.Staff said this promoted shared learning and expertise and enabled complex patients who switched between services to have consistent care.

- General nursing staff on the wards told us they were confident patients could access end of life care services when needed, during normal working hours. The SPCT routinely engaged with nursing staff, local hospices and adult social care providers so patients could be referred promptly and to provide advice, where necessary.

- There was open access for relatives to visit patients who were at the end of life.

Meeting people's individual needs

- The chaplaincy service responded to the spiritual needs of end of life patients and their families. This included

providing last rites services. However, we noted that whilst the chaplaincy service had access to a multi-faith room, during our inspection of the service, we saw an individual of a faith other than Christian, having to pray in the middle of the open service room. As this room is a walk through to the chaplaincy office, we were not assured that support was fully available to everyone who may require it.

- Mortuary services did not fully meet the needs of families of those who had died. For example, we noted that families could only view their deceased relative during specific viewing times laid out by the mortuary. In discussion with the mortuary manager, we were told that this was due to Post Mortem's [PM's] being undertaken during the mornings. However we noted that the visiting times remained the same on those days when there were no PM's being undertaken. This did not assure us that mortuary services were meeting people's individual needs.

- Staff within the SPCT were responsive to patients' needs and provided an appropriate level of care and support, based on prognosis, and the individual complex needs of each patient. Staff communicated on a daily basis with ward nurses and we observed staff regularly checking patients' electronic records.

- Patients' needs were assessed and care and treatment was planned and delivered in line with their individual care plan. We saw that risk assessments were completed by staff and updated as the patient's condition changed.

- We saw records, which confirmed that where a patient was identified as having issues relating to learning disabilities, dementia or cognitive impairment staff could contact specialist nurses within the trust for advice and support.

- The SPCT were part of a multi-disciplinary team responsible for arrangements for rapid discharge to ensure patients at end of life died at their preferred place.

- Patients who used the service were asked about their spiritual, ethnic and cultural needs as well as their medical and nursing needs. General ward staff took the needs and wishes of the patients into account when caring for them.

End of life care

- There was a policy in place for the rapid release of a deceased patient from the mortuary. Medical and mortuary staff demonstrated an understanding of the processes to follow. This enabled the cultural wishes of families to be respected.

- There was printed information available for patients and their relatives, including leaflets on what they needed to do after their relative died, as well as the emotional support available. However, we noted that all of this information was only readily available in English.

- Staff could access an interpreter for patients whose first language was not English if needed.

Access and flow

- There was a clear standard set for referring patients to the specialist palliative care team (SPCT). End of life care was delivered when required by ward staff throughout the hospital. The SPCT was accessible during normal working hours each day. Outside of those hours, advice was available to staff via telephone.

- Referrals to the SPCT were made by ward staff using the trusts information technology system or by telephone. The team met daily Monday to Friday to review current work and allocate new referrals, which were prioritised and allocated based on urgency and need.

- The trust had a rapid discharge service for discharge to a preferred place of care (PPC). Following on from NICE guidance, the National End of Life Strategy (2008) was clear that people at the end of life should be able to make choices about their place of death. The rapid discharge pathway was to support patients to be discharged from hospital in the last hours and days of life.

- Ward staff said that on occasion, delayed discharges of days or weeks impacted on end of life patients. Staff said this was due to the time taken by the local authority to arrange the appropriate care packages for patients. During this inspection, there were no patients that were delayed in being discharged from the trust.

- Doctors and nurses told us they had access to diagnostics and test results promptly. This was confirmed by records we reviewed.

Learning from complaints and concerns

- Complaints were handled in line with the trust policy. Records we reviewed confirmed that all complaints should be recorded on a centralised trust-wide system. The clinical leads would then investigate formal complaints relating to specific teams.

- Data received from the trust prior to our inspection, confirmed that complaints and concerns raised over the 12 months prior to our inspection had been handled in line with trust policy. We also noted that outcomes from investigations were shared among staff across the trust in order to aid further learning. This assured us that the trust had an overview of complaints and the actions that arouse following receipt of a complaint or a concern.

Are end of life care services well-led?

Requires improvement ●

We rated well-led as requires improvement because:

- None of the general ward staff we spoke with could tell us about the trusts vision for palliative care or end of life services.

- Robust processes had not been fully implemented, to ensure staff were trained, supported and appraised in relation to End of Life Care.

- There was a new care and communication document, developed by an integrated group including representation from the local hospice and the community palliative care team. However, we found that this had not, as yet, been communicated to and embedded within, all general ward teams.

- Ward and ancillary staff had limited awareness about the trusts audit strategies in relation to End of Life care.

However,

- Records we reviewed confirmed that actions were being taken by the trust in response to incidents.
- The Specialist Palliative Care Team[SPCT] were aware of issues relating to their specialties and had developed appropriate strategies to ensure incidents were recorded and fed into the wider trust.

End of life care

- We saw evidence that the individual teams working with patients and their families, were raising incidents using the trust internal system.

- The Specialist Palliative Care Team[SPCT] were aware of issues relating to their specialties and had developed appropriate strategies to ensure incidents were recorded and fed into the wider trust.

Vision and strategy for this service

- We spoke with 26 members of staff as part of this inspection. Whilst senior managers and members of the SPCT were clear on the trusts vision for palliative care/ end of life services, none of the general ward staff we spoke with could tell us about the trusts vision for palliative care or end of life services (a framework for care and support for patients and staff). Nor could any of the general ward staff we spoke with, give us examples of how the existing service strategy was being used to deliver trust services.

- General ward staff had limited awareness about the trusts audit strategies in relation to End of Life care. For example, no one within bereavement services or general wards was able to tell us about the audit schedule of key processes, or if one was in place.

Governance, risk management and quality measurement

- We saw evidence of an effective, overarching performance quality system for specialist palliative or end of life care. Records we reviewed confirmed that the various aspects of the service were monitoring their own performance with monthly updates which consisted of reviewing patient feedback, waiting times from referral to first appointment, patients care files, and access to death certification.

- We saw evidence that the individual teams were raising incidents/concerns, using the trust internal system. This was supported by data provided to us prior to inspection, which evidenced the actions being taken by the trust in response to incidents being highlighted by the staff. This meant that there effective communications in place to support governance, risk management and the quality of the End of Life services overall.

- Information received from the trust prior to inspection confirmed that a trust board member had been identified in line with national best practice.

- During our inspection we were told that audit results for do not attempt cardio-pulmonary resuscitation (DNA CPR) forms are discussed at the resuscitation committee. This was supported by the records we reviewed which confirmed action plans and shared learning had been undertaken because of these audits.

Leadership of this service

- The SPCT demonstrated effective local leadership and the leader understood the challenges to provide good quality palliative and End of Life care services across the trust.

- The specialist palliative care (SPCT) nurses were described by colleagues as knowledgeable, supportive and passionate about end of life practice. Several staff members of the team said the team was brilliant to work in because of team's good communication and excellent peer support.

- Staff throughout the trust told us that the SPCT team were visible, approachable and accessible. Ward staff we spoke with valued the expertise and responsiveness of the SPCT and said patient outcomes and clinical practice improved because of the support they provided.

Culture within this service

- Staff reported that working with the SPCT was a generally a positive experience. Staff we spoke with told us that their major source of support when caring for patients at the end of their life was the other ward team members and the team manager. In discussion with us, ward staff said that they felt the specialist team was a source of support for patients. However, none of the general nursing staff we spoke with could give us examples of being supported by the SPCT.

- Staff we spoke with across the trust were positive about the bereavement service as a whole. Staff said they felt that both the chaplaincy and the bereavement office were responsive and supportive to both patients and their families.

End of life care

- Staff within the SPCT were highly motivated and positive about their work. Staff told us they received constant positive support and guidance from their immediate line manager.

Public engagement

- The bereavement officer gave out information leaflets to families when they came in to pick up death certificates.

- On some of the wards we visited, we saw information for relatives, relating to financial advice and support/ bereavement counselling services and details relating to accessing occupational therapy and social work support. However, this information was not available across all wards were patients receiving palliative or end of life care.

- Surveys were used to evaluate users of the service experience.

Staff engagement

- We found that the annual appraisal system worked well and that staff were up to date or had received dates for their appraisals. Staff reported that this was useful and gave an opportunity to address any problems.

- Staff had an annual appraisal, which they told us worked well, and as a small team, they had the opportunity to raise and discuss any problems with each other.

Outpatients and diagnostic imaging

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

Information about the service

Outpatient and diagnostic services are provided mainly at the Countess of Chester Hospital (COCH) but also there is a small unit at Ellesmere Port Community Hospital. There were 444,045 outpatient attendances between July 2014 and June 2015.

The Outpatient Department clinics includes OPD1, OPD2, OPD3, OPD4, breast, ear, nose and throat (ENT) & audiology, eye clinic, paediatrics, gynaecology, antenatal clinic and maternity ultrasound. The main outpatient clinics include all medical and surgical specialities such as cardiology, rheumatology, vascular, urology, general surgery, orthopaedics and orthodontics. The clinics are situated in different locations in the hospital accessed via the main entrance and corridor.

The radiology department is located near the accident and emergency department and includes the main x-ray and scanning facilities such as computerised tomography (CT), magnetic resonance imaging (MRI) and interventional radiology services (IR).

We spoke to about 70 staff members of all grades and about 20 patients. We observed care and viewed records of 18 patients. We also held an event at the Countess of Chester hospital where patients and relatives shared their experiences as well as receiving comments via our website.

Summary of findings

Overall we found the outpatient and diagnostic service as good because:

- There was strong reporting culture with staff reporting incidents via the trusts electronic system. There was some learning from incidents, although similar incidents continued to be reported in radiology areas.
- Systems were in place for the maintenance of equipment. Processes were in place for daily checking of resuscitation equipment.
- Any prescribed medications were stored in locked cupboards and there was no controlled drugs or intravenous fluids stored in outpatients at COCH. Patients' records were maintained on paper and via electronic systems, although; plans for changes in electronic systems were in place.
- Staff had received mandatory training, although some groups were not up-to-date with safeguarding requirements. There was some staff shortages identified, although recruitment processes were in progress.
- There was a caring culture embedded in all areas visited and from all members of staff we met. We observed good, compassionate care being delivered.
- Reception staff were polite and helpful. Patients and their relatives were very positive about the staff in outpatients and radiology. They said they were supportive and communicated well. We observed respectful interactions between staff and patients.

Outpatients and diagnostic imaging

- Staff actively involved those close to patients with initiatives in place to support relatives of patients who attended regularly.
- There was specialist staff in clinics with good multidisciplinary working, although not all had been appraised annually.
- Services were available seven days a week.
- Consent for procedures was obtained although by different clinicians.
- There were audit plans in place and good use of the WHO safety checklist, for radiological interventions, was observed.
- The outpatient and diagnostic services were available at both Countess of Chester Hospital (COCH) and Ellesmere Port Hospital (EPH). The main activity was at COCH with a small department at EPH for routine care of patients in the local area.
- Targets of referral to treatment targets were within national guidelines, however; there was a wide variation in waiting times for individual consultants. Extra clinics were arranged, out of hours and at weekends to manage the demands of the local population.
- There was support for patients with individual needs including visually impaired, hearing impaired, learning disability or dementia.
- There was evidence of learning from complaints and how changes had been implemented.
- There was a clear vision and strategy for the future.
- The management teams were stable and committed to patient well-being in both out patients and diagnostics despite challenges.
- There were governance processes embedded with action plans in progress to improve services. Waiting list initiatives took place to meet demands of the local population.
- There were regular meetings, at all levels. Staff felt supported by their line managers and there was good team working in the departments.
- There were several innovations taking place with plans to increase services.

- Radiology trust guidelines and standard operating procedures were in place although not always clear and robust. There had been recent reviews of procedures.

- There were delays in reporting in radiology, which meant there could be delays in treatment. The trust had responded to increased demand by outsourcing x-ray reporting.

However,

- There was dust found on some medical equipment.

- In the nuclear medicine department of radiology, we observed that a prescribed medication was not always signed as administered.

- There were delays in reporting in radiology, which meant there could be delays in treatment. The trust had responded to increased demand by outsourcing x-ray reporting.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Good ●

We rated as good because:

- There was strong reporting culture with staff reporting incidents via the trusts electronic system. There was evidence of learning from incidents, although similar incidents continued to be reported in radiology areas.
- Any prescribed medications were stored in locked cupboards and there was no controlled drugs or intravenous fluids stored in outpatients at COCH.
- Processes were in place for daily checking of resuscitation equipment. In the nuclear medicine department of radiology we observed that a prescribed medication was not always signed as administered.
- Systems were in place for the maintenance of equipment.
- Patients' records were maintained on paper ad via electronic systems, although; plans for changes in electronic systems were in place.
- Staff had received mandatory training, although some groups were not up-to-date with safeguarding requirements.

However,

- There was some dust found on medical equipment that was addressed on inspection.
- There was some staff shortages identified, although recruitment processes were in progress.

Incidents

- Incidents were reported by the trusts electronic reporting system.

- The trust had a higher than average reporting culture and staff were confident and competent in reporting incidents. Staff could request feedback from incidents if required.

- There were no never events reported between November 2014 and October 2015. Never events are very serious, largely preventable safety incidents that should not occur if the available preventative measures are in place.

- Between 1st December 2014 and 30th November 2015, there were 379 incidents mostly reported as no harm.

- From November 2015 to February 2016, there were 75 IR (ME) R incidents; most were reported as no harm. (The ionising radiation (medical exposure) regulations (IR (MER) R) 2000 is legislation intended to protect a patient from the hazards associated with ionising radiation). These included 13 delays in x-ray film being reported, 27 incorrect referrals, and four misidentification of patient and nine wrong body part requested.

- From January 2015 to February 2016, there were 11 IR (MER) R notifications submitted. These were noted as minor incidents with normal to low reporting numbers.

- The radiology department had appointed a patient safety lead in 2015 to monitor incidents and act upon findings.

- Between May 2015 and December 2015, there were four unexpected deaths in the radiology department, which were investigated as part of a thematic review.

- The thematic review by the quality, safety and patient experience committee (QSPEC), in February 2016, reviewed radiology incidents that had increased from 201 in 2013 to 404 in 2015. This review identified unclear processes regarding patient transfer and recommended that all patients being transferred back to their ward / area should be escorted to CT / MRI.

- The lone worker policy highlighted the trust's responsibilities in supporting lone working staff in the department.

- Examples of lessons learned were provided including in outpatients where incorrect labelling, on a patient's records was identified prior to any treatment being provided.

- In radiology, there was sharing of lessons learned that included an 'away day' in July 2015 where real scenarios were discussed as well as in staff meetings.

- The trust provided an example of when internal guidelines were not followed. This was reported as a serious incident, which was investigated appropriately with completed action plans.

Outpatients and diagnostic imaging

- Serious incidents trust wide were discussed in departmental meetings. Human factor training was introduced as part of mandatory training requirements. This included how and why errors are made and how they can be avoided.

- The interventional radiology - IR task and finish group, in December 2015, reported that incidents were decreasing although there was an emerging concern regarding availability of anaesthetic sessions.

- Radiology introduced 'PAUSED' cards and posters (patient, anatomy, user checks, system/settings, exposure, and draw to a close) as an additional check prior to a procedure to protect patients.

- Staff were aware of their responsibilities to be open and transparent with patients, however; not all understood the term Duty of Candour (the regulation introduced for all NHS bodies in November 2014, meaning they should act in an open and transparent way in relation to care and treatment provided). The term was included in mandatory training.

Cleanliness, infection control and hygiene

- The outpatient clinic areas looked visibly clean, at COCH, although there was dust seen on some equipment, for example, tops of resuscitation trolleys, behind x-ray machines, underneath bed trolleys and on top of cupboards. Cleanliness in CT was highlighted in the February 2016 staff team meeting.

- There were laminated cleaning schedules in the out patents department which staff followed.

- We observed that staff followed good practice in relation to the control and prevention of infection. Staff were 'bare below the elbow' in clinical areas as per the trust policy on infection control. There were wall - mounted hand gel dispensers visible in all areas.

- Internal audits of hand hygiene scores between May 2015 and October 2015 showed a red rating of 83% in May, 97% (amber) in October 100% (green) in June. Results were not available July, August & September.

- Infection control training, included in mandatory training, had been completed by 89% of staff, which was below the trust target of 95%.

Environment and equipment

- There were four main outpatient areas and other smaller clinics throughout the Countess of Chester hospital (COCH) as well as the diagnostic radiology department. The outpatient areas, at COCH include open reception close to the seating for waiting patients. Outpatient areas at COCH were accessible for people with additional needs.

- Maintenance contracts were in place to ensure that specialist equipment in the outpatient and diagnostic areas were serviced and maintained as needed.

- The system for checking resuscitation trolleys had recently changed for adult trolleys. Adult trolleys, at the Countess of Chester hospital, were secured with a plastic tag and had been checked weekly and recorded appropriately. The paediatric resuscitation trolley in OPD 1 did not include a secure tag and along with the defibrillator was checked daily; however, previous records had not been stored.

- Fridge temperatures were checked daily and recorded appropriately.

- Oxygen cylinders were stored in purpose built holders, at COCH, however; dusty.

- In the respiratory clinic, there was a spirometry machine (equipment used to diagnose lung conditions) in use. There was an updated machine, however; staff had not yet received training to operate this.

- At COCH, the ophthalmology and pre – op assessment areas included display boards to monitor the completion of daily tasks.

- A patient led assessment of the care environment (PLACE) audit took place in OPD1 in November 2015 with all areas passing. In a PLACE assessment at Ellesmere Port, in August 2015, radiology was described as having 'décor very tired'. Staff told us that there were plans in place to update one of the two radiology rooms. As a trust, the PLACE score, for condition was 89%. Other trusts, in England, scored between 80% and 100%.

Medicines

- There were processes in place for managing and storage of medication in the outpatient and diagnostic departments.

Outpatients and diagnostic imaging

- Any prescribed medications were stored appropriately in locked cupboards and there was no controlled drugs or intravenous fluids stored in outpatients at COCH.

- In the nuclear medicine department of radiology, we observed that nine out of eleven patient records of prescribed medication, of adenosine, (a drug used for heart conditions) were not signed and completed which meant it was not evident if patients had received it.

- Medicines management was included in mandatory training that was 89% across all staff groups; below the trust target of 95%.

Records

- Patient records were made up of a combination of paper records and electronic records. Paper records were colour coded to identify if there was an additional electronic version.

- Patient's records were stored centrally and transferred to outpatient areas prior to clinics starting. These were stored with the reception staff until required.

- Any notes not available were identified on a checklist. Reception staff then located any missing records. If needed a copy of the GP referral or electronic records from the clinician or test results could be obtained.

Safeguarding

- Staff were aware of their roles and responsibilities in safeguarding and knew how to raise matters of concern appropriately.

- Outpatient and diagnostic areas were open with easy access including patients and visitors from the accident and emergency department. Radiology staff expressed concerns about security, however; other departments preferred an open system. A swipe card system was recently introduced on the interventional radiology corridor to reduce inappropriate access.

- Any patient at risk or vulnerable was identified in their medical records, which alerted staff. Staff we spoke to were aware of where this information was held.

- Staff attended safeguarding training that showed that 79% of outpatients and diagnostic staff had received safeguarding adult's level two and safeguarding children's level two. The trust target was 80%.

- For staff employed in additional clinical services, 100% had received safeguarding level three training for both adults and children. There was 50% of medical and dental staff that had received level three training.

Mandatory training

- Mandatory training was delivered using face-to-face training and e learning.

- Staff received training in areas that included infection prevention, medicine management, information governance, fire training, clinical risk and patient safety, transfusion, manual handling and resuscitation.

- There was 100% of medical & dental staff and allied health professionals that had received mandatory training, 95% of healthcare scientists and 94% for nursing staff. The trust target was 95%.

Assessing and responding to patient risk

- We observed reception staff confirming the identity of patients on arrival to the departments.

- Staff received training in resuscitation as a requirement of mandatory training. Resuscitation trolleys were easily accessible at COCH.

- If a patient presented as a concern, in OPD, observations of vital signs would be taken. Consultant doctors were available in the department if needed.

- The lead nurse carried a bleep and was contactable for emergencies.An example of this being implemented was that a patient had left the department but collapsed in the corridor. There were processes in place to manage the situation and transfer the patient safely to the accident and emergency department close by.

- In radiology, the World Health Organisation (WHO) safety checklist for radiological interventions was in place. (This is adapted from the National Patient Safety Agency (NPSA) surgical checklist to detect any potential error before it leads to harm).

Nursing & Radiology staffing

- Nursing staff in the departments worked effectively across both sites to meet the demands of the service. The outpatient's department's staff included registered nurses and dental nurses, advanced practitioners and health care assistants.

Outpatients and diagnostic imaging

- The lack of specialist nurses, out of hours, in radiology was highlighted on the risk register.

- There was a vacancy rate in OPD and diagnostics of 13% although recruitment processes were in process. There was a sickness rate of around 3%.

- There was 120 staff employed for diagnostics. This included radiographers and support staff. Fifty of the radiographers were band six qualified.

- Any shortfalls were filled with bank or locum staff.

- There were five radiographers that worked in the department each weekday evening until 8pm, three radiographers until midnight and two to cover until the early morning shifts.

- A radiographic support worker was available until 8.30pm to assist with escort duties for the wards and accident and emergency department. In addition, the clinical site supervisors were available to cover ward areas if a ward member was needed for escorting a patient. The radiology department accepted patients from the wards until 10pm.

Medical staffing

- Medical staffing was provided to the outpatient department by various specialties that ran a range of clinics. Medical staff undertaking clinics were of all grades; there were usually consultants on duty to support lower grade doctors.

- There was a turnover rate of 12% and a sickness rate of 0.54% for the last financial year.

- There was an appropriate mix of general radiologists and interventional radiologists. The Trust has 4 interventional radiologists which was appropriate for the service.

- Diagnostic imaging reporting was regularly outsourced to meet reporting time targets. There was a service level agreement and contract written for this and radiologists undertook quality checks in line with departmental policies.

Major incident awareness and training

- There were trust wide major incident and business continuity plans in place.

Are outpatient and diagnostic imaging services effective?

Good ●

We inspected but did not rate effective. Our findings were:

- Radiology trust guidelines and standard operating procedures were in place although not always clear and robust. There had been recent reviews of procedures.
- There was specialist staff in clinics with good multidisciplinary working, although not all had been appraised annually.
- Services were available seven days a week at the Countess of Chester hospital, whereas Ellesmere Port hospital offered a week day service.
- Consent for procedures was obtained although by different clinicians.

- There were audit plans in place and good use of the WHO safety checklist, for radiological interventions, was observed.

Evidence-based care and treatment

- Care and treatment was evidence-based and provided in line with best practice guidance.

- Standard operating procedures (SOP's) were in place to support staff and there was a process in place to review and update these based on latest national guidance.

- The feedback from the radiation protection advisor was that IR (ME) R guidelines were being followed well; however, we observed that trust guidelines were difficult for staff to locate on the trust intranet system.

- Trust guidelines were not always clear, for example the administration protocol for Buscopan (medication uses to treat abdominal discomfort) in magnetic resonance imaging (MRI) administration was not complete when viewed on the trusts intranet.

- We observed good practice in radiology that included a pre assessment pathway was in place for interventional radiology patients.

- The radiology department was part of the trusts improvement projects that has included training new clerical staff, a new GP referral system and the communication of urgent reports to G.P.s

Outpatients and diagnostic imaging

- Evidence of good practice was observed with the World Health Organisation (WHO), safety checklist for radiological interventions.

Nutrition and hydration

- There were water dispensers available in all waiting areas.

- Staff were able to provide food, for patients, if needed in the OPD area at COCH.

Pain relief

- Staff could access appropriate pain relief for patients within clinics and diagnostic imaging settings for example, medication was available as part of the pain management clinic.

- There were processes in place to assess patient's pain levels and act appropriately

Patient outcomes

- The service had key performance indicators for outpatients and radiology in line with national standards and targets.

- Radiology was working towards Imaging Services Accreditation Scheme (ISAS) licenced by the Royal College of Radiologists.

- Radiology was also accredited with another trust with dual reporting by radiographers and cardiology teams.

- There were local audit programmes for radiology and anticoagulation in place. There were monitoring arrangements in place to review findings of clinical audits and monitor progress.

- In a review of IRMER related incidents, (report completed February 2015), 73% of IRMER related incidents were due to misidentification, 93% of IRMER near miss incidents were referrer errors. This report does not support findings within national CQC IRMER related incidents which show 38% were referrer errors, 20% were wrong site/side, 81% were near miss i.e. picked up within radiology before radiation dose given and 7% of IRMER related incidents were due to radiology error.

- Audits of the WHO interventional radiology safety checklist showed partial compliance of 93% for the period of July to September 2015 and 95% October 2015 to December 2015 The areas identified as requiring the most work were identified as the "sign in" and "sign out" process.

Competent staff

- Staff were supported in their development using the appraisal process, which was undertaken annually. The trust target was 95%. The average for all groups was 79% in outpatients and diagnostics, although medical & dental staff were 96%, and nursing and midwifery registered were 91%. Staff also attended group and individual supervision sessions.

- All staff held the required professional registration and received notice when it was due to expire.

- There were specialist nurse practitioners and radiologists in the departments.

- In the outpatient department specialist included dieticians, physiotherapists as well as specialist nurses in all specialities. Support workers were trained to cannulate patients and were assessed using observation competency assessment. This meant trained nurses were able to perform other duties.

- Patient group directives (PGD's) were in place for nursing staff in the ophthalmology clinic and staff had been assessed as competent to prescribe medications using PGD's.

- In the cardio, respiratory and vascular (CRV) department eight staff were registered with the Registration Council for Clinical Physiologists (RCCP) and five staff were accredited with the British Society of Echocardiography (BSE). There was also a vascular clinic scientist who was a member of the Society of Vascular Technicians (SVT); three staff had undertaken the post graduate certificate in vascular ultrasound. One member of staff had passed the International Board of Heart Rhythm Examination (IBHRE).

- There were approximately 55 members of staff that had received training in IR (ME) R Regulations 2000 during 2015.

Multidisciplinary working

- There were systems in place for working with neighbouring trusts, in radiology, as a central 'hub' at this trust.

Outpatients and diagnostic imaging

- The respiratory team supported wards with a 'buddy' system, internally and liaised with neighbouring trusts.

- There were specialist staff that supported outpatients and diagnostics such as physiotherapists, occupational therapists, dieticians, speech and language therapists.

- Doctors, nurses, allied health professionals and clerical staff worked well together.

- The lead radiologist led multi-disciplinary teams and the consultant met twice a week for peer review. There was also a team briefing board in interventional radiology.

- We were told there was good working with the stroke service to enable patients to receive CT scans, which were performed within an hour of request.

- The reporting radiographers were supported by consultant and registrar radiologists when needed.

Seven-day services

- At the Countess of Chester hospital, clinics were open weekdays 8am to 8pm and radiology services were routinely open until 8.30pm. There were also outpatient clinics at weekends from 8.30am until 5pm dependent on the needs of the population. The radiography department was open 24 hours a day. Overnight the department was opened for emergencies referred from accident and emergency as well as ward areas.

- There were two computerised tomography (CT) scanners. (a scan that uses X-rays and a computer to create detailed images of the inside of the body). The CT scanning service has a 24/7 on-call service, seven days a week. At weekends between 10am and 2pm CT runs a routine in-patient service. The CT scanning service has a 24/7 on-call service, seven days a week. At weekends between 10am and 2pm CT ran a routine in-patient service.

- There were two Magnetic Resonance Imaging (MRI) scanners. The MRI was open for 12 hour days Monday to Friday and 7 hours on Saturday and Sunday for outpatients, and between 11am and 2pm for in-patients.

- After 5pm, on weekdays, one of each of the scanners were utilised for elective patients that included waiting list initiative and the other for emergencies.

Access to information

- Staff accessed information from the trusts electronic systems and paper records that were readily available.

- The radiology department used picture archive communication system (PACS) to store and share images, although systems were not integrated. A new electronic system was due to be implemented which including speech recognition technology. This system was being implemented to support quicker reporting in order to meet the Royal College of Radiologist guidelines.

- Policies and procedures were available on the trusts intranet where the most current versions were stored.

- Staff received information, via the intranet in a weekly newsletter.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Consent for interventional radiology (IR) was obtained in different ways including by the referring clinician prior to the IR appointment or on the day of the procedure. In addition, radiologists obtained consent to treatment on the day of a procedure or IR radiographers were trained and designated to obtain patient consent.

- The trust target for training in mental capacity was 80%. Only 40% of outpatients and imaging staff had received training. This included nursing & midwifery registered staff, medical & dental staff, allied health professionals and healthcare scientists.

- Obtaining informed consent of patients was highlighted on the risk register following audits carried out involving 29 senior doctors. The results were between 54% and 67% documentation accuracy for January 2015 to March 2015. The report in October 2015 included recommendations and an action plan that included a review of the policy and consent forms.

Are outpatient and diagnostic imaging services caring?

Good ●

We rated caring as good because:

Outpatients and diagnostic imaging

- There was a caring culture embedded in all areas visited and from all members of staff we met.
- We observed good, compassionate care being delivered.
- Reception staff were polite and helpful. Patients and their relatives were very positive about the staff in outpatients and radiology.
- They said they were supportive and communicated well. We observed respectful interactions between staff and patients.
- Staff actively involved those close to patients with initiatives in place to support relatives of patients who attended regularly.

Compassionate care

- We observed that the privacy and dignity of patients was maintained during consultations. They took place in individual closed rooms in both outpatients and diagnostics.

- We observed staff being compassionate towards patients. Patients waiting, for planned out of hours computerised tomography (CT) scans said they had received good verbal explanation of the test, at the hospital although no written explanatory leaflet received at home prior to the investigation.

- Patients were very positive about the care they received from all staff in the CT department and said that staff were helpful and supportive.

- A patient satisfaction survey was completed in October 2015, in outpatients and diagnostics. The results showed that 96.2% of patients were "satisfied with the service that was provided". When asked, "was there anything you particularly liked?" 81.65% said the staff described as friendly, reassuring, polite, respectful, professional, courteous, cheerful, helpful, considerate and charming.

- The NHS friends and family test (FFT) (a survey, which asks patients whether they would recommend the NHS service they have received to friends, and family who need similar care) showed a response rate of 30% (5546 responses) in January 2016 in OPD. There were 91.3% of patients who said they were "Likely to recommend". A change in the provider has included a text messaging service had resulted in an improved response rate.

- A swipe card system had been installed on the interventional radiology corridor. This meant that the recovering patients were given more privacy.

- The layout of the reception desks and waiting areas meant that there was no space for a privacy line and conversations could easily be overheard. Reception staff were polite and friendly and if patients preferred not to confirm details verbally, they could be written down, to protect confidential information.

Understanding and involvement of patients and those close to them

- There were very visible 'meet and greet' and volunteer staff directing to all areas as well as other staff, clinical and non – clinical actively directing patients and those attending with them.

- There were many family groups in all areas inspected. These could accompany patients if required.

- Patient identified with complex needs were able to wait in a quiet room if preferred with the aim to be seen as quickly as possible.

- There was a call system that kept people updated of wait times as well as calling patients. Nurses also collected patients personally.

- A 'carers' strategy' was in place that supported families including access to drinks whilst waiting as well as a 'bleep' system which enabled patients to

Emotional support

- There were a number of leaflets available that could be modified for people to understand, such as in a language, other than English or large print.

- There was a learning disabilities champion to support patients.

- There were a number of clinical nurse specialists and therapists in a variety of clinic areas to support individual patient need such as the respiratory team, breast clinic and orthopaedics.

- There were rooms available where staff could speak to patients and families in private.

- There was a spiritual care centre, at the Countess of Chester Hospital and a chapel at Ellesmere Port Hospital.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services responsive?

Good ●

We rated responsive as good because:

- Radiologists work with other neighbouring trusts as part of an acute hub of hospitals. At the Countess of Chester hospital, outpatient clinics and the radiology department were routinely open in the evenings, on weekdays and at the weekend in response to patient need.
- National targets of referral to treatment times were within national guidelines, however; there was a wide variation in waiting times for individual consultants.
- Waiting list initiatives took place to meet demands of the local population.
- In January 2016, the trust achieved the referral to treatment (RTT) targets, of 95%, in all areas and specialities with the exception of ear, nose and throat at 94%.
- All three cancer wait measures (patients seen within two weeks, 31 day wait and 62 day wait) were generally better than the England average from 2013/14 to 2015/16, although October and November 2015 were below the target of 85% for 62-day wait at 77% and 79.8% for the planned care division.
- There was support for patients with individual needs including visually impaired, hearing impaired, learning disability or dementia.
- There was evidence of learning from complaints and how changes had been implemented.

However,

- There were delays in reporting in radiology due to increasing demand, which meant there may be delays in treatment, however: the trust had responded to this and were outsourcing X-ray reporting to support this. Reporting had been identified, on the risk register, as high priority. The trust target to be signed in 14 days was 90%.
- There was no data available for waiting times in the outpatient department or if a clinic starts late.

Service planning and delivery to meet the needs of local people

- The main out – patient and diagnostics services were provided at the Countess of Chester Hospital and peoples needs were considered in service planning and delivery.
- Radiologists work with other neighbouring trusts as part of an acute hub of hospitals. At the Countess of Chester hospital, outpatient clinics and the radiology department were routinely open in the evenings, on weekdays and at the weekend in response to patient need.

Access and flow

- There were 444,045 attendances between July 2014 and June 2015.
- Clinics and diagnostic imaging appointments were planned in order to meet national referral to treatment targets.
- In January 2016, the trust achieved the referral to treatment (RTT) targets, of 95%, in all areas and specialities with the exception of ear, nose and throat at 94%.
- All three cancer wait measures (patients seen within two weeks, 31 day wait and 62 day wait) were generally better than the England average from 2013/14 to 2015/16, although October and November 2015 were below the target of 85% for 62-day wait at 77% and 79.8% for the planned care division.
- The trust target for outpatient letters sent within 14 days was 50%. Between January 2015 and January 2016, 7.6% to 30.9% of rheumatology letters were sent. Targets were achieved in cardiology, clinical haematology, endocrinology, gastroenterology and general medicine.
- The trust target for did not attend (DNA) for a new appointment was 5%. There were consistently higher percentages, monthly, between January 2015 and January 2016. The trust sent out text reminders prior to appointments.
- The trust target for echocardiography (under six weeks) was 95%. Between January 2015 and January 2016, the trust achieved this target in January and February 2015. (The lowest was 61% in August 2015).

Outpatients and diagnostic imaging

- There were 9% of appointments cancelled by patients, (July 2014 to June 2015), compared to an England average of 6%.

- Similarly there were 9% of appointments cancelled by the trust (July 2014 to June 2015), compared to an England average of 7%.

- Between December 2015 and February 2016 the main reasons for cancellations of procedures was by the patient on the day of the examination including 48 for CT scans, 52 for MRI and 89 for ultrasound scans.

- For radiology, the trust target to be seen within three weeks was 90%. Between January 2015 and October 2015, for appointments for computerised tomography (CT), magnetic resonance imaging (MRI) and non-obstetric ultrasound, this target was achieved once in January 2015 for CT. The national target for 100% to be seen within six weeks was nearly achieved for each area: three times for CT (98% - 99% otherwise), twice for MRI (99% otherwise) and six times for ultrasound (99% otherwise) for the same time period. There were out of hours scanning clinics arranged in the evenings.

- Reporting was on the risk register, as high priority. The trust target to be signed in 14 days was 90%. For CT scan January 2015 to January 2016) this target was not achieved, except for January 2015 and May 2015, and ranged between 54% and 78% in other months. For MRI, same time period, the reporting rates were between 50% and 81% with the exception of January 2015 and May 2015 when targets were achieved.

- The trust had identified reporting as an issue and reporting of x-rays, CT scans and MRI scans had been outsourced to an external company with volumes increasing through 2015, particularly with plain x-rays to respond to increasing demand.

- There were waiting list initiatives implemented when the needs of the local population increased with the provision of additional clinics as required.

- There was no data available for waiting times in the outpatient department or if a clinic starts late. We observed announcements on the 'call system to expect at least a sixty minute wait for orthopaedic clinics.

Meeting people's individual needs

- Access to the out – patient areas, at the Countess of Chester hospital, was via a central corridor. All the signage was colour coded yellow. This meant signs were easier to see for visually impaired patients and visitors. The main boards, however; were colour – coded in different colours that may be confusing to follow. The outpatient entrance displayed details of the clinics in operation.

- An audio email system was available, for appointments, for visually impaired patients and appointment letters were available in larger fonts.

- The waiting areas in the main outpatients included standard seating, but; no raised seating was observed. This meant the seating might not be suitable for a patient with mobility difficulties. In the healthy ageing unit, at Ellesmere Port Hospital, the waiting room included high – back chairs with arms.

- There was an interpreter service available if needed for non-English speaking patients and staff knew how to access this service. Leaflets were written in English although the patient advisory liaison leaflets (PALS) were available in languages other than English when requested.

- Sign language experts were available for the hearing impaired. Learning disabilities champions supported patients identified as having a learning disability. Patients were able to wait in a quiet room, if needed, and seen as quickly as possible. '

- Reasonable adjustment' cards were used for some patients, such as people with autism, that families submitted to reception staff which supported patient's individual needs.

- Staff were seen displaying the 'purple flower' identifying that they were dementia friends. Dementia training was part of mandatory training requirements for all staff.

- Transgender training had been introduced for reception staff and staff participated in disability and equality meetings.

- A 'one stop' shop was available where patients attended for multiple appointments, at the hospital, in one day which reduced the need for patients attending on multiple occasions

Outpatients and diagnostic imaging

- There was a community ultrasound service provided to rural locations to support patients getting diagnostic tests promptly.

- Patients were offered 'bleeps' if there a prolonged wait in the outpatient department or they were attending for a number of clinics or investigations This meant they were able to move around the hospital until 'bleeped' to return for the appointment.

- An example was given of nurses and doctors' providing home visits for a patient, as it was more appropriate to meet their individual needs.

- Out patients were in the process of developing a booking system that identified available rooms to book additional clinics as part of waiting time initiatives.

- There were bariatric outpatient facilities, however; these were provided by an external company

Learning from complaints and concerns

- Complaints were managed in line with the trust procedure for listening and responding to concerns and complaints policy. There were Patient Advice and Liaison Service (PALS) leaflets available that included how to request a copy in a language other than English.

- Between December 2014 to December 2015, there were 44 complaints for outpatients and diagnostics, most of which were responded to in a timely manner. Three remained open whilst under investigation.

- Patients we spoke to complained about lack of car parking, particularly disabled spaces and waiting times in the queue at reception and to be seen for an appointment. The Out – patients department has implemented a 'bleep' system meaning that patients were able to leave the department and return for their appointment.

Are outpatient and diagnostic imaging services well-led?

Good 🟢

We rated as well-led because:

- There was a clear vision and strategy for the future.

- The management teams were stable and committed to patient well-being in both outpatients and diagnostics despite challenges.
- There were governance processes embedded with action plans in progress to improve services.
- There were regular meetings, at all levels. Staff felt supported by their line managers and there was good team working in the departments.
- There were several innovations taking place with plans to increase services.

Vision and strategy for this service

- The trusts vision was based on the model hospital. All staff we spoke to were familiar with this vision. The trusts long-term strategy was based on three key programmes of work, which focused on working with internal and external stakeholders across Cheshire. Staff were aware of the long-term strategy for the trust and the local strategy related to outpatients and radiology.

- The strategy for outpatients included: "streamlining the booking processes, reception areas and treatment rooms to ensure they are utilised as effectively as possible."

- The trusts 'operational plan document for 2015 – 16 included the expansion of vascular services and integrated interventional radiology provision with neighbouring trusts.

Governance, risk management and quality measurement

- Staff reported on risk, incidents, and complaints. They discussed incidents at departmental meetings, led by the service line manager and clinical directors attended to discuss trends and serious incidents.

- Staff completed daily situation reports in the outpatients departments (OPD) that included details about clinics, which identified and risks to delivery of key outpatient targets.

- The trust corporate risk register and the divisional register included interventional radiology processes, incident trends and a lack of reporting capacity had led to a backlog in reporting. There were controls measures in place and staff updated registers regularly. Staff were aware of the risks recorded in the register.

Outpatients and diagnostic imaging

- There were processes in place to evaluate the quality of care delivery including internal inspections and actions for improvement were identified and acted upon.

- The quality, safety and patient experience committee (QSPEC) met monthly and reports were presented including a thematic review of outpatient and diagnostic areas in February 2016.

- There were clinical IR task and finish group meetings, radiation protection supervisors group meetings, district radiological safety committee meetings and clinical (heads of department) HODs meetings, which monitored key risk and quality measures.

- Staff held monthly meetings that included OPD governance meetings, radiology directorate meetings, senior nurse forums and heads of nurses met with the deputy director of nursing. Meetings were used to cascade key information to staff.

- The integrated radiological services reported quarterly on key safety issues and gave recommendations with supported the departments risk and governance framework. The integrated radiological services report, in January 2016 included a number of recommendations including that there was no "common system for document management across all departments that use ionising radiation" and "documentation should be standardised wherever possible." It was also recommended that a trust radiation safety policy should be created.

Leadership of service

- Staff found the local managers of the service to be approachable and supportive. Most staff we spoke with told us they were content in their role and many staff had worked at the hospital for many years.

- Staff felt they could approach managers with concerns but some medical staff in diagnostic imaging did not always feel listened to, or confident action would be taken.

- We saw good, positive, and friendly interactions between staff and local managers.

- The managers of the out patients and radiology services were visible in the departments and meet with staff twice daily.

- Managers had acted upon staff concerns and put plan in place to improve access and flow.

- Consultant radiologists had contacted senior executives with their vision for the future. Managers listened and understood, however; it was felt that other priorities were being considered first due to financial constraints.

- A business case had been proposed to develop the service to include an interventional radiology day case unit

- Radiology attended meetings, as required with the director of nursing to escalate any issue that included an increase in complaints or increase in cancellations.

Culture within the service

- All staff told us that they were supported by their line managers.

- Radiographers said it was a good hospital to work in and there was good teamwork in radiology.

- Some staff felt they could speak up and air their views, although other staff did not feel that the senior management team were approachable and would support them.

Public engagement

- Volunteers provided support to patients and staff throughout outpatient areas, directing patients and relatives to waiting areas.

- There were opportunities doe the public to provide feedback in the outpatient department via the friends and family test. The trust had recently changed provider for recording of any patient feedback with positive results.

- There were information leaflets displayed in all areas we visited available for members of the public to take.

- There were support groups for different specialities such as a 'drop in' with the respiratory team at the Countess of Chester hospital or Age UK with the healthy ageing team at Ellesmere Port hospital.

Staff engagement

- There was a weekly newsletter, available on the trusts intranet for staff.

Outpatients and diagnostic imaging

- Staff attended monthly meetings held in the outpatients department; the minutes were cascaded to all staff, via email. An additional hard copy was also available.

- Student quality ambassador newsletters were available for students.

- Staff attended monthly radiology meetings with the minutes cascaded to all radiology staff.

- The business manager, for the respiratory team held monthly staff meetings, which enabled staff to share ideas.

Innovation, improvement and sustainability

- The trusts 'high quality care costs less programme' (HQCCL) included "identifying efficiencies from four work streams; outpatients, theatres, flow and processes."

- The HQCCL has included the 'No need to bleed' pilot. This meant that people were having blood tests when necessary.

- The colorectal OPD model offered a variety of communication methods for the vast majority of patients that will have normal results via modern communication techniques such as videoconferencing.

- Nurse led clinics were available in vascular clinics that included a combination of face-to-face consultations and telephone appointments.

- In ophthalmology, a cataract one-stop clinic was available for routine cataract procedures. In addition, virtual clinics were available for triaging patients to the appropriate care pathway.

- A virtual fracture clinic is planned which would be run a consultant, senior orthopaedic clinical nurse specialist and secretary in attendance. Patients would then be given a diagnosis and their treatment planned.

- There were breast pathways for identified groups of patients to ensure seen appropriately.

- Initiatives in radiology have included rural community ultrasound, implementation of specialist techniques and the adoption of SCoR 'pause' posters and cards to reduce misidentification events.

Outstanding practice and areas for improvement

Outstanding practice

- The sentinel stroke national audit programme (SSNAP) latest audit results rated the trust overall as a grade 'B' which was an improvement from the previous audit results when the trust was rated as a grade 'E'.

- The trust were rolling out care and comfort worker roles to work across the wards to assist patients with nutrition and hydration.

- We observed a theatre morning briefing which included all staff within the theatre areas. This briefing ensured that all staff were aware of theatre wide issues and safety concerns and also ensured that staff felt they were part of the wider theatre team.

Areas for improvement

Action the hospital MUST take to improve
Urgent and emergency care

- Ensure that there are sufficient staff trained in adult and children's safeguarding procedures in the accident and emergency department.

Medical care (including older people's care)

- Ensure there are sufficient numbers of suitably qualified and skilled staff on medical wards.

- Ensure that all medications are stored in a secure environment at all times.

Children and young people's services

- Ensure staffing levels are maintained in accordance with national professional standards on the neonatal unit and paediatric ward.

- Ensure that there is one nurse on duty on the children's ward trained in Advanced Paediatric Life Support on each shift.

- Improve the waiting times for reporting of radiology investigations.

Surgery

- The trust must ensure that adequate numbers of suitably qualified staff are deployed to all areas within the surgical services to ensure safe patient care.

- The trust must ensure that patients outlied outside their speciality meet the trusts criteria and the areas which they are outlied to are staffed by suitably qualified staff.
- The trust must ensure that patients nutritional and hydration needs are met at all times.
- The trust must ensure that all staff are able to understand and apply the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

Action the hospital SHOULD take to improve
In urgent and emergency care services :

- The trust should review medical record storage to ensure that records are accessible for staff easily, but mitigate the risks of the public being able to access records.

- The trust should ensure all premises and equipment used by the service provider are clean.

- The trust should review processes to improve access and flow through the accident and emergency department.

- The trust should review processes of managing patients own medications in accident and emergency areas.

In medical care services :

- The trust should ensure the electronic paper records system is robust and staff are sufficiently trained and competent in using and understanding the system.

Outstanding practice and areas for improvement

- The trust should ensure all patients' records are secure.

- The trust should ensure at all patients and staff across the trust has access to dementia services.

- The trust should ensure that all staff receive mandatory training including mental capacity act training.

- The trust should consider that basic monitoring equipment (blood pressure machine) is available in the discharge lounge.

In surgery :

- The trust should ensure that all staff receive the adequate level of safeguarding training.
- The trust should ensure that all staff are treated with dignity and respect during their course of employment.
- The trust should ensure that staff are able and feel comfortable to raise concerns.
- Staffing levels on some wards were below 95% of the planned target with levels less 90% on some occasions. Staff worked extra shifts and agency staff were used on a regular basis to ensure patient safety. At night the staff skill mix on the wards was not always sufficient to meet the needs of the patients as staff with specialised competencies for their area of work would be moved to support ward areas that required additional staff.

In critical care:

- Ensure that all critical care staff are aware of Duty of Candour regulations and their responsibilities within this.

- Ensure that there are robust procedures in place to monitor impact and reduce the numbers of patients that are delayed in being discharged from the critical care unit.

- Ensure that there are robust procedures in place to monitor impact and reduce delays of patients waiting to be admitted to the critical care unit.

- Consider supporting critical care patients who have been discharged from hospital to identify any psychological support that may be needed.

- Ensure that the critical care unit achieves 50% of nursing staff have a specialist critical care qualification.

In maternity and gynaecology :

- The trust should ensure that all areas, all fridges and equipment are clean and checked as required.
- The trust should ensure robust systems are in place to evaluate and improve their practice in respect of incidents and all investigations relating to the safety of the service.
- The service should review procedures for evacuation from the birth pool and consider regular drills including practising removing women from the pool.
- Undertake robust risk-assessment for the women and children's building so that the risks associated with baby safety are maximised.
- Deploy sufficient clinical and midwifery staff with the appropriate skills at all times of the day and night to meet the needs of patients using the service.
- The provider should provide staff with opportunity to and need for staff to receive yearly individual appraisals.
- The provider should consider producing regular updates specifically about the stages maternity and gynaecology audits have reached.
- The provider should consider ways of supporting women to feel confident in choosing a birth plan which does not require intervention unless necessary.
- The provider should ensure the general public are given opportunities to comment on their strategic plans.

Children and young people's services:

- The trust should take steps to ensure that resuscitation equipment is checked in line with trust policy.
- The trust should ensure that the door to the kitchen on the children's ward is locked and access restricted as appropriate.
- Consideration should be given in relation to safe storage of records on the children's ward. The notes trolley and storage cupboard should be kept locked to ensure safe storage.
- The trust should ensure controlled medicines are checked daily in line with trust policy.

Outstanding practice and areas for improvement

- Consideration should be given to the introduction of a routine nutritional assessment tool for all patients on the children's ward.
- The trust should ensure staff attend mandatory and safeguarding training as required for their role.
- Consideration should be given for the development of a winter management plan.

End of Life:

- Ensure the roll out of the Care and Communication documentation across the trust.

- Ensure all staff have appropriate End of Life training and support.

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

- Ensure all staff are aware of the vision and strategy for end of life services.

In outpatients and diagnostic imaging services:

- The trust should improve the waiting times for reporting of radiology investigations.

- The trust should ensure staff are assured that equipment has been maintained safely.

- The trust should consider the layout of the waiting area to provide privacy for patients when confirming confidential details.

- The trust should consider improving the environment for children in the outpatients department as it is not child-friendly.

- The trust should ensure that all resuscitation equipment is checked and positioned appropriately in order that it is available in an emergency.

- The trust should ensure all equipment and clinical areas are free from dust.

- The trust should ensure that all guidelines are clear and followed using national guidance for best practice.

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
Nursing care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regulation 17 Good Governance **How the regulation was not being met:** Records were not always accurate, complete and detailed records in respect of each person using the service because: Some records lacked detail in relation to nutrition and hydration on surgical wards. HSCA 2008 (Regulated Activities) Regulations 2014, Regulation 17 (2) (c)

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 18: Staffing **How the regulation was not being met:** There were not always sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed to meet the needs of the patients in surgery, medicine, paediatrics and neonatal services. There were delays in reporting of diagnostic investigations in radiology. In addition, there was an insufficient number of staff on duty per shift with training in paediatric life support on the paediatric unit.

Requirement notices

HSCA 2008 (Regulated Activities) Regulations 2014,

Regulation 18 (1) (2) (a)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) Regulation 12 (2)(g) **How the regulation was not being met:** The proper and safe management of medicines was not always followed because: Staff on ward 52 did follow policies and procedures about storing medicines safely. HSCA 2008 (Regulated Activities) Regulations 2014. Regulation 12 (2) (g).

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 13: Safeguarding service users from abuse and improper treatment. **How the regulation was not being met:** Safeguarding training was not provided for in line with best practice guidance. This is because there were not sufficient numbers of staff trained in level 3 safeguarding children in urgent and emergency care. In addition, not all staff understood how to apply the mental Capacity Act 2005 principles deprivation of liberty safeguards.

Requirement notices

HSCA 2008 (Regulated Activities) Regulations 2014, Regulation 13 (2) (5)

Enforcement actions

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.

Enforcement actions (s.29A Warning notice)

Action we have told the provider to take

The table below shows why there is a need for significant improvements in the quality of healthcare. The provider must send CQC a report that says what action they are going to take to make the significant improvements.

Why there is a need for significant improvements	Where these improvements need to happen
Start here...	Start here...