

## The Walton Centre NHS Foundation Trust

# The Walton Centre

## 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

Outstanding



Medical care (including older people's care)

Good



Surgery

Good



Critical care

Good



Outpatients and diagnostic imaging

Good



Specialised rehabilitation

Outstanding



# Summary of findings

## Letter from the Chief Inspector of Hospitals

The Walton Centre NHS Foundation Trust is the only specialist hospital trust in the UK dedicated to providing comprehensive neurology, neurosurgery, spinal and pain management services. The trust receives patients from Merseyside, Cheshire, Lancashire, Greater Manchester, the Isle of Man and North Wales and has a catchment area of approximately 3.5 million people. Due to the areas of expertise the trust often receive referrals from other geographical areas, sometimes this includes international referrals.

Care and treatment is provided from two buildings on the same site; The Walton Centre main building and the purpose built Sid Watkins Building, which was opened in 2015. There are 192 beds, 123 of which are neurosurgery, 29 neurology and 40 for rehabilitation.

We carried out this inspection as part of our comprehensive inspection programme. The announced element of the inspection took place on 5 April 2016 to the morning of 8 April 2016. We also undertook an unannounced inspection on 21 April 2016. As part of the unannounced inspection, we visited Chavasse ward, Lipton ward, Dott ward, Caton ward, theatres, critical care and the complex rehabilitation unit (CRU).

Overall we rated The Walton Centre as 'Outstanding'. We rated the hospital as 'Outstanding' for Effective and Caring. We also rated the hospital as 'Good' for Safe, Responsive and Well-Led care.

Our key findings were as follows:

### Cleanliness and infection control

- All areas we inspected were visibly clean and well organised. The trust were rated as the overall top acute trust in England in relation to the patient-led assessments of the care environment (PLACE) in 2015. The trust scored 99% for cleanliness and 98% for condition, appearance and maintenance.
- Cleaning schedules were in place, with allocated responsibilities for cleaning the environment and decontaminating equipment. However, on one occasion we found a resuscitation trolley in the critical care area that had not been cleaned despite the records indicating that it had. We brought this to the attention of management and it was rectified immediately.
- We observed staff using personal protective equipment (PPE), such as gloves and aprons, and changing them between patient contacts. We saw staff washing their hands using the appropriate techniques and all staff followed the 'bare below the elbow' guidance. There was ample access to hand washing facilities. Staff followed procedures for gowning and scrubbing in the theatre areas.
- There were regular environmental and hand washing audits across the trust, with generally high levels of compliance.
- The trust had implemented a 'stop, think, sink' campaign to encourage visitors, families and patients to wash their hands before entering and leaving clinical areas.
- Staff were aware of current infection prevention and control guidelines, and were able to give us examples of how they would apply these principles.
- 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. However, one door in the complex rehabilitation unit did not have clear signage indicating that the patient was identified as an increased infection control risk. We raised this with senior staff who rectified the situation immediately.

# Summary of findings

- Between April 2015 and February 2016, the trust overall reported a total of eight cases of clostridium difficile and one incident of Methicillin-Resistant Staphylococcus aureus (MRSA) infection meaning the trust was on plan to meet its locally set target. In addition, between April 2015 and December 2015, there had been one cohort of carbapenemase producing enterobacteriaceae (CPE) colonisation involving six patients and five incidents of methicillin sensitive staphylococcus aureus (MSSA).
- When there were incidents of hospital acquired infections, a full investigation was carried out using a root cause analysis approach so that lessons could be learnt and improvements made. We saw an example of a change in practice following an incident of pseudomonas (microorganisms that live in water). Regular water testing was being undertaken at the time of the inspection and filters had been put on all taps.

## Nurse staffing

- The trust used recognised and validated tools to determine the required levels of nursing staff.
- The majority of areas were staffed with sufficient numbers of suitably qualified nurses at the time of the inspection. However, during our visit we noted there was a lack of visibility of staff on the complex rehabilitation unit (CRU) which had been identified by the service partially due to the layout of the new building.
- 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.
- In quarter four of 2015/16, the trust had received 'high assurance' from its internal auditors, the highest level of assurance possible, for both its daily escalation/staffing actions and the bi-annual reviews.
- End of life care was the responsibility of all staff across the trust and was not restricted to the end of life care (EOLC) team.
- The EOLC team was led by a neurological oncology advanced nurse practitioner who managed one whole time equivalent (WTE) end of life facilitator and a 0.4 WTE amber care bundle facilitator. The facilitators provided advice, support and training to staff and met daily to discuss patients. Each provided cover when the other was not available, for example on leave. Staff told us this worked well.
- In addition, staff had access to the specialist palliative care team at another hospital and a hospice both which located on site. The facilitators told us they would fax referrals along with discussing patients that required reviewing.

## Medical staffing

- Medical treatment was delivered by skilled and committed medical staff.
- The information we reviewed showed that medical staffing was generally sufficient to meet the needs of patients at the time of the inspection.
- On weekdays in the critical care service, the level of consultant cover did not exceed the Intensive Care Society (ICS) standard of a staff to patient ratio of between 1:8 and 1:15. However, at the weekend and during the night the ratio was higher at 1:20. The unit had two Advanced Critical Care Practitioners (ACCPs) to help fill this shortfall but at the time of the inspection, they were only available to cover one in three shifts. There had been no incidents reported about the level of medical cover in critical care and staff told us that they felt that this was being managed safely.

# Summary of findings

Two additional ACCPs had been appointed at the time of the inspection and were due to start in July 2016. Both the medical trainees and ACCP's who were available on the unit during the night were all trained in advanced airway techniques and were competent in managing a deteriorating patient. There was also out of hours support from the surgical medical assessment Response Team (SMART) when needed.

- Consultants made up 54% of the medical and surgical workforce across the trust which was higher than the England average of 39%. There were less middle grade doctors at 4% compared with the England average of 9%. The number of registrars within the service was higher than the England average at 41% compared to the England average of 38%.
- Consultants provided an on call rota for both Hub and Spoke units within the rehabilitation network, which provided 24 hours, seven days cover. The service had 4.2 WTE consultant cover for the CRU and was available on call from home between 10pm and 8am.

## Mortality rates

- Regular multidisciplinary mortality and morbidity committee meetings took place which fed into the monthly mortality and morbidity seminars. We observed the monthly reports for July 2015 to September 2015. The September 2015 report identified eight mortality cases. Patient records were reviewed to identify any trends or patterns. There was evidence of discussion and learning from cases within the report.
- The most recently available and validated Intensive Care National Audit and Research Centre (ICNARC) data (April 2015 to September 2015) showed that the patient outcomes and mortality were similar to benchmarked units nationally. The exception to this was for emergency neurosurgical admissions, where mortality was consistently lower (better) than that of similar units. Subsequently, acute hospital mortality was also consistently lower (better).
- The ICNARC (2013) model mortality was 0.76 for the period July 2015 to September 2015 meaning that the number of observed deaths were less than those predicted. Overall performance was similar to that of other trusts that the unit was benchmarked against. In comparison, the mortality ratio for the same period using APACHE 2 (2013) model was 0.69. (APACHE stands for acute physiology and chronic health evaluation and is a severity score and mortality estimation tool developed in the United States of America). This result was again similar to other trusts.
- Mortality rates were lower (better) than average mortality rates at similar units between April 2012 and March 2015, as reported in the Neurosurgical National Audit Programme.

## Nutrition and hydration

- Patients' nutrition and hydration needs were generally well managed.
- In all the records we reviewed, a nutritional risk assessment had been completed and updated regularly. This helped identify patients at risk of malnutrition and adapt to any ongoing nutritional or hydration needs.
- Staff consistently completed charts used to record patients' fluid input and output and where appropriate staff escalated any concerns.
- The trust had a protected meal time's initiative which ensured there were minimal interruptions to patient's meal times. During set times when meals were served all staff were focused solely on meal times and assisting patients. Medical and therapy staff were not able to examine or perform any routine interventions during these times to ensure patients had protected time to eat.
- The guidelines for fasting before surgery (the time period where a patient should not eat or drink) were clear and met national guidance.

# Summary of findings

- Patients records showed that those patients identified as approaching end of life had their nutrition and hydration needs evaluated. An audit of 20 patient records from January 2015 to February 2016 identified that, during the dying phase, two patients were able to eat and drink, 18 patients were assessed for clinically assisted nutrition and hydration, with ten of those having clinical assisted nutrition or hydration in place at time of death.
- There was access to a dietetic service. A dietitian was available to attend ward rounds when required during normal working hours.

We saw several areas of outstanding practice including:

- In medical services, we found examples of outstanding care where patients' individual needs were met using alternative approaches to rehabilitation pathways which involved patients and their families. This included developing a garden area where family were encouraged to attend and garden with the patient.
- The trust had received a Certificate of Recognition Excellence for the National Institute for Health Research (NIHR) for their work in promoting the benefits of clinical research, and encouraging recruitment of patients into clinical trials. In 2014 to 2015 the trust increased their proportion of NIHR studies from 39 to 56 studies compared to the previous year which was more than any other trust in the region.
- The use of functional magnetic resonance (MR) scanning in the diagnosis and treatment of patients. It was usually used for research purposes in other trusts but the trust was developing a range of applications that would improve diagnosis and outcomes for patients.
- The MR claustrophobia clinic was very supportive for patients and following the service winning funding to develop a service the trust had agreed to continue funding to support the service. Other members of staff were now involved in the further development of the service.
- The development of the advanced healthcare scientist role in neurophysiology to support an area that was previously consultant led. The role involved the healthcare scientist undertaking aspects of theatre monitoring that would have previously been the remit of a consultant neurophysiologist.
- The critical care service used an electronic system which identified the need for appropriate risk assessments to be undertaken for patients. This helped to ensure that patients were assessed in a timely manner by providing a visual aid to staff via a television screen in the main area of the unit. This tool was available throughout the hospital.
- The critical care service had introduced a memorial tree for patients who had passed away in the unit and donated organs. A yearly memorial service was held for relatives which had been well attended.
- The trust had developed a 'home from home' service which provided accommodation for relatives. The accommodation provided was of a high standard and had been designed as the catchment area for the unit was large, with patients using the services regularly from the Isle of Man and North Wales. The trust had recognised that relatives may have to visit on short notice and may not always bring what they need. Items such as toothbrushes were provided for relatives to use if this was the case. Access to refreshments was also available.
- There was a well-established multidisciplinary team approach that was seen as integral to the critical care service. There were regular meetings through the day with staff from other departments, internally and externally.
- The introduction of the nationally recognised rehabilitation network was found to be outstanding practice due to the focussed approach to rehabilitation and ability to move a patient to the most appropriate setting for care in a timely manner across the hub and spoke model.
- The interactive 'TIMS' theatre live tracking system was an innovative system which allowed live tracking of patients through their theatre journey. This system also allowed consultants to book their own patients on to theatre lists while in clinic. A number of other organisations had visited the centre to benchmark against this system.

# Summary of findings

- The trust took part in the Multiple Sclerosis Trust 'Generating Evidence in Multiple Sclerosis Services' (GEMS) 2014/15. This report documented an extensive service analysis which informed the national GEMS project which in turn was used to support NICE (National Institute for Health and Care Excellence) guidance. The services are then evaluated for compliance with NICE standards.
- The trust participated in the international Spine TANGO program which benchmarked their surgical outcomes against other services across Europe.
- The trust were rated as the overall top acute NHS trust in England in relation to the patient-led assessments of the care environment (PLACE) in 2015. The trust scored 99% for cleanliness; 98% for the food it served; 97% for privacy, dignity and wellbeing; 98% for condition, appearance and maintenance and 95% for patients living with dementia, an average of 97%.
- The trust had been named as an NHS vanguard site after applying for the status in September 2015. The new model of care, the neuro network, should provide additional and more effective support for people with long-term neurology conditions outside the trust hospital site; this should enable patients with spinal conditions across the region to receive more effective and timely care. The network models led by the trust aim to provide a high quality, cost effective and sustainable neuroscience service, working in partnership with other acute trusts and primary care.
- The trust had introduced a listening line that patients and their families could call and speak directly to the senior nurse on duty so that the trust could respond to concerns in a timely manner particularly for those patients on the ward at that time.
- The trust held 'Berwick' sessions, which were open to all staff to discuss what they are proud of and what keeps them awake at night. The trust considered this a key component of their open and honest culture and staff speaking out.

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

Importantly, the trust must:

## **In medical care**

- Ensure all equipment is available and in date on the resuscitation trolleys on Lipton and Chavasse wards.

In addition the trust should:

## **Trust-wide**

- Review the numbers of staff required to undertake level three children's safeguarding training.

## **In medical care**

- Schedules for cleaning should be updated and completed.
- All medical consultants should have a completed job plan annually.
- There should be access to lockable boxes for syringe driver pumps.
- Relevant staff should receive training to operate a syringe driver pump.
- The processes in place to request deprivation of liberty safeguards (DOLS) should be reflected in the trust's policy.
- Training compliance for Mental Capacity Act 2005 (MCA) and DOLS training should be improved to meet the trust target.
- Bed occupancy on Chavasse ward remains within the limits to enable quality of care to be delivered.

# Summary of findings

- Information should be available for patients and relatives about making formal complaints so that they are aware of the correct process to follow.
- Audit processes should be able to benchmark patient outcomes with other specialist neurology services.

## In surgery

- The service should make sure that all areas used to store medications are locked securely.
- The service should improve compliance with all areas of mandatory training.
- The service should improve the numbers of staff that have received their annual appraisal.

## In critical care

- The unit should make improvements to the number of delayed discharges from the unit and ensure that all occurrences are reported as clinical incidents in line with trust policy so that improvements can be made.
- The unit should take into consideration the escalation beds that are available in the Short Stay Surgical Unit (SSU) when completing the next staffing review.
- The unit should complete staff appraisals in a timely manner so that they are able to address any requirements for support and development.
- The unit should make sure that staff complete all mandatory training updates when required.
- The unit should consider increasing the number of pharmacists for the unit so the intensive care society guidelines are met.
- The unit should monitor fridges to make sure they are checked on a daily basis and temperatures are recorded in line with trust policy.
- The unit should make sure that resuscitation trolleys are checked in line with trust policy and that tamper tags are replaced when required.
- The unit should collect data to monitor the effectiveness of the surgical, medical acute response team (SMART) team and the use of the track and trigger system.
- The unit should monitor if patients are admitted to the unit within four hours of the decision being made.
- The unit should improve access to information about how to make a formal complaint so that patients are aware of the correct process to follow.
- The unit should ensure that the review dates for risks identified on the risk register are clear.
- The divisional team should make sure that plans for development of the critical care service are clearly documented as part of the plans for divisional service improvement so that progress can be monitored and measured effectively.
- The unit should make sure that staff have a full understanding of the duty of candour and know when this should be applied.
- The unit should consider ways in which to meet the HBN-04-02 standards in the high dependency unit (HDU).
- The unit should consider ways in which to provide immediate life support training to all critical care staff.
- The unit should ensure that the timetable for the planned recruitment and training of advanced critical care practitioners (ACCPs) is met so that the correct staff to patient ratio is met out of hours.

# Summary of findings

## **In specialised rehabilitation services**

- The service should continue to continuously review its caseload acuity to enable the service to accurately assess the staffing levels required for the provision of specialised rehab services in line with national guidance.
- Review how it proactively supports families and patients to access information on local support organisations and care of the patient requiring specialised rehabilitation

## **In outpatients and diagnostic imaging**

- The outpatient department (OPD) should improve the quality of written patient records.
- The trust should reduce the waiting times for patients in the OPD.
- The trust should consider moving the visual field testing in the OPD from the waiting room to a private area.
- Senior staff in the OPD should have level three safeguarding training for children and young people as some young people in transition between children's and adult services use the department.

**Professor Sir Mike Richards**

**Chief Inspector of Hospitals**

# Summary of findings

## Our judgements about each of the main services

### Service

**Medical care  
(including  
older  
people's  
care)**

### Rating

**Good**



### Why have we given this rating?

Overall we rated the service as being 'good' with the caring domain as 'outstanding'. There were robust systems in place to keep people safe. Incidents were reported and investigated with evidence of the outcomes being disseminated to staff and lessons being learned. People were protected against hospital acquired infections and when these did occur investigations took place and learning was shared. The trust had implemented the 'stop, think, sink,' initiative to encourage patients, families, and visitors to wash their hands and had invested in ultra-violet technology to decontaminate ward areas. There were nursing staff vacancies and the trust had an ongoing recruitment plan in place. The nursing staff ratio to patients on the wards we visited at the time of our inspection and prior to the inspection, on the whole, maintained safe staffing levels for patients. Patient risks were assessed, planned and managed with processes in place to identify and escalate the deteriorating patient. Due to the specialism of the trust they did not meet the criteria for a number of national audits. The trust had a range of policies and clinical guidelines that had been developed using evidence-based care and practice standards. We saw evidence of adherence to the Association of British Neurologists Quality Standards for Unscheduled Care including: rapid bed access, urgent scanning availability for diagnostics, and daily review of all patients by a consultant. There was a strong ethos of multi-disciplinary working across the trust and we observed medical, nursing and allied health professionals working well together. We saw evidence of multi-disciplinary review and care planning in patient records. We were given examples of outstanding care, where staff had gone 'the extra mile'. One example shared involved supporting a patient who remained on Chavasse ward for nine months, to return home to their family instead of being admitted to a secure unit. The team received an award from the Encephalitis Society for an exceptional service award for their care to the patient. There was a clear vision

# Summary of findings

which staff were aware of and a positive culture where staff felt supported by their leaders. The leadership team were visible to the staff on the wards on a daily basis.

## Surgery

Good



Staff were aware of how to report incidents and we saw evidence that the service undertook robust and appropriate incident investigations. Learning was shared widely. 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 neurosurgical care which was evidence-based and met national guidelines. Clinical audits were routinely undertaken and actions taken as a result were evident. Outcomes for patients were the same or better when compared to similar services. Patients were assessed for, and provided with, appropriate pain relief. Knowledge of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards was good. Staff treated patients with kindness, dignity and respect and patients told us they were happy with the care they received. 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 managed effectively. Patients had timely access to consultant led care. Staff could articulate the trust's vision and values. 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.

## Critical care

Good



The unit used best practice guidance when providing care and treatment and submitted regular data to both the Intensive Care National Audit and Research Centre (ICNARC) and the Cheshire and Mersey Critical Care Network (CMCCN). This allowed the service to be compared against similar units both nationally and locally. Care and treatment was discussed in a number of well-established multidisciplinary team meetings that were held on a daily basis with staff from inside and outside the unit. Care and treatment provided was always led by a consultant intensivist. There were sufficient numbers of nursing and medical staff to keep patients safe both during and prior to the time of

# Summary of findings

inspection. There were robust systems in place to protect patients from avoidable harm. Incidents were reported and investigated with evidence of the outcomes being disseminated to staff and lessons being learnt. Infections in the unit were kept to a minimum and when they did occur, a full investigation into their cause was carried out so that improvements could be made. We saw evidence of patients being treated with compassion and having their privacy and dignity maintained at all times. There was a positive culture demonstrated by staff in the unit and this was supported by a highly visible leadership team.

## Outpatients and diagnostic imaging

Good



Incident reporting was good; staff knew how to report incidents and this was fed back to staff. Mandatory training levels were at 100% and the environment was visibly clean. There were procedures in place for the prevention and control of infection. The care and treatment delivered was evidence-based and followed national guidance. Staff were competent to perform their roles and worked together in a multi-disciplinary environment to meet patients' needs. Throughout our inspection we witnessed exemplary patient centred care being given. Services were delivered by caring, committed, and compassionate staff who treated people with dignity and respect. Staff knew some of the patients who had been attending the trust for many years and there were caring interactions between them. Staff greeted patients like old friends. Patient satisfaction surveys were consistently positive and the results were used to improve. Staff were willing to be flexible with patients and recognised that patients regularly travel to the trust from far away. For example, one patient arrived at the hospital OPD at 6pm; staff rang the consultant who agreed to see them. There were good support services for patients, both from the trust and through engagement with the voluntary sector. Since April 2014 the percentage of people seen within two weeks for urgent cancer treatment was mainly at 100% and always above the England average. The management and leadership was good and the departments engaged with patients and staff. Risks were well managed and systems were in place to ensure quality.

## Specialised rehabilitation

Outstanding



There was a strong multidisciplinary team (MDT) approach to care for patients undergoing rehabilitation. There was a joined-up and thorough approach to

## Summary of findings

assessing the range of people's needs and a consistent approach to ensuring assessments were regularly reviewed by all team members and kept up to date. Outcomes throughout the service were above, or in line with, the expected national average. The service had a culture of learning and staff, including post graduates, had regular access to training for development to enhance their skills and knowledge. We found the service had worked within its commissioning arrangements to implement a complete service redesign of specialised rehabilitation services. It operated a hub and spoke model to make best use of resources and provide high quality responsive care for people requiring specialist rehabilitation. There were systems for reporting actual and near miss incidents across services. Staff were familiar with and encouraged to use the trust's procedures for reporting incidents. We saw evidence where findings from incidents were discussed and learning was shared. Care was delivered that was kind, compassionate and ensured patient dignity was maintained. Patients were well informed and felt their input was valued when planning their care and treatment. People were supported to raise concerns or complaints. Complaints were investigated and lessons learnt were communicated to staff. There was a clear governance structure and learning was discussed and disseminated at key meetings. The majority of staff said they felt supported and well led. The service was proactive in promoting research and innovation and there was a culture of supporting post graduate education and striving to improve service delivery.

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# The Walton Centre

## Detailed findings

### Services we looked at

Medical care (including older people's care); Surgery; Critical care; Outpatients and diagnostic imaging and Specialised rehabilitation.

# Detailed findings

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## Background to The Walton Centre

The Walton Centre NHS Foundation Trust (the trust) is the only specialist hospital trust in the UK dedicated to providing comprehensive neurology, neurosurgery, spinal and pain management services.

The trust is co-located on a large site with other NHS providers. Care and treatment is provided from two buildings; The Walton Centre main building and the purpose built Sid Watkins Building, which was opened in 2015. Located in Fazakerley, Liverpool, The Walton Centre's catchment population is about 3.5 million and is drawn from Merseyside, Cheshire, Lancashire, Greater Manchester, the Isle of Man and North Wales.

Liverpool itself has population of approximately 470,537 and the metropolitan area of about 2,241,000. The health of people in Liverpool is generally worse than the England

average. Deprivation is significantly higher than average 64.4% (303,377 people) and about 25,335 children (32%) live in poverty. Life expectancy for both men and women is lower than the England average.

Due to the areas of expertise, referrals are received from other geographical areas of the UK, sometimes internationally. Service delivery is achieved via a 'hub and spoke' system and the trust have partnerships with 13 NHS trusts. The trust have been named as an NHS vanguard which will see the trust leading new models of care that aim to develop a high quality and cost effective neuroscience service chain, working in partnership with other acute trusts. The trust has a total of 192 beds, 123 of which are neurosurgery, 29 neurology and 40 for rehabilitation.

## Our inspection team

Our inspection team was led by:

**Chair:** Nick Bishop, (retired) Medical Director; National Professional Advisor at CQC

**Head of Hospital Inspection:** Ann Ford, Care Quality Commission

**Inspection Manager:** Simon Regan, Care Quality Commission

The team included 6 CQC inspectors, a senior analyst and a variety of specialists including: a director of nursing and quality, a director, a governance specialist, a pharmacy inspector, a neurological nurse, a surgeon, a theatre nurse, a consultant anaesthetist, a critical care nurse, a consultant palliative care nurse, an outpatient nurse, a rehabilitation physiotherapist, and a student nurse. We also used two experts by experience who have experience of using healthcare services.

# Detailed findings

## How we carried out this inspection

The Walton Centre NHS Foundation Trust (the trust) was inspected previously in November 2013. No rating was applied at the previous inspection; this is the trust's first comprehensive inspection as part of our new inspection methodology.

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

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

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

As part of our inspection, we held focus groups and drop-in sessions with a range of staff in the trust. We also spoke with staff individually as requested. We talked with patients and staff from all 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.

The announced inspection of The Walton Centre took place on 5 April 2016 to the morning of 8 April 2016. We also undertook an unannounced inspection on 21 April 2016. As part of the unannounced inspection, we visited Chavasse ward, Lipton ward, Dott ward, Caton ward, theatres, critical care and the complex rehabilitation unit (CRU).

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

## Facts and data about The Walton Centre

The Walton Centre NHS Foundation Trust is the only specialist hospital trust in the UK dedicated to providing comprehensive neurology, neurosurgery, spinal and pain management services. The trust receives patients from Merseyside, Cheshire, Lancashire, Greater Manchester, the Isle of Man and North Wales and has a catchment area of approximately 3.5 million people. Due to the areas of expertise the trust often receive referrals from other geographical areas, sometimes this includes international referrals.

Care and treatment is provided from two buildings on the same site; The Walton Centre main building and the purpose built Sid Watkins Building, which was opened in 2015. There are 192 beds, 123 of which are neurosurgery, 29 neurology and 40 for rehabilitation.

Between July 2014 and June 2015 there were 5,757 inpatient admissions, 12,057 day case attendances and 105,340 outpatient attendances across the trust.

The trust employs over 1,300 members of staff and the full cost of providing services in 2014/15 was approximately £102 million.

## Our ratings for this hospital

Our ratings for this hospital are:

# Detailed findings

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Good	Good	★ Outstanding	Good	Good	Good
Surgery	Good	Good	Good	Good	Good	Good
Critical care	Good	★ Outstanding	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	Not rated	★ Outstanding	Good	Good	Good
Specialised rehabilitation	Good	★ Outstanding	Good	★ Outstanding	Good	★ Outstanding
Overall	Good	★ Outstanding	★ Outstanding	Good	Good	★ Outstanding

## Notes

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

# Medical care (including older people's care)

Safe	Good	●
Effective	Good	●
Caring	Outstanding	☆
Responsive	Good	●
Well-led	Good	●
Overall	Good	●

## Information about the service

The Walton Centre NHS Foundation Trust is the United Kingdom's only specialised neurosciences trust. It treats patients from Merseyside, Cheshire, parts of Lancashire and Greater Manchester, the Isle of Man and North Wales. It has an approximate catchment population of some three million people.

The trust offers medical inpatient services to adults aged from 16 years old and which includes; assessment of epilepsy, Parkinson disease, multiple sclerosis, headaches, and deep brain stimulation. Pain medicine is also offered to inpatients and includes pain management of nerve (neuropathic) pain, spinal pain, neuromodulation and palliative pain management.

There are a total of 192 beds in the hospital. There are two medical wards at the hospital; Chavasse which has 29 beds and Lipton, which has 10 beds. Both wards receive planned and unplanned emergency admissions or transfers from other hospitals.

End of life services were reported with medical care services due to the size of the end of life team and there had been 20 deaths on the wards at the hospital during the period of January 2015 to December 2015. Palliative care was provided on all wards at The Walton Centre. All staff were caring and committed to meeting patients' needs at the end of their life.

The end of life team was relatively new with the facilitator commencing the role in October 2014 and the end of life strategy introduced in February 2016. Bereavement and

palliative support and advice was provided by the specialist palliative care team at another hospital and from a hospice on the same site. Mortuary services and facilities were also provided at the other hospital.

At the time of our inspection there were no patients at the end of life and we were unable to review the electronic prescription charts; however, we observed previous patients' records including syringe driver medication prescribed and administered.

We visited Chavasse ward, Dott ward, Cairns ward, and Lipton ward, information services, home from home unit and a multi faith prayer room. We spoke with 40 staff including senior managers, end of life facilitator, amber care facilitator, doctors, specialist nurses, allied health professionals, porters, trained and untrained nursing staff. We reviewed 20 patient records and nine prescription charts, and spoke with eight patients and one relative.

# Medical care (including older people's care)

## Summary of findings

Overall we rated the service as being 'good' with the caring domain as 'outstanding' because:

- There were robust systems in place to keep people safe. Incidents were reported and investigated with evidence of the outcomes being disseminated to staff and lessons being learned. People were protected against hospital acquired infections. The trust had implemented the 'stop, think, sink,' initiative to encourage patients, families and visitors to wash their hands and had invested in ultra-violet technology to decontaminate ward areas.
- There were 4.95 whole time equivalent nursing vacancies and 4.27 whole time equivalent medical vacancies at the time of our inspection. The trust had an ongoing recruitment plan in place and had taken a positive approach in an attempt to attract new staff to the trust. There were systems in place to monitor staffing daily, to ensure safe staffing was in place. We found, at the time of our inspection, and during January and February 2016, the trust had the required number of staff on duty.
- Patient risks were assessed, planned and managed with processes in place to identify and escalate the deteriorating patient. These included risks of pressure ulcers, falls, nutrition and hydration and aimed to keep patients free from harm.
- Guidance and care plans had been put in place following the removal of the Liverpool Care Pathway nationally in 2013. Medicines relating to symptom and pain control for people at the end of their life were prescribed appropriately with guidelines available across the wards
- Due to the specialism of the trust they did not meet the criteria for a number of national audits. The trust had a range of policies and clinical guidelines that had been developed using evidence-based care and practice standards. We saw evidence of adherence to the Association of British Neurologists Quality Standards for Unscheduled Care including: rapid bed access, urgent scanning availability for diagnostics, and daily review of all patients by a consultant.

- There was a strong ethos of multi-disciplinary working across the trust and we observed medical, nursing and allied health professionals working well together. We saw evidence of multi-disciplinary review and care planning in patient records.
- We were given examples of outstanding care, where staff had gone 'the extra mile'. One example shared involved supporting a patient who remained on Chavasse ward for nine months, to return home to their family instead of being admitted to a secure unit. The team received an award from the Encephalitis Society for an exceptional service award for their care to the patient.
- There was a clear vision which staff were aware of and a positive culture where staff felt supported by their leaders. The leadership team were visible to the staff on the wards on a daily basis.

However;

- We saw that cleaning rotas were not always completed which meant there was limited assurance that cleaning had taken place.
- Medical staff were not achieving the trust target for consultants having a completed job plan which may result in learning needs not being identified or actioned.

# Medical care (including older people's care)

## Are medical care services safe?

Good



We rated medical care services as 'good' for safe because:

- There were systems in place to report, monitor and investigate incidents. We saw evidence where findings from incidents were discussed and learning was shared. We observed all appropriate documentation was in place on Lipton ward for patients on special observation and staff were aware of the process. Openness and transparency was encouraged and was evident in the root cause analysis we observed.
- Harm free care was monitored and we saw patient risk assessments completed and management plans were in place for patients where a risk had been identified. The service had made improvements in the care of patients with an indwelling urinary catheter as an outcome of monitoring and reviewing harm free data.
- The neurology division overall was achieving the trust target in relation to adherence to mandatory training. Chavasse ward was slightly below the trust target but plans had been put in place to improve compliance. Both Chavasse and Lipton wards were achieving the trust target in relation to safeguarding training and there was a clear process that staff were aware of to escalate any safeguarding concerns.
- Patients were protected against healthcare associated infection and staff adhered to infection control policies. On the occasion when there was an infection outbreak the trust responded with appropriate action. The trust had invested in a new system using ultra-violet technology to decontaminate ward areas.
- The trust was in a transitional period of implementing electronic held records. Healthcare assistants were unable to access patient electronic records at the time of our inspection; however, the trust was aware of the situation and alternative processes were put into place to enable staff to have access to records to maintain patient safety. Records we reviewed were contemporaneous, and legible.
- There were 4.95 whole time equivalent nursing vacancies and 4.27 whole time equivalent medical vacancies at the time of our inspection. The trust had an ongoing recruitment plan in place and had taken a positive approach to try to attract applications to the

trust. The ratio of nursing staff to patients was higher (better) than the England average of 1:8 which demonstrated the trust had considered the complexity of the patients and increased care required to meet the patient's needs.

- The ward areas were visibly clean and tidy at the time of our inspection. The trust had scored high in the patient-led assessments of the care environment (PLACE) scores for cleanliness in 2015.
- Medication was stored and managed in line with the trust's policy.

However:

- We saw that cleaning rotas were not always completed which meant there was limited assurance that cleaning had taken place.
- Resuscitation trolleys were checked daily; however at the time of our inspection we found two pieces of equipment that had exceeded the expiry date on the resuscitation trolley on Chavasse ward and some items on the trolley on Lipton ward. In addition, there was an empty box that should have contained an ampoule of adrenaline. The trust was made aware of this at the time of our inspection and took immediate action to resolve the issue.

## Incidents

- The trust used an electronic system to record incidents. Staff were aware of their responsibilities to report incidents, knew how to report incidents and had access to the system.
- There were no never events (serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should be implemented by all healthcare providers), reported for the period February 2015 to January 2016.
- There were 889 medical incidents reported between January 2015 and January 2016. Of these incidents, 240 were reported from Chavasse ward and 98 reported from Lipton ward. There were 21 incidents recorded for Chavasse and Lipton wards which were classified as minor and included; patient acquired infection, pressure area damage, and medication errors. We observed evidence that the trust reported incidents via the National Reporting and Learning System (NRLS).

# Medical care (including older people's care)

- There was one incident reported on Lipton ward which was identified as a potential for major permanent harm following a fall. The trust had a standard operating procedure (SOP) for investigating incidents graded as moderate harm or above.
- We reviewed the root cause analysis (RCA) record for the level three incident and found evidence of duty of candour, identification of potential areas for improvement, and an action plan. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. The actions included daily review of patient risk assessments, daily education regarding special observation, and special observation documentation to be completed. At the time of our inspection we reviewed a patient record on Lipton ward. The patient had been placed on special observations and the documentation was in place and complete. Staff we asked were aware of the documents to be completed for patients on special observations and when to complete them.
- There was one incident reported for end of life (EOL) from 1 January 2015 to 1 January 2016. This incident was regarding a patient who had developed multiple pressure ulcers in the last days of their life. A pressure ulcer root cause analysis concluded it was unavoidable and identified shared learning, duty of candour, good practice and recommendations including, involving the tissue viability nurse (TVN) at the earliest opportunity. Staff we spoke with told us they referred all patients with pressure ulcers to the TVN.
- Incidents were discussed at the monthly neurosurgery governance, risk and quality meetings. A governance bulletin was circulated monthly and we observed team meeting minutes on Chavasse ward where learning from incidents was shared.
- Weekly harm meetings took place to discuss incidents and share learning across the division.
- Weekly mortality and morbidity committee meetings took place which fed into the monthly mortality and morbidity seminars. We observed the monthly reports for July 2015 to September 2015. The September 2015 report identified eight mortality cases, two of which were medical cases and were deemed to be managed appropriately. There was evidence of discussion and learning from cases within the report.

- Staff reported abusive behaviour as an incident on the electronic reporting system of which we saw evidence.

## Safety thermometer

- Safety thermometer data was collated and analysed by the division and the ward. The NHS safety thermometer was designed to use as a tool for measuring, monitoring and analysing patient harms. This information formed 'harm free care'. The data for this included patient falls, pressure ulcers and catheter acquired urinary tract infections (CAUTIs).
- We reviewed the neurology divisional dashboard for November 2015 and December 2015 and found there had been no incidence of pressure ulcers, falls with moderate harm, clostridium difficile or methicillin-resistant staphylococcus aureus (MRSA) bacteraemia; this resulted in 100% harm free care for this period. During March 2016, the trust reported no pressure ulcers, and no catheter acquired urinary tract infections via the safety thermometer for both Lipton and Chavasse wards, and reported three falls on Chavasse ward.
- The medical wards were performing better than the national average reported by the Health and Social Care Information Centre for March 2016 which reported; 4.4% of patient harm due to pressure ulcers and 0.7% patient harm for CAUTIs. It was difficult to compare the falls as it was not clear if the three falls on Chavasse had caused harm to the patient. The trust had ongoing actions in place to reduce the number of falls which were identified in the falls prevention steering group minutes from December 2015 and included: falls alarm training for staff and a red ninja device which used a beam to detect fallers however the red ninja device was due to be installed in early 2016 and was not available at the time of our inspection and there were no timeframes identified for the falls alarm training.
- Guidance from the National Institute for Health and Care Excellence (NICE) states that all patients should have a VTE and a risk of bleeding assessment carried out within 24 hours of admission. This was the case in all of the 10 records that we looked at.
- At the time of our inspection the trust had not caused a grade three or above pressure ulcer for a period of 372 days which reflects good pressure risk management.

## Cleanliness, infection control and hygiene

- Staff complied with the trust's policies and national guidance on the use of personal protective equipment

# Medical care (including older people's care)

and adhered to 'bare below the elbow' guidelines. There was ample access to hand washing facilities and personal protective equipment such as aprons and gloves.

- The wards we visited were visibly clean and tidy. We observed wipe clean covers on computer keyboards and saw these cleaned by staff after use.
- The trust undertook hand hygiene audits on a monthly basis. We viewed hand hygiene audits completed from October 2015 to December 2015. The trust overall, scored between 96% and 98% against compliance: however Chavasse and Lipton wards were 100% compliant across this period.
- We asked five patients if they saw staff washing their hands and all told us they always washed their hands prior to providing care.
- The trust had implemented a 'stop, think, sink' campaign to encourage visitors, families and patients to wash their hands before entering and leaving clinical areas.
- We observed cleaning taking place on Lipton ward at the time of our inspection which included the bed spaces. On Chavasse ward, staff informed us that the housekeeper performed a deep clean which included cleaning the bed space and bed weekly and we observed tags on the beds to confirm this had been done. There were cleaning schedules in place; however, we reviewed the two forms in use and found them not to be consistently used each week. We reviewed cleaning schedules for a 12 week period between January and March 2016 and found no forms completed for six weeks. We also found that no forms were completed for April 2016 up to 18 April 2016. Therefore we were not assured that all the cleaning tasks were performed regularly.
- The trust had invested in ultra-violet technology which used ultra-violet light to kill bacteria. The system took 20 minutes to clean a side room and specifically used ultra-violet rays to decontaminate the environment.
- Patients told us they found the hospital to be very clean. The trust achieved 99.9% in the PLACE assessments for cleanliness in 2015 which placed them in the top ten trusts nationwide.
- The trust did not undertake routine audits of MRSA and clostridium difficile. If a patient sustained one of these

hospital acquired infections whilst in their care then a full RCA was performed, this was then reported through the infection control committee. We saw evidence of this process being in place.

- During the period July 2015 and November 2015 the trust had reported nine episodes of carbapenemase-producing enterobacteriaceae (CPE) colonisation which is a bacterium that is resistant to antibiotics. Six of the nine episodes were acquired in the hospital. The trust has a zero tolerance for CPE episodes. Four of the six were acquired on Lipton ward. The unit was closed, infection control procedures were in place and included barrier nursing and the trust invited the public health team to visit to offer any further guidance.

## Environment and equipment

- Samples for diagnostics were taken and labelled in line with the trust policy. The only samples stored on the wards were the 24 hour urine collection which we observed clearly labelled and kept in the sluice at the time of our inspection.
- An external audit was performed in October 2015 to audit the segregation of waste, fill efficiency, labelling, and locking of the sharps waste containers. Ten containers were audited across the trust the one box from Lipton ward achieved 100% in all audit areas confirming safe disposal of clinical sharps waste. There were no sharps containers from Chavasse ward included in this audit: however, we observed sharps waste containers on Lipton and Chavasse wards labelled and closed when not in use.
- There was limited space for storage on Lipton ward and items were being stored behind a curtain area. Managers were aware of this and it had been recorded on the risk register. Work was in progress to identify additional space for the ward following some building work: however, there was no time schedule for when this would be completed.
- We observed patients being nursed on pressure redistribution equipment on Lipton ward and at the time of our inspection there were no patients on the ward with a pressure ulcer.
- The trust had a service level agreement in place with a local provider to provide technical advice, maintenance and repair of equipment. We observed two blood

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pressure monitors, a weighing chair and a stand aid with in date portable appliance testing (PAT) labels in place which identified that the equipment had been maintenance checked.

- We observed the resuscitation trolleys on Lipton and Chavasse wards and found checklists completed; however, at the time of our inspection there were two pieces of equipment that had exceeded the expiry date on the resuscitation trolley on Chavasse ward and some items on the Lipton trolley. We found an empty box of adrenaline in the anaphylaxis kit on the trolley on Lipton ward leaving the trolley with no available adrenaline. This had the potential to place patients at risk if they had a cardiac or respiratory arrest. The trust was made aware of this at the time of our inspection and took immediate action to resolve the issue.

## Medicines

- The trust had a policy for medicines management which was accessible on the intranet. The policy identified the procedure for stock replenishment, withdrawal, administration and disposal of medicines.
- The storage and monitoring of medicines including intravenous fluids was managed according to the trust policy. Controlled drugs were appropriately stored with access restricted to authorised staff and accurate records were maintained. Balance checks were performed regularly in line with the trust policy.
- A new electronic system had been installed and the pharmacist was closely monitoring the balance checks while the system was embedded. The pharmacy provided a medicines reconciliation service with dedicated pharmacists.
- The trust had a service level agreement with a nearby provider to provide pharmacy services, which included out of hours access to medication.
- Records indicated the medication fridges on Chavasse and Lipton wards were monitored daily and we saw temperatures were recorded within the recommended ranges.
- Each ward had a nominated pharmacist who visited the wards daily.
- There were protocols for anticipatory prescribing which enables medication to be readily available for symptom relief for patients approaching end of life. The protocols included guidance to staff in assessing and prescribing

appropriately in the management of pain, nausea and anxiety. Staff we spoke with were aware of the protocols and, during our inspection, we saw these in the palliative care resource folders on the wards we visited.

- We observed 10 sets of paper records of previous patients who had received palliative care. In these records we saw that the specialist palliative care nurse had reviewed and recommended palliative care treatments including anticipatory medicine. There was also documentation regarding the discontinuation of non-essential medication. We were unable to review the electronic prescriptions of patients as they were not current inpatients. However, we reviewed clearly documented paper syringe driver prescriptions that had been administered which included anticipatory medications such as pain relief, sedation for agitation and medication for secretions and nausea.
- There was a system in place to identify patients with a recorded medication allergy. Any patient with an allergy was given a red wrist band. We observed one bay of patients on Chavasse ward of which two had allergies identified on their medication record, both patients were wearing a red wrist band. We checked a further five medication records that all had allergy status recorded.
- On Lipton ward we observed the use of an amber card in patient records, which was used to alert staff of any previous allergies or risks.
- The trust used a local microbiology protocol for the administration of antibiotics. We reviewed a patient's record that were prescribed antibiotics, at the time of our inspection, and found these to be prescribed as per protocol.

## Records

- Nursing records and care plans were held electronically and nursing staff had access to them. Health care assistants could not access the electronic records at the time of our inspection. To enable health care assistants to record and have access to patient information, some paper documents were available at the end of the patient's bed. These documents included physiological observations, fluid balance charts, comfort round records and any individualised information to support the staff to provide special care when a patient required close one to one observation. There was a plan in place which identified healthcare assistants were in the next cohort to receive training to access the electronic records.

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- In addition to current electronic care plans there were EOL care plans, specifically focusing on symptoms, for staff to complete. Staff also had the opportunity to document any variance that arose, which was easily identifiable when reviewing the records.
- Medical diagnostic results and medical letters were held electronically. Medical management plans and reviews were paper held as there was a period of transition and work was ongoing to enable all patient records to be held electronically in the future, however no date had been set for completion.
- At the time of our inspection we found patients records to be complete, legible and up to date.
- We saw paper medical records stored in locked rooms when not being used on both medical wards.

## Safeguarding

- Staff understood, and were able to explain, the process for reporting safeguarding concerns. Staff reported good timely responses from the safeguarding matron and could ring the matron if they needed advice.
- We saw the safeguarding process and contact details on display on the wards. The trust provided level one and level two mandatory safeguarding adults training. Both medical wards were achieving above the trust target of 85% for safeguard adults in March 2016, which met the trust target of 85%.
- In March 2016 Lipton ward met the trust target of 85% for completion of safeguarding children level one. Chavasse ward were 74% compliant with safeguarding children level one and were therefore not achieving the trust target: however, both wards met the trust target for completion of safeguarding children level two.
- Information provided by the trust stated that the trust did not deliver safeguarding level three training and the training and development department did not hold any information centrally regarding who had completed the training: however previously the trust had stated that senior managers attend safeguarding level three training.

## Mandatory training

- Staff received mandatory training on a rolling programme in areas such as infection control and medicines management, safeguarding, manual handling, and fire. Mandatory training was delivered both as face to face sessions and via e-learning. Core clinical skills training was also provided and was mandatory for clinicians.

- The neurology division was 88% compliant with mandatory training at December 2015 which was better than the trust target of 85%. At 31 March 2016 Chavasse ward achieved 81% overall compliance with mandatory training which was slightly below the trust target, and Lipton ward had achieved 86% compliance.
- We observed systems in place to monitor and coordinate training and there was a practice facilitator based on the wards. Staff were offered overtime to attend mandatory training if it was difficult for them to attend during their working hours to improve compliance.

## Assessing and responding to patient risk

- We viewed ten sets of records and found that risk assessments for nutrition, pressure ulcer, VTE and falls were completed and documented in all ten records. Diagnosis and management plans were also completed for all ten records.
- Ward staff had contact details for the end of life team, specialist palliative care team, and the hospice and were fully aware of when to contact them. Staff told us the services responded promptly and we observed this in the patient's records we reviewed.
- Patients with palliative care needs and who were approaching end of life were discussed at staff handovers. A printed handover sheet was also given to staff. Staff told us there were plans for palliative patients to be flagged on the electronic patient records; however, this was not in place at the time of our inspection and we were not made aware of any timescale.
- There was a trust policy for monitoring and responding to the deteriorating patient which was available to staff on the intranet. Staff were familiar with the policy and we saw evidence of the policy being followed.
- An outreach team was available within the hospital 24 hours a day. The surgical medical acute response team (SMART) comprised of advanced critical care practitioners (ACCPs), doctors and nursing staff with a background in critical care or anaesthesia.
- The SMART team had a clear operating policy in place, to respond to calls in relation to the deteriorating patient and responded to resuscitation calls.
- The trust used a neurological early warning score (NEWS) tool that was calculated using physiological observations to assist in identifying a patient's deteriorating condition. The trust also used the Glasgow Coma Scale (GCS) to determine the level of

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consciousness in patients with brain injury. The trust had a clear policy that determined the escalation process should a patient be identified as deteriorating. Of the ten sets of records we reviewed all had the NEWS score documented. Staff on Lipton ward advised us that some patients due to their complex conditions always scored high but discussions had taken place with the medical team to determine how regular their physiological observations were to be recorded. Regular training days in relation to recognition and management of the deteriorating patient were provided to support all levels of staff.

- The wards had a nominated duty consultant allocated to the ward for a period of seven days to promote continuity of care. We observed a board round where medical, nursing, occupational therapists, physiotherapists and the pharmacist discussed patients each day. This provided an opportunity to raise concerns and prompt patient review.
- All new admissions were accepted by a consultant and were seen on the ward by the duty consultant.
- The trust had its own intensive care unit and a neighbouring trust on the same site had a trauma unit and accident and emergency facilities, which could be utilised if required.

## Nursing staffing

- The trust used the safer nursing care tool to determine the acuity of staff required and this was reviewed on an bi-annual basis. The acuity tool had identified safe nursing staffing levels as one nurse to three patients on Lipton ward and one nurse to six patients on Chavassee ward.
- Nursing care was provided by trained nurses and healthcare support workers. During the period of September 2015 to December 2015 Chavassee ward had a ratio of one nursing staff member to six patients for two months and a ratio of one nursing staff member to five patients for two months. The ratio of one nurse to five patients was due to a lesser bed occupancy on the ward.
- Lipton ward achieved a ratio of one staff to three patients for the period of September 2015 to December 2015. At the time of our inspection the numbers of actual nursing staff on duty on Lipton ward was the same as the planned for trained nurses. When we visited Chavassee ward on the 6 April 2016 we found them to have a shortfall of one qualified nurse on the day shift.

The ward manager was subsequently working clinically on the day and stated it was a problem due to vacant positions. We reviewed the off duty for four weeks from the 29 February 2016 to 28 March 2016 and there was only one other occasion where there was one nurse less than planned on the off duty.

- At the 31 March 2016, there were a total of 9.95 whole time equivalent (WTE) nursing vacancies across both wards. Of these 9.95 vacancies, five WTE had been recruited to and were going through the recruitment process, which left 4.95 WTE vacancies. The recruitment process was ongoing to fill these positions. At the time of our inspection new staff in post were supernumerary whilst completing an induction period. The trust also offered student placements to encourage newly qualified nurses into post.
- For the period April 2015 to December 2015 the turnover rate for nursing in the Neurology Division as a whole was 15.4%. The trust target for turnover rates was below 10% which was not being met. The vacancy rates across the division for nursing at December 2015 was 6.8% with a trust target of below 6% which the trust was not meeting however, there was ongoing recruitment plans in place.
- Sickness rates for Chavassee ward for the period April 2015 to March 2016 were 4.91% slightly higher than the trust target of 3.8%.
- Sickness rates for Lipton ward for the period April 2015 to March 2016 were 3.92%.
- Additional healthcare assistants were placed on the rota for patients requiring special care and observation and we observed this in place on both wards at the time of our inspection.
- Handover was observed on Chavassee ward from the night shift to the day shift. Staff had printed handover sheets and all areas of risks were identified and informative updates were given for each patient.
- End of life care was the responsibility of all staff across the trust and was not restricted to the end of life care (EOLC) team.
- The EOLC team was led by a neurological oncology advanced nurse practitioner who managed one whole time equivalent (WTE) end of life facilitator and a 0.4 WTE amber care bundle facilitator. The facilitators provided advice, support and training to staff and met daily to discuss patients. Each provided cover when the other was not available, for example on leave. Staff told us this worked well.

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- In addition, staff had access to the specialist palliative care team at another hospital and a hospice both which located on site. The facilitators told us they would fax referrals along with discussing patients that required reviewing.

## Medical staffing

- At December 2015 the division had 4.27% WTE medical vacancies which was lower than the trust target of 6%.
- The proportions of consultant grade staff at the trust were higher than the national average.
- The Medical Director was aware of the difficulty in recruiting to the vacant consultant positions. At the time of our inspection, positions were out to advert and the trust was in the process of updating the recruitment package in an attempt to gain more interest.
- There was no specialist palliative care consultants based at the trust. Medical staff on the wards had 24 hour access to advice from the EOL care facilitators at the trust along with the Specialist Palliative Care Team (SPCT) which included a palliative care consultant from a nearby trust and hospice.

## Major incident awareness and training

- Major incident preparedness and business continuity policies were readily available on the intranet and had been developed alongside a neighbouring hospital; however, two out of three staff that we spoke with had not accessed the policies or the training.
- We saw contingency plans in place at the time of our inspection to cover the junior doctor strike which included cover details and contact numbers.

## Are medical care services effective?

Good



We rated medical care services as 'good' for effective because:

- Due to the speciality of the trust, the trust did not meet the criteria to participate in a number of national audits; however, there was a trust audit programme in place. The trust was actively involved in national research projects and non-commercial research projects funded by charities. The trust was also meeting quality standards outlined in the Association of British Neurologists.
- The trust did not meet the criteria to participate in the national Summary Hospital-level Mortality Indicator (SHMI). There were a low number of deaths, with 20 recorded on the wards at the hospital in the period January 2015 to December 2015. There were morbidity and mortality meetings held which reviewed deaths at the trust to determine any learning opportunities.
- There was evidence of best practice standards in a number of areas including: VTE assessment, assessing and monitoring nutrition, and assessment, treatment, and follow up of pain. We reviewed patient records and found risk assessments completed and management plans were in place to keep people safe and free from harm.
- Guidance and care plans had been put in place following the removal of the Liverpool Care Pathway (LCP), which supported the individual needs of patients and their families
- There was a strong ethos of multi-disciplinary working within the trust and we observed this at the time of our inspection on the wards we visited. Professionals used a collaborative approach to assessing, planning, and reviewing patient care. We observed daily board rounds with all members of the multi-disciplinary team involved and handover processes between shifts, which were well structured and informative.
- The trust provided staff with training on the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards. We saw systems in place that supported patients and included documentation of patients' 'best interest'.
- We found there were processes in place to manage people's pain, nutrition and hydration needs for patients who were approaching end of life. We found, in the records we reviewed, that non-essential medication was discontinued and patients received medication for symptom control of pain via a subcutaneous syringe driver pump when they were assessed as in the last days of life.
- Staff felt supported to learn and develop. All 14 nursing staff we asked at the time of our inspection told us they had received an appraisal within the previous 12 month period.
- The trust had improved the process to manage inpatients having telemetry assessment for symptoms of epilepsy. This had resulted in no seizures going unrecorded, thus improving the assessment and diagnostic process.

# Medical care (including older people's care)

However;

- Chavasse were not achieving the trust target of 85% for compliance with Mental Capacity Act and Deprivation of Liberties Safeguards training and were 60% compliant at the end of March 2016.
- End of life training and syringe driver training compliance were both low. Action plans were in place and syringe driver training was on the risk register.
- There was limited evidence that outcomes in medical services were measured and used to inform improvements in practice.

## Evidence-based care and treatment

- The trust had a range of policies and clinical guidelines that had been developed using evidence-based care and practice standards. These were held on the trust intranet and staff were able to demonstrate how to access them.
- We saw evidence of adherence to the Association of British Neurologists Quality Standards for Unscheduled Care including: rapid bed access, urgent scanning availability for diagnostics, and all patients receiving a daily review by a consultant.
- At the time of our inspection the trust did not participate in the National Audit of Seizure Management as they had no accident and emergency department and therefore did not meet the criteria.
- The trust had registered with the Fractures Audit Programme; however, the trust did not meet the criteria for 2014/15 so did not submit data.
- There was a policy in place for the management of VTEs and patients were assessed on admission. We viewed ten sets of records and found that the assessment had been completed at the time of admission and patients identified as at risk had been prescribed prophylaxis treatment in line with NICE guidance. The nurses were unable to check via the electronic system whether the VTE had been reviewed within 24 hours, as only the pharmacist or medics had access to this information; however, we were told by staff that the VTE was reviewed as part of the daily consultant ward round.
- The multiple sclerosis specialist team participated in the Generating Evidence in Multiple Sclerosis Services (GEMSS) with 14 other teams across the country to provide evidence to improve services in the future.
- A named consultant was assigned to a ward for a period of seven consecutive days to enable continuity of medical care. A daily board round took place with

members of the multi-professional team who were involved in the patient's care. We viewed ten sets of patient records and found risk assessments, care plans, diagnosis and managements plans evident in all ten records.

- The trust performed a trust wide documentation audit in 2014/15 which identified a 90-100% compliance rate in most areas. Areas identified for improvement were use of the 24 hour clock to record interventions and for staff to print their name on the first record page. An audit was performed in quarter two of 2015 to 2016 in the neurology division and consisted of 35 medical and 35 nursing records. The results showed a compliance rate of 100% for all entries in the following areas: entries were legible, entries were signed and dated; however, 15.7% of subsequent entries were not timed using a 24hr clock and in 10% of entries the practitioner did not print their name. Recommendations were identified in the audit and included: the continuation of quarterly audit to continue to address areas for improvement, and to circulate the compliance actions to staff.
- Audits were performed in May 2015 on both medical wards in relation to peripheral intravenous care and urinary catheter care. Both wards achieved 100% which demonstrated best practice and adherence to guidelines.
- The trust provided an inpatient telemetry assessment for patients who presented with symptoms of epilepsy. Patients were closely monitored by a trained healthcare assistant. Staff told us how processes had been improved to monitoring patients, and included working behind a screen to prevent interruptions and the period of observation was changed to 30 minutes. This had improved the service as we observed the safety report for February 2016 and there had been no patient epileptic type attacks missed by the observer for a period of six months.
- There were individual care plans for patients at the end of their lives which reflected national guidance and replaced the Liverpool Care Pathway after the 'more care less pathway' report was published in July 2013.
- The end of life strategy incorporated the five priorities of care and NICE guidelines and was ratified in January 2016 and launched in February 2016. As part of the strategy there was an action plan 2016/17 in place which was to be discussed and reviewed at future quarterly steering group meetings.

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- The end of life strategy identified key enablers and work streams to maintain and deliver end of life care. This included the national transform programme which used five key enablers, for example advance care planning, and coordination of care. Each action was clearly colour coded with corresponding rationale documented. Data provided up to December 2015 identified that one action was outstanding and related to care planning. The communication record was not being used by medics and waiting for nursing records to go electronic was identified as a reason. At the time of our inspection electronic care plans were in place: however, we did not see any end of life EOL communication records in the patients' paper records we reviewed.
- Staff told us syringe drivers were available at all times for palliative patients requiring subcutaneous pain relief with information on wards as to their location. However, we were told only one was lockable which increased the risk of tampering and potential accidental or intentional increase of medication. This was not on the risk register and there were no risk assessments completed. The EOL facilitator told us there were no plans to obtain lockable syringe drivers.
- There was a senior house officer available on call if pain medication needed to be prescribed during out of hours.
- We observed staff returning to patients to ask about their pain after they had been administered analgesia for pain.

## Pain relief

- Pain relief was managed on an individual basis and was regularly monitored for efficacy. We asked a patient on Chavasse ward if they felt their pain was controlled. At the time of our inspection the patient described a slight pain in relation to her tremors and she was not distressed. We reviewed the patient's record and found that analgesia had been administered within 30 minutes of pain being recorded on previous days.
- Staff could access support and guidance in relation to pain between Monday and Friday 9-5pm from the EOL team. Out of hours staff could access a local hospice for support and advice.
- There was clear guidance, which was accessible to staff, on anticipatory medications which enables medication to be readily available for symptom relief for patients requiring care at end of life. Staff had support from a pharmacist, the specialist palliative care team and hospice staff.
- We inspected ten sets of paper records for patients who had received palliative care. We saw that the specialist palliative care nurse had reviewed and recommended palliative care treatments including anticipatory medicine where appropriate. There was also documentation regarding the discontinuation of non-essential medication. We were unable to review the electronic prescriptions of patients as they were not current inpatients; however, we reviewed paper prescriptions for syringe driver use that had been administered for symptom management of pain, nausea, secretions and agitation and medication for secretions in line with the policy and guidelines.

## Nutrition and hydration

- Both medical wards had protected meal times in place. We observed staff encouraging patients to be independent in feeding and, where possible, providing encouragement, prompts and assistance if required.
- Meals came to the ward in individual barcoded packs. This enabled meals to be warmed for patients at an alternative time if the patient did not want to eat at the protected time, or if they were off the ward having treatment or diagnostics.
- We observed nutritional assessments as part of the nursing assessment tools and it also formed part of the pressure ulcer risk assessment. We viewed ten sets of records and found the nutritional risk assessment completed appropriately in all the ten records. We viewed three patients' fluid balance charts on Lipton ward and found they were all fully completed. We found, where indicated, referrals were in place for review by a dietician.
- Patients records showed that those patients identified as approaching end of life had their nutrition and hydration needs evaluated. An audit of 20 patient records from January 2015 to February 2016 identified that, during the dying phase, two patients were able to eat and drink, 18 patients were assessed for clinically assisted nutrition and hydration, with ten of those having clinical assisted nutrition or hydration in place at time of death.

## Patient outcomes

- There was recognition by the divisional Clinical Director and Operational Manager that there was room for improvement within the recording of patient outcome

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measures. The nature of the trust's specialism had excluded the trust from a number of national audits due to not meeting the criteria. The plan to work as part of the acute care collaborative vanguard site was identified as a way to support development in this area. The vanguard sites had been chosen to support new models of care that aimed to develop a high quality and cost effective neuroscience service chain, working in partnership with other acute trusts.

- The trust had received a Certificate of Recognition Excellence for the National Institute for Health Research for their work in promoting the benefits of clinical research, and encouraging recruitment of patients into clinical trials.
- The trust participated in non-commercial research projects funded by charities. One project ongoing was to develop a collaborative transition pathway for young people with epilepsy.
- The trust was a member of the Liverpool Health Partners (LHP), which aimed to create a strategic partnership for improving health and pursuing excellence in the delivery of care research and education.
- 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. SHMI is not applicable to specialist trusts; therefore, no data was available at the time of our inspection.
- The trust was involved in a project to produce specialist trust mortality indicators. This project was anticipated to be completed by the end of March 2017.
- All cases were reviewed by senior clinical staff and reported through the Morbidity & Mortality Committee on a quarterly basis. We observed the minutes from the meeting held in September 2015 which identified eight deaths.
- During the period January 2015 to December 2015 there were 20 deaths on the wards at the hospital. Due to the low number of deaths, the trust was unable to participate in the National Care of the Dying audit; however, the EOL facilitator undertook the audit locally to monitor compliance and presented it at the EOL steering group.
- In October 2015 the trust had piloted the amber care bundle trust wide to recognise, manage and improve the quality of care for patients whose recovery was uncertain, including planning ahead if their condition

deteriorated further. This was then rolled out trust wide in January 2016. Trust data showed that, from October 2015 to March 2016, 5.6% of qualified staff had attended the training; however all staff we spoke with were aware of the amber care bundle and felt supported by the facilitator. There was evidence in patient records that conversations had taken place with patients and their family and clear plans were in place for escalation, if required. Delays in implementing the amber care bundle was on the risk register.

- The trust had a number of planned audit projects relating to neurological conditions being undertaken that were not completed at the time of our inspection and therefore, had no recent results or agreed actions. The audits included: motor neurone disease pathway audit and management of Parkinson's disease.
- The trust participated in the National Cancer Patient Experience Audit in 2014 and had developed an action plan which identified 15 actions to improve. At the time of our inspection there were ten outstanding actions and there was a re-audit in place with results available in June 2016.
- During the period of January 2015 and December 2015 81% of patients had no ward moves.

## Competent staff

- The members of the EOL team had completed a range of courses between them with the EOL facilitator gaining post registration palliative care qualifications.
- Each ward had a practice educator in place who managed and arranged mandatory and additional training along with providing clinical supervision. Some of the nurses told us that, in their previous jobs, they had received training and transferrable skills and knowledge in caring for palliative patients but welcomed the opportunity to expand on this.
- Training specific to EOL was not mandatory and had an overall low attendance from all disciplines. The highest attendance for qualified staff for the period January 2015 to March 2016 was 7% in the end of life care preceptorship course, healthcare assistants highest attendance was 4.5% in skin care and communication, and 21% of allied health professionals attended principles of end of life care. Some medical staff had accessed training at the clinical senate and at a training day held at the trust. An action plan was in place to raise awareness of the training and work in partnership with a local hospital and the practice educators.

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- The EOL team told us they would regularly provide opportunistic clinical supervision to staff on the wards along with debriefing sessions. Staff told us these were very helpful.
  - There were 14 EOL link nurses across the trust that had recently commenced training for their role. The link nurses supported staff and disseminated information to colleagues following monthly meetings
  - Although not mandatory, staff were expected to complete syringe driver training yearly. Data provided showed that 4% of qualified nursing staff had attended syringe driver training between January 2015 and March 2016. The EOL facilitator told us the trust was aware that uptake on training was low but felt confident there would be competent staff available should a syringe driver be required to be set up. In addition we were told the SPCT were available 24 hours a day for support. Low uptake in syringe driver training due to staffing levels and demands remained on the risk register since 26 January 2016 and was documented as a moderate risk. An action plan was in place with assurance documented that the EOL team were available Monday to Friday 9am-5pm and practice educators were being trained to provide training on the wards.
  - The trust had an induction process in place for new staff with relevant competency checklists for completion. We observed two new staff members on Chavasse ward on induction and not included in the staffing numbers. Staff were not included in the numbers for a period of four weeks and longer if there were ongoing learning needs identified.
  - Staff training needs were discussed during the annual appraisal process. At the end of December 2015, 100% of nurses and 90% of healthcare assistants on Lipton ward had received an appraisal in the 12 months prior to our inspection. On Chavasse ward, at the time of our inspection, 38 out of 40 staff had received an appraisal with the two remaining booked to take place in April 2016.
  - We saw evidence that a training needs analysis had taken place seven months prior to our inspection when the new ward manager was appointed on Lipton ward. This had identified the training needs and gaps to meet the needs of patients, with a plan in place that identified individual's training. On Chavasse ward training needs were identified via the appraisal system.
  - We found that ad-hoc training also took place, for example the tissue viability nurse would offer training and educational advice to staff when visiting patients on the wards.
  - Staff we spoke with all felt supported to learn and develop.
  - Medical staff were able to access a peer to discuss any difficult cases and on Wednesdays all the consultants were on site and had lunch together as part of a clinical meeting to provide support for each other.
  - Consultants should have an annual job plan which sets out the consultant's responsibilities and objectives for the following year and to support the improvement of quality and patient care. The trust measured the consultant's job plans quarterly and at December 2015 there were 77.5% completed which was lower than the trust target of 90%. We did not see this on the risk register however, a new appraisal and revalidation policy had been ratified in June 2016 which identified specific reporting data to improve the reporting process.
  - The trust offered healthcare assistants the opportunity to complete the care certificate. The care certificate is knowledge and competency based and sets out the learning outcomes and standards of behaviours that must be expected of staff giving support to clinical roles such as healthcare assistants.
  - The trust had processes in place to support medical and nursing staff with revalidation to maintain their professional registration.
  - Catheterisation study days were provided by the trust for both healthcare assistants and nurses. A total of 84 staff eligible for training were identified across Lipton and Chavasse wards and at January 2016, 16 of the 84 had attended the training with six staff attending in January 2016. The training was offered as a rolling programme and had recently been implemented to all nursing staff and staff were booked on the training throughout the year to attend.
  - The trust had a policy in place to performance manage and support any identified poor staff performance.
- ## Multidisciplinary working
- Multidisciplinary team (MDT) working was well established on both medical wards. There was a daily board round which was attended by medical, nursing, pharmacy and therapy staff such as physiotherapists and occupational therapists. They reviewed discharge

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planning and confirmed actions for those people who had complex factors affecting their progress or discharge. We observed a board round and saw that it was well attended by a range of professionals.

- We observed a handover from night nursing staff to day nursing staff. This was well structured and informative with identified patient risks clearly communicated.
- Ward teams had access to the full range of allied health professionals. Team members described good, collaborative working practices. There was a joined-up and thorough approach to assessing the range of people's needs and a consistent approach to ensuring assessments were regularly reviewed. Lipton ward had monthly joint goal setting meetings in place. The EOL team would attend these meetings if any patients were at the end of life.
- There was no EOL multidisciplinary meeting; however the facilitator's had a daily informal handover to discuss patients. The EOL team faxed and telephoned potential patients along with those who required review to the SPCT. There was good cross organisational working in relation to EOL care with a local NHS trust and a local hospice.
- There was a service level agreement in place with the (SPCT) at another trust on the same site to provide 24 hour palliative care to patients. All staff we spoke with said they responded quickly and felt that staff, patients and families were well supported by the team.
- There was a discharge planner who visited the wards daily. They told us they liaised with patients and their families along with primary and secondary care services across the country including Wales and the Isle of Man and arranged for patients to be transferred to their preferred place. We observed in patient's records that patients were successfully repatriated in a timely manner.

## Seven-day services

- The end of life facilitator was available 8am to 4.30pm on weekdays and visited the wards daily. The SPCT were available seven days a week from 9am to 5pm and at other times staff could call the hospice for urgent advice. Advice could also be sought from the on call palliative physician, if required. We observed regular reviews by the specialist palliative care nurse in patient records and staff told us they would visit and review patients at weekends and out of hours, if required.

- There was seven day per week access to medical consultants, diagnostic services and pharmacy.

## Access to information

- Staff had access to computer systems and the trust intranet where policies, guidelines and standard operational procedures could be accessed.
- Nursing records, care plans, and drug prescription charts were all held on an electronic record. All nursing staff were able to access the system and populate updates. Healthcare assistants did not have access to the electronic system at the time of our inspection; however, plans were in place for them to have access in the future. There were some paper held charts and individual care plans to enable the healthcare assistance to update any observations.
- Medical notes were paper held and could be accessed on the ward. Letters and test results were held electronically. The trust achieved 99.5% for case note availability on admission which was better than the trust target set at 98%.
- All wards had recently been provided with a resource folder which included information such as setting up a syringe driver and anticipatory prescribing. In addition most wards had an EOL information board for staff, patients and relatives with details of the referral process to the EOL team, information on the five priorities of care of the dying person and the amber care bundle. We also observed the sepsis pathway, managing acute kidney injury and the anaphylaxis algorithm on display on Lipton ward.
- On the wards there were files containing minutes of meetings and ward protocols.
- Communication was sent to the patient's General Practitioner when they were discharged with a copy of the letter sent to the patient. At December 2015, the trust was achieving the target to complete and send copies of letters out to include the patient. The division as a whole achieved 98.5% against a target of 90% to send a copy of the letter to patients.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff we asked were aware of the key principles of the Mental Capacity Act (MCA) 2005 and how these applied to patient care. Staff received training in relation to the MCA and DOLs. We found processes in place should patients require a DOLs and the trust had access to mental health healthcare assistants and consultants

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from a nearby service should this be required. The medics took responsibility for assessing and documenting patient's capacity which we observed in patient records.

- There was an up to date trust wide policy for mental capacity, best interest decisions and deprivation of liberty (DOLS) available on the intranet.
- Information provided by the trust for both medical wards showed that compliance rates for MCA and Deprivation of Liberty Safeguards (DOLS) training was below the trust target of 85% with Lipton ward achieving 84% at the end of March 2016 and Chavasse achieving 60%. We did not see this on the risk register at the time of our inspection.
- The 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. We saw examples of completed DOLS paperwork which were in line with guidance and best practice. However, the local authority was unable to process the applications in the timeframe identified in the trust policy and some patients had multiple DOLS assessments completed. Of the patients awaiting a formal DOLS assessment by the local authority, all had a best interest meeting documented in their records.
- Staff knew the principles of consent and we saw from the patient records we reviewed that consent had been obtained from patients prior to procedures.
- We reviewed 13 do not attempt cardio-pulmonary resuscitation (DNACPR) forms and all were clear, legible and signed by an appropriate senior clinician. Of the 13 forms, 11 had documentation regarding why cardio-pulmonary resuscitation was not in the patient's best interests and discussions were documented with the next of kin. In 13 of the records we reviewed six patients were identified as having capacity, one patient had no capacity as was unconscious and six did not have a capacity assessment documented.
- At the time of our inspection we observed staff on Chavasse ward explaining procedures to patients and gaining informed consent.

## Are medical care services caring?

Outstanding



We rated medical care services as 'outstanding' for caring because:

- Patients were treated with dignity and respect and there was a strong person-centred culture. We observed patient's privacy being maintained at the time of our inspection and patients told us when bathing or having examinations the area was always made private.
- People using the service were extremely positive about the care they received. Feedback received via a patient survey during January and February 2016 identified that 96% of respondents were likely or extremely likely to recommend the service to family or friends.
- People who used the service and their families were actively involved in their care and staff recognised people's personal, cultural, and social needs. There were examples where staff had 'gone the extra mile' to support patient's individual needs showing determination and creativity to overcome difficulties when delivering care.
- We were told of examples where a patient who was on the ward for nine months was supported to return home instead of a secure unit by staff understanding and being creative in meeting the individual's needs.
- Staff had arranged for part of the court-yard to be changed into a gardening plot to provide alternative therapy approaches which empowered relatives and patients to be partners in care. The staff arranged a baby shower for a patient who had recently given birth and was returning to the ward.
- Staff were proud of the care they gave and the positive outcomes that had been achieved for patients with complex needs. They valued patient's emotional and social needs and found ways outside the usual rehabilitation programmes offered to meet those needs.

## Compassionate care

- At the time of our inspection we observed patients being treated with respect and dignity. Staff introduced themselves to patients and explained what they were about to do. Three patients that we asked told us their privacy was always maintained when they were bathing

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or using the toilet. The curtains were always pulled around the bed when having any examinations, which we also observed on both medical wards on numerous occasions.

- Patients on the wards told us “care is excellent”, “staff are absolutely fabulous and treat me so well”, “This is a very warm caring environment”.
- We observed staff taking time to speak with patients and walking with them around the ward talking to them and placing them at ease. We observed the matron also participating in ‘walking and talking’ to the patients during her visits to the ward.
- We observed staff responding to patients who became distressed in a supportive manner and were able to talk to them to calm the situation for the patient.
- Staff we observed at the time of our inspection respected and maintained patient’s confidentiality.
- At the time of our inspection all staff we observed on both wards engaged with patients and their relatives in a pleasant, caring, manner.

## Understanding and involvement of patients and those close to them

- There were flexible visiting times for patients’ friends and relatives and staff offered relatives drinks which we observed on Chavasse ward.
- A patient on Lipton ward was in a single room and required a member of staff with them at all times. Their relative visited at the time of our inspection and we observed staff asking the relative if they wanted time on their own with the patient or would they like the staff member to stay in the room with them.
- Patients told us they felt treated as an individual.
- We observed relatives being offered the opportunity to assist with patient care, for example assisting to support at meal times.
- One patient’s family told us they were asked to come to the ward to discuss the patient’s care and could not make the time that the consultant had requested. The consultant subsequently agreed to meet them on the ward at a time that was suitable to them.
- Staff gave us an example of a very difficult situation they had managed which resulted in a positive result for a patient who was able to be discharged to their own home. Multi-disciplinary meetings were held with mental health, social services, with risk and governance involvement, to discuss future care needs. The outcome of the continued effort from the staff enabled the

patient to return home to their own home and family. The parent of the patient nominated the ward for an award from the Encephalitis Society for an exceptional service award. The ward won the team of the year for 2014 to 2015 following the nomination.

- The trust used the NHS Friends and Family test to gain feedback from service users and their families. The trust had received 674 responses from inpatients for January 2016 and February 2016. Of the 674 responses, 612 stated they were extremely likely to recommend the service to family and friends and 36 stated they were likely to recommend the service to family and friends.
- We saw no evidence of advance care plans being used, although on admission, the electronic system prompted the question of advanced decision or power of attorney. Staff told us this was not asked again throughout the patient’s stay in hospital. An audit of 20 palliative patients’ records from January 2015 to February 2016 showed there were discussions regarding the plan of care for the dying phase with patients and their relatives.
- Following the death of a patient, staff told us the doctor would be asked to certify the death and they would perform last offices. Relatives and friends were given as much time as they wanted with their loved one and arrangements would be made for them to collect the death certificate at an agreed time. Bereavement folders which included a sympathy card and practical information and advice about what to do after a death were provided to relatives by ward staff.

## Emotional support

- Staff supported patients to be as independent as possible to support their rehabilitation programme.
- Patients had a holistic assessment of all their needs which included physical and psychological needs and this was evidenced in the patient records. The patients were seen by a consultant daily for review.
- There had been a patient on Chavasse ward who was pregnant. They were transferred to a nearby trust to give birth; however, after 48 hours the patient was requesting to come back to Chavasse. The staff arranged for the patients return and surprised the patient with a baby shower on her return to celebrate the birth and provided the patient with gifts for the baby. Due to the nature of other patients on the ward the baby was unable to stay overnight on the ward; however, it was arranged that the baby could be brought to the ward daily to stay with the

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patient to enable them to bond. The staff accessed some charitable funds to create a more homely environment in the side room for the patient and the baby.

- At the time of our inspection a patient described the staff as “very special people”
- Bereavement services were available on site at another hospital. However, there was an information centre at the hospital which patients and their loved ones could drop in for information or emotional support. The service also provided practical support, sign posting to other services and access to counselling at weekdays. There was also a chaplaincy service which visited all the wards daily.

## Are medical care services responsive?

Good



We rated medical care services as ‘good’ for responsive because:

- We observed patients with learning difficulties and additional care needs being well supported and supervised.
- There were services to support patients whose first language was not English which included written information and access to translation services. Staff were aware of the processes and could access them in a timely manner.
- The trust was achieving the 18 week referral to treatment national indicator and performance was consistently higher than national averages.
- Bed occupancy and allocation of beds was well managed to cause the least disruption to patients. There had been minimal bed moves and surgical patients who were admitted to medical wards were reviewed by both a medical and surgical consultant daily.
- We found facilities, on the whole, appropriate for the services being delivered

However:

- The ward area on Lipton ward was cramped but the trust had recognised this, it was identified as a risk on the risk register and options to improve the area were being considered at the time of our inspection.

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

- Potential single sex breaches were managed through the use of side rooms. This complied with the standard set by the Department of Health which states that male and female patients must be accommodated on separate wards or in separate areas. We observed this to be in place at the time of our inspection.
- We found Lipton ward to be small and cramped. The trust was aware of the lack of space and had identified it on the risk register and options for development were being considered.
- The trust had a wide and varied catchment area and worked closely with other acute trusts with a dedicated discharge coordinator to facilitate discharge back to a trust in the patient's local area once specialist treatment was completed.
- Bereavement services were available on site at another hospital. However, there was an information centre at the hospital which patients and their loved ones could drop in for information or emotional support. The service also provided practical support, sign posting to other services and access to counselling on weekdays. There was also a chaplaincy service which visited all the wards daily.

## Meeting people's individual needs

- There was a nominated lead nurse for learning difficulties and dementia and the staff could access them for advice and training. We observed that the ward had responded well to a patient living with learning difficulties and challenging behaviour by assigning the same staff to care for the patient to maintain familiarity and had implemented open visiting for the patient's family.
- There were translation services available should a patient's first language not be English. Staff knew how to access the service and this could be achieved in a timely manner.
- There were information leaflets available at the wards for specific conditions and support groups. The leaflets we saw at the time of our visit were in English but there was a contact to request in alternative languages.
- The trust had a local agreement in place which enabled them to have 24 hour access to a mental health consultant. The trust also had access to healthcare assistants who were mental health trained, should this be required, to meet a patient's needs.

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- Staff on Chavasse ward gave us examples of how they had met patients' individual needs and included: converting part of the courtyard into an area for a patient to do gardening as a form of rehabilitation.
  - The trust did not provide a psychology service for patients but this could be accessed from a neighbouring hospital when required.
  - The motor neurone disease specialist nurse told us they were currently piloting an advance care plan in outpatients which the patient would complete and keep with them. However, there was no advance care plan for in-patients to complete and express their wishes and needs. The EOL facilitator told us they were currently looking at developing one in conjunction with the one used at the general hospital on the same site. We observed clear documentation regarding discussions with families in patients' records.
  - There was a chaplaincy service which responded to the needs of staff, patients and their families. This included providing last rites services and blessings. There was a chaplaincy service which visited all the wards daily. The multi-faith prayer room and a 'retreat' room provided multi-faith services, quiet time and reflection and individual support and guidance. There was multi-faith information and holy texts, prayer mats, prayer cards with chaplaincy information and a prayer book which prayers for loved ones were requested, some we noted were from children. A dot was placed by the side of the prayer request to signify it had been prayed for.
  - Staff told us patients' cultural and religious preferences were documented on the electronic system and these were shared at handover.
  - Staff told us they strived to ensure that people staying with their loved ones, who were at their end of life, were as comfortable as possible and in addition to emotional support they ensured they were provided with drinks, refreshments and if they wanted to stay overnight next to their loved one a reclining chair, pillow and blanket.
- negative effect on quality of care. At the time of our inspection we observed on Chavasse ward, all risk assessments for patients were completed and staff were spending time with patients offering care and reassurance.
- The average length of stay for elective medicine at the hospital was four days in December 2015 and five days in November 2015 which was similar to the England average at 4.5 days and almost met the trust's own target of four days. For non-elective medicine length of stay was longer (worse) than the England average at eight days in December 2015 and 17.5 days in November 2015. The England average was 6.8 days and the trusts own target was seven days. However, due to the nature and complexity of the patients and the speciality of the hospital, patients may require a longer stay and the hospital had experienced delays in trying to return patients to a general hospital to continue with care when specialist care needs had been met.
  - At the time of our inspection there were two patients on the ward who were surgical patients; however, we saw evidence in the patient records that they were seen daily by both a medical and a surgical consultant. Due to the nature of the patients at the trust the medical and surgical consultants worked closely to support patients' care.
  - The Matron attended both of the wards daily and reviewed bed occupancy and staffing each day based on patient need.
  - Complex discharges were supported by the discharge coordinator. The most common reason for delayed transfers of care were awaiting further NHS non-acute care and this accounted for 46.6% of delays.
  - Between April 2015 and March 2016 there were 51 referrals to the specialist palliative care team, of which, 48 were seen within 24 hours of referral.
  - There was a rapid discharge pathway in place for those patients who wished to die at home. However, since April 2015, no patients were in hospital that required discharge via this pathway.
  - The hospital had a discharge planner who coordinated patient's discharge to their preferred place. The ward would ensure that the patient was discharged with at least two weeks of take home medication. There was no clear process in place for the return of syringe drivers when patients were sent home with it in-situ; however, staff told us the syringe drivers were always returned once it had been replaced.

## Access and flow

- Referral to treatment within 18 weeks was consistently above (better) than the England average from April 2015 until January 2016. The trust had achieved 100% in most months in this period.
- During the period September 2015 to December 2015, bed occupancy for Chavasse ward averaged 89.6%. For the same period the bed occupancy on Lipton ward averaged 74.3%. Bed occupancy above 85% may have a

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## Learning from complaints and concerns

- The trust had a complaints policy which was up to date and available on the intranet. Staff knew how to access this when needed.
- Staff were able to give appropriate information to patients and relatives if they wanted to make a formal complaint; however we did not see any information available, such as posters or leaflets, on the wards we visited.
- There had been two complaints received during the period September 2015 to December 2015, one for each medical ward. One complaint was in relation to lapses in care for a patient on Lipton ward with CPE. The trust had several meetings with the family and there were lessons learnt in relation to communication and the management of the patient with CPE.
- Learning from complaints was disseminated to staff through team meetings, safety huddles and the quarterly 'harm free care' newsletter.

## Are medical care services well-led?

Good



We rated medical services as 'good' for well-led because:

- The trust had a clear vision and strategy, including an end of life strategy, which staff were aware of. The trust included assessment against the trust values in staff member's annual appraisal to ensure the values were embedded within the trust.
- A neurology divisional dashboard was produced monthly to inform managers about national and local targets and compliance with these targets. Governance structures were robust and there were regular meetings where information was reviewed and shared with staff. Risk registers were reviewed regularly and risks were well managed.
- The service managers were committed to service improvement and development and were supported by their staff and the clinicians.
- Staff told us they liked working at the trust, they felt listened to and were supported to learn and develop.

- The trust had been named as an NHS vanguard which will see the trust leading new models of care that aim to develop a high quality and cost effective neuroscience service chain, working in partnership with other acute trusts.

## Vision and strategy for this service

- The trust had a clear mission, vision and values statement which was shared throughout the division and at ward level. The mission was to provide high quality treatment, care and patient experience in the most appropriate place for the needs of their patients. The vision was to provide excellent services based on research and education. The values of the trust were caring, dignity, respect, pride and openness. Together these were described as the 'Walton Way'.
- Staff who we spoke with at the time of our inspection were able to describe what the vision and strategy was and they felt they provided an excellent service for patients.
- The trust had an end of life strategy which aimed to put patients and their families at the centre of decisions about their care and treatment as identified in the 'Priorities of Care for the Dying Person' (2014). The strategy was ratified in January 2016 and launched in February 2016. As part of the strategy there was an action plan for 2016-2017 in place and a plan to discuss and review at future quarterly steering group meetings. Seven of eight staff we asked were aware of the end of life strategy.
- The trust appraisal process included assessment against the trust values. We asked three nurses who confirmed that the trust values were discussed during their appraisal

## Governance, risk management and quality measurement

- The executive and non-executive directors conducted ward walkabouts each month and staff we asked, welcomed the opportunity to see and speak with board members.
- Clinical audit is defined as a quality improvement process that aims to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change. The Walton Centre NHS Foundation Trust had a clinical audit programme for 2015-2016. The plan included both local and national audits. The audit plan had on-going review

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and we observed evidence of this in the Neurology Governance Group Meeting from March 2016 which included a review of outstanding audits, results from audits completed and actions to be implemented.

- Moderate harms were presented to the weekly harm meetings and a root cause analysis was completed and shared.
- Safety huddles took place daily across neurology and neurosurgery to manage staffing levels, bed occupancy and to communicate other issues of concern.
- The trust had a dashboard which provided the monthly performance report for the division. This was presented monthly to the heads of the division and was disseminated to ward managers.
- Divisional governance meetings were held monthly. Heads of service attended, audits actions risks were discussed and information was disseminated at local ward manager and ward meetings.
- The trust had introduced an internal accreditation system for wards which assessed the ward against standards in relation to best practice and quality. We saw this had been implemented and at the time of our inspection Chavasse ward were achieving all the standards.
- The EOL steering group met quarterly and included specialist nurses, consultants, senior managers, chaplain along with the medical director who led EOLC, with the group being chaired by a non-executive director. The minutes we reviewed included discussion around EOL strategy, patient experience and education and had actions documented for specific individuals to address. We did not see any evidence the EOL risk register was reviewed although the low uptake in training was discussed.
- Monthly bulletins were circulated via email which included risk, governance and included lessons learnt.
- Ward meetings were held monthly. We observed minutes from a meeting in February 2016 which included governance, incidents and training. Staff that were unable to attend had access to the minutes by email or could access them in the staff rest area.
- Readmission rates were monitored within the monthly performance report and the patient details were sent to the Clinical Lead. The performance report was presented at both the hospital management board and the trust board. Readmissions were also presented to the mortality and morbidity meetings.

- If there were months when the readmission rates were higher than usual a case by case analysis of the neurosurgical readmission was performed by senior and clinical staff using a case note review. Any lessons learnt were cascaded to staff via ward meetings or the monthly newsletter.
- There was a risk register in place which highlighted risks across medical services and end of life services and actions were in place to address the risks, for example staffing levels and the environment of Lipton ward which was consistent with what we found at the time of our inspection .

## Leadership of service

- The lead nurse and the matron attended the wards on a daily basis to offer support and review staffing levels. At the time of our inspection we observed them on the ward and we observed the matron assisting in the provision of care to a patient.
- The senior nurse team worked well together across medicine and surgery to enhance a holistic care approach for patients.
- The trust had been responsive to the needs of the service and was in the process of recruiting an additional matron to work with the matron over rehabilitation and neurology. The trust saw this as an opportunity to improve the monitoring of key performance indicators and best practice.
- The Clinical Director was working with the nursing leads to develop and improve the role of the specialist nurses to include a more generic approach, subsequently reducing duplication for patients.
- The trust were offering a leadership programme for ward managers to develop the leadership within the trust
- End of life services had an executive and a non-executive lead for end of life care along with a clinical lead who managed the EOL and amber care bundle facilitator.
- The EOL clinical lead and facilitators demonstrated understanding of their challenges in providing good quality palliative and end of life care, including poor uptake of EOL training. However, we saw no evidence of targeted planning or training needs analysis in place for staff although we were told this was going to be devised in the near future.
- Staff throughout the trust said that the palliative care and EOL team were accessible, visible and

# Medical care (including older people's care)

approachable. Ward staff told us they valued the expertise of the team and welcomed further opportunities to develop knowledge and skills in EOL care.

- The executive summary of the 2015 NHS staff survey results for the trust identified that 45% of staff felt communication with senior management was good, which was better than the national average of 38%

## Culture within the service

- A lead nurse told us they were proud of the flexibility of their staff and commitment to prevent harm to patients. The Director of Nursing was supportive and adopted an open door policy.
- We spoke with a nurse who had been qualified for six months who told us they felt supported by their peers and by management.
- Staff told us that the trust offered therapeutic interventions for staff on the wards. This included a range of massage therapy which staff could receive on the ward.
- We saw that nurses, doctors and allied health professionals all worked well together. Staff communicated well, helping and supporting each other on a regular basis.

## Public engagement

- The trust had introduced a listening line that patients and their families could call and speak directly to the senior nurse on duty so that the trust could respond to concerns in a timely manner particularly for those patients on the ward at that time.

- The trust held an annual open day which the public were encouraged to attend. The events were generally well attended and were an opportunity for the trust to showcase the specialist services they provided.
- The EOL service had not collated feedback from patients or relatives; however, we were told they were planning to take this forward with funding received following winning the 'compassionate care award'.

## Staff engagement

- Staff we asked told us they felt listened to when they raised concerns.
- The trust held listening events for staff and patients to improve communication and engagement. Information was cascaded to staff through a number of different methods. It was done by email, information in staff areas, daily huddles, team meetings, a monthly newsletter, and appraisals.

## Innovation, improvement and sustainability

- The trust had been named as an NHS vanguard site after applying for the status in September 2015. The new model of care, the neuro network, should provide additional and more effective support for people with long-term neurology conditions outside the trust hospital site; this should enable patients with spinal conditions across the region to receive more effective and timely care. The network models led by the trust aim to provide a high quality, cost effective and sustainable neuroscience service, working in partnership with other acute trusts and primary care.
- The trust had invested in ultra-violet technology which used ultra-violet light to kill bacteria. The system takes 20 minutes to clean a side room and specifically uses ultra-violet rays to decontaminate the environment.

# Surgery

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

## Information about the service

The Walton Centre carries out a range of emergency and planned neuro surgical services including spinal, nerve and brain surgery. There are four surgical wards and six theatres that carry out emergency and elective procedures, including day case procedures. The centre is also part of the Liverpool and Mersey trauma network and accepts patients with traumatic neurological conditions and injuries.

Data provided by the surgical services showed that 6,458 patients were admitted for surgical care between September 2014 and August 2015 at The Walton Centre. The data showed that 31% of patients had day case procedures, 49% 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 three operations and visited four inpatient surgical wards. We observed a scheduled theatre briefing meeting, nursing and medical handovers.

We spoke with 18 patients and observed care and treatment. We reviewed 23 care records and spoke with 42 staff members of different grades and specialities including nurses, doctors, ward managers, theatre managers, divisional directors and senior nurses.

## Summary of findings

Overall we rated surgical services at The Walton Centre as 'Good'. This is 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. Learning was shared widely.
- 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 neurosurgical care which was evidence based and met national guidelines.
- Clinical audits were routinely undertaken and actions taken as a result of these was evident.
- Outcomes for patients were the same or better when compared to similar services.
- Patients were assessed for, and provided with, appropriate pain relief.
- Knowledge of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards was good.
- Staff treated patients with kindness, dignity and respect and patients told us 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.

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- The access and flow within the surgical services was managed effectively.
- Patients had timely access to consultant led care.
- The service was well led and staff respected their local leaders.
- Staff could articulate the trust's vision and values.
- 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;

- Some areas used to store medications were not locked securely.
- There were some areas of low uptake in areas of mandatory training.
- The number of staff who received their annual appraisal was low in some areas.

## Are surgery services safe?

Good



We rated surgical services as “Good” for Safe. This is because;

- Staff were aware of how to use the incident reporting system.
- We saw evidence that the service had responded and learned from adverse incidents.
- The service collected and displayed safety data. Rates of avoidable harm were comparable with the national averages.
- The uptake levels of mandatory training were variable between areas and subjects with some areas of low and high compliance across the service.
- 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. Equipment was well maintained and checks of this equipment were completed and up to date.
- Staff managed medicines appropriately.
- 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 trust's major incident policy.

However;

- Only 53% of medical staff who required level two safeguarding children's training had completed this training and we did not see evidence of action plans to address any areas of low uptake.
- We found that the anaesthetic rooms in the main theatre were unlocked. In these rooms there were unsecured medications in unlocked cupboards and fridges. We highlighted this to the service who rectified the situation immediately.

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## Incidents

- There was an electronic incident reporting system in place which was available to all staff. When staff reported incidents, managers reviewed them and took appropriate responsive actions. We saw evidence of this in the reviews we undertook of incident reports. Staff told us they received feedback from the incidents they had raised, on an individual basis.
- The service was a high reporter of incidents and staff told us they were actively encouraged to report any incidents. There were 1,732 incidents reported across surgical services between 1 January 2015 and 1 February 2016. Of these, 1,361 incidents were categorised as no harm, 298 were categorised as low or minimal harm and 73 were categorised as moderate harm. There were no incidents with a category of severe harm or death. In all cases where the harm level had been specified as moderate, further investigation had been undertaken by the service and we saw evidence of actions taken as a result of these investigations.
- The highest reporting categories were relating to patient falls and pressure ulcers. When this data was reviewed it was evident that the majority of pressure ulcers were either acquired prior to the patient's admission or were categorised as being low grade ulcers. We observed that pressure area care was routinely undertaken in all areas we visited and pressure ulcer management and incidence was an item on a number of meeting agendas for staff. The service also held a falls prevention steering group which examined falls incidence and developed ways to reduce the number of falls. We saw evidence of minutes from this meeting.
- There was one serious incident reported between February 2015 and January 2016 and there were no never events reported during this period. Never events are serious, wholly preventable patient safety incidents that should not occur if the available preventative measures are in place.
- In response to the serious incident, the service had undertaken a root cause analysis (RCA) review and investigation. This review was thorough and robust with key areas of learning identified and shared widely throughout the service.
- All staff we spoke with were able to demonstrate an understanding of duty of candour which 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. We also saw evidence in investigation reports that this was considered when adverse incidents occurred.

## 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 by ward and theatre managers and matrons. This information was then fed into a variety of managerial committees and meetings with any areas of action clearly highlighted.
- 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 two falls with harm, seven catheter urinary tract infections and seven pressure ulcers, which was within expected ranges.

## Mandatory training

- There was a practice educator employed specifically for theatre areas. They monitored staff training records and prompted staff to undertake training when it was due. In the ward areas ward managers and matrons monitored mandatory training uptake levels.
- The majority of mandatory training was completed face to face with some modules and aspects via e-learning. The trust target for training subjects was 90%.
- Uptake levels of mandatory training were variable across areas within the service with high uptake rates in some areas and areas of low uptake in some subjects.
- Mandatory training requirements varied between staff groups and clinical areas. There was no set program but rather individual courses in each subject.
- All nursing staff were required to undertake medicines management training and 99% of staff required to undertake this training had done so. However, only 80% of staff required had undertaken the mandatory training in the mental capacity act.
- In addition, 78% of staff working in the service had undertaken the mandatory infection control training; 81% of staff had undertaken mandatory hand hygiene training; 78% of staff had undertaken the mandatory training in health and safety; 84% of staff required to

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undertake basic life support had received this training. These were all lower than the trust's target of 90%. However, 95% of staff had undertaken their mandatory corporate induction which included training on subjects such as infection control and health and safety.

- Staff told us that they were offered mandatory training and reminded when their training was due for renewal.

## 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.
- 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 in staff areas of the wards and theatre areas displaying the contact details for the safeguarding team.
- Training data provided in relation to safeguarding showed that 88% of nursing staff working on the surgical wards had completed level 2 safeguarding adults training; which was higher than the trust's target of 85%. However, only 77% of medical and nursing staff in the theatre areas had completed this training which was lower than the trust's target.
- In terms of children's safeguarding, 90% of nursing staff working on surgical wards and 94% of nursing staff in the theatre areas had received level 2 safeguarding children training, which was higher than the trust target of 85%. However, only 53% of medical staff had completed this training, which was much lower than the trust target.
- We did not see evidence of action plans to address any areas of low uptake of safeguarding training.
- Staff told us 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. The ward and theatre areas we inspected were visibly clean and well maintained.
- Rates of infections were low and staff followed measures to protect patients from infections. Each

identified case of infection, such as *Clostridium difficile*, was subject to a full root cause analysis investigation and audit to assess whether the trust's pathway in relation to this infection had been followed.

- The service regularly undertook infection control and prevention audits and we reviewed three months data in relation to these audits. All showed good compliance with hand hygiene and basic infection prevention measures.
- 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.
- 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 Methicillin Resistant *Staphylococcus Aureus* (MRSA) during patient admissions and preoperative assessments. This meant that staff could identify and isolate patients early to help prevent the spread of infections.
- The trust were also rated as the overall top trust in England in relation to the patient-led assessments of the care environment (PLACE) in 2015. The trust scored 99% for cleanliness.

## Environment and equipment

- Equipment on the wards and in theatre areas was visibly clean and well maintained.
- Staff in the theatre and ward areas told us they had access to the equipment and instruments they needed to care for patients.
- Portable appliance testing was up to date for all equipment we checked at the time of the inspection.

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- 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, which is used for patients with obesity, was readily available.

## Medicines

- We observed nurses undertaking medication rounds in the surgical ward areas. Appropriate checks were carried out 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 main theatre areas where we found anaesthetics rooms and cupboards in the recovery area unlocked. This was highlighted to senior staff who arranged for them to be locked immediately and were arranging for a more permanent and practical solution for future use. One of the options that they were considering as a solution was swipe card access to all cupboards.
- Emergency medicines were readily available and there was a procedure in place to ensure they were fit for use.
- Fridges used to store medicines were locked in all areas. 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. 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

- 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 and theatre areas daily to provide support and advice in relation to medication stock reconciliation and prescribing.
- We reviewed eight medication charts and medical staff had completed all sections on all 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. Any issues highlighted were fed up into managerial and divisional meetings.
- Discharge medications and prescriptions were managed well and completed in a timely way.

## Records

- The service and trust used paper based patient records. We reviewed 23 patients' care records and found them to be legible and easy to follow. We found that patients' nursing and medical records were kept up to date and fully completed in all cases.
- Records were audited during routine mortality reviews, a 'consent to treatment' audit and an audit of surgical checklists. If any issues were identified then these were highlighted to the staff involved and managers monitored trends and themes.
- Records were stored in records trolleys in the main ward areas. These trolleys were found to be unlocked but were not easily accessible to members of the public.

## 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 who were susceptible to these risks, they placed patients on the relevant care pathway and treatment plans.

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- We reviewed 16 records specifically in relation to these risk assessments. We found that assessments were completed in all records.
- 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.
- The service was also in the process of developing a neuroscience early warning system to identify patients at risk of deterioration. This was with the aim of identifying specific neurological symptoms which may indicate an early deterioration in a patient's condition. It was hoped that this would facilitate a faster response and earlier intervention in patients with a neurological deterioration.
- Patients received observations at the frequency specified by the medical teams and, where indicated, we observed staff escalating concerns regarding conditional changes.
- We observed parts of three operations and observed that the theatre teams undertook the 'five steps to safer surgery' procedures fully in all cases, 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. The service audited their compliance with this checklist on a regular basis. These audits showed good compliance with the checklist at all stages for a 12 month period.
- We found that this checklist and process was followed appropriately in the main theatre areas and included all the relevant staff required.
- Staffing in the ward areas was also sufficient and 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.
- The biannual review conducted and written by the Director of Nursing showed that all four surgical wards had an average shift fill rate of over 90% for day time shifts for the four month period prior to the review. Two surgical wards for the same period had a shift fill rate of 100% for night time shifts. The other two surgical wards had a shift fill rate of less than 90% at 86% and 88% respectively.
- 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 and a theatre briefing which were 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.

## Medical staffing

- There were sufficient numbers of suitably qualified medical staff within surgical services.
- Middle grade and registrar 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 54% of the medical workforce across the trust which was higher than the England average of 39%. There were less

## Nurse staffing

- The surgical services used a nationally recognised acuity tool twice a year to determine the staffing levels required in each area.
- 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.

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middle grade doctors at 4% compared with the England average of 9%. The number of registrars within the service was higher than the England average at 41% compared to the England average of 38%.

- 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

- The trust had a major incident policy in place which was available on the trust's intranet. Staff were able to tell us how they would access this.

## Are surgery services effective?

Good



We rated surgical services as "Good" for Effective. This is 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.
- Patients' nutritional and hydration needs were met and managed appropriately.
- Patients were assessed and provided with appropriate pain relief.
- The service participated in local, national and international audits and the results of these showed that patients received better outcomes in relation to trauma care and spinal surgery.
- The service had some aspects which were nationally and internationally recognised. There were some innovative approaches such as their hydrocephalus service and their study into whether radiotherapy could improve outcomes for patients with a rare brain tumour following surgery.
- Mortality rates were lower (better) than average mortality rates at similar units between April 2012 and March 2015, as reported in the Neurosurgical National Audit Programme.

- Services were available seven days a week including emergency services.
- Staff knew how to apply the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards to patients in their care.

However;

- Not all staff received their annual appraisal.
- The trust was only able to provide us with a limited range of surgical outcomes data across the broad range of services provided.

## 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. These pathways were comprehensive and were designed to meet patient's needs.
- Senior staff within the service regularly benchmarked against other neurological centres in England and in Europe to ensure they were delivering evidence based care.
- The service and trust contributed to national and international studies used by organisations such as NICE to design guidelines for neurological care and treatment.
- Policies and procedures reflected current national guidelines and were easily accessible via the trust's intranet site.
- Other centres and units regularly visited the service to adopt guidelines and benchmark their practice against the service.
- The service undertook a Sentinel audit for reported accidental awareness under General Anaesthetic and compliance with NICE guidelines for depth of anaesthesia. This audit found that there were no cases of awareness (being awake during surgery) during the audit period and the service was compliant with national guidelines.

## Nutrition and hydration

- The guidelines for fasting before surgery (the time period where a patient should not eat or drink) were clear and met national guidance.

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- Patients were well supported with nutrition and hydration.
  - There was a system in place to identify patients in need of assistance with eating and drinking. This included highlighting patient on handover to other staff and listing this need on the patient information board.
  - Fluid intake was recorded accurately on all six fluid charts we reviewed. It is important that charts to record fluid intake and output are maintained accurately as this can affect a patient's overall care and treatment.
  - Food intake was recorded accurately when indicated.
  - The trust had a protected meal time's initiative which ensured there were minimal interruptions to patient's meal times. During set times when meals were served all staff were focused solely on meal times and assisting patients. Medical and therapy staff were not able to examine or perform any routine interventions during these times to ensure patients had protected time to eat.
  - Staff told us they were able to access specialist dietetics advice and support easily.
  - Patients told us 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. They also worked across all services and were able to deliver a tailored pain management service to all patients.
  - We reviewed 18 patient records in relation to pain relief, which showed that staff gave patients appropriate pain relief when required in all cases. This was confirmed by the patients we spoke with. Pain scores were routinely completed and reviewed regularly.
  - Patients told us that they had no concerns regarding pain relief.
- ## Patient outcomes
- Surgical services participated in national, international and internal audits to monitor patient outcomes.
  - Data on hospital episode statistics August 2014 to July 2015 showed the number of patients who were readmitted to this hospital after discharge following elective and non-elective surgery was similar to the England average for all specialties.
  - The service was participating in the (TARN) Trauma, Audit and Research Network audits and submitting data regularly. Data from the TARN audits undertaken in 2015 showed that the trust performed above most other trusts in the area and met all standards in relation to data completeness and accreditation.
  - Mortality rates were lower (better) than average mortality rates at similar units between April 2012 and March 2015, as reported in the Neurosurgical National Audit Programme.
  - The service participated in the 2014 National Comparative Audit of Patient Information and Consent for Blood Transfusions. This audit highlighted two areas of improvement for the service and at the time of the inspection we found that the service had a comprehensive action plan to address these areas. However, the re audit date was 2015 and there was no evidence that this re audit had taken place and the action plan had not been updated since 2015.
  - The service participated in a number of trust wide audits on subjects including Deprivation of Liberty Safeguards (DoLS) and the care provided to patients living with a learning disability. These audits were completed on an ongoing basis; unfortunately the results of these audits were not made available to the inspection team.
  - The service was also in the process of joining the Damsell Study (The Detection and Assessment of Malignancy by Symptom Evaluation). They were only one of two centres in the United Kingdom taking part in this study. This study provided a tool for the capture and storage of individual patient data and enabled clinicians to identify symptom clusters to develop algorithms for detecting high-risk combinations. Staff told us that this study was working with multiple partners including technology firms and charities and, it was anticipated that it would help the service benchmark their practice.
  - The rate for surgical site infections within the service (infections at the site of surgery which can lengthen the recovery time for patients) was low at 2.6%.
  - The service had a comprehensive and detailed audit program for the year and were making excellent progress against this plan.

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- The service participated in the Spine TANGO study and data comparative. This was an international collaborative outcome study specifically looking at the outcomes for patients undergoing surgical spinal interventions. The study and registry covers a number of European countries and allows the service to compare their outcomes to other centres and services across Europe. This study was a continuous study and the data from this study showed that patients treated for specific spinal conditions in the service had outcomes either similar or better in most cases than other units across Europe.
- A Consultant Neurosurgeon had recently won an internal award for his successful effort to secure National Institute for Health Research (NIHR) funding to investigate whether radiotherapy could improve outcomes for patients with a rare brain tumour following surgery. Patients taking part in the study, called ROAM (radiotherapy versus observation following surgical resection of atypical meningioma) will be assessed over 10 years.
- There were informal mechanisms for nursing staff in ward areas to seek clinical supervision. In the theatre areas the practice development facilitated regular clinical supervision for nursing staff. This included practical supervision arrangements where they would work alongside staff if they requested.
- 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 well supported by their line management.
- There were extensive opportunities for staff to take up additional training and develop their skills. The service supported staff to undertake additional training in universities and additional courses were provided for staff which were relevant to their role.
- In the theatre area there was a mock theatre simulation laboratory which had all the equipment available to stage full situation training exercises. The practice development lead within the theatre area was passionate about providing good quality on the job training and regularly worked through scenarios with staff to improve their skills. This lead would also work alongside staff to improve and develop their skills.
- Staff members that we spoke to told us that they generally felt they had good opportunities for development within their roles. However, two members of staff out of 42 told us that they felt there was little opportunity for promotion within the service and that they would consider moving to another area to gain promotion.

## Competent staff

- Newly appointed staff had a comprehensive induction and senior staff assessed their competency before they were allowed to work unsupervised.
- There was a comprehensive and extensive set of competencies for staff to complete when starting work in the theatre areas of the service.
- Agency and locum staff completed local inductions and were required to complete an induction checklist when they attended a new ward area.
- 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 74.5% of nursing staff on the surgical wards had received their annual appraisal which was below the trust's target of 90%. Management staff told us that this was due to unexpected management absence on one ward area and they were working hard to improve the figure. Only 69% of staff in theatres had received their annual appraisal, this however was an improvement on the last year's total of 43%. All junior medical staff had received their annual appraisals and 89% of consultants had received their annual appraisal, which was better than or similar to the trust's target.

## 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.
- Staff handover meetings took place during shift changes to ensure all staff had up-to-date information about risks.
- Nursing staff told us they had a good relationship with consultants and ward-based doctors.

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

## Seven day services

- Acute and emergency surgical services were available seven days a week. Out of hours cover by medical staff was sufficient 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 or 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.
- Microbiology, imaging (for example x-rays and scans), physiotherapy and pharmacy support was available outside of normal working hours.
- Medical staff told us they had adequate access to urgent imaging outside of normal working hours. This meant patients could have scans and x-rays urgently out of hours, if required.

## Access to information

- Staff told us that they found accessing records and test results easy in most cases. However some medical staff told us they sometime had difficulty accessing information for patients transferring into the trust, specifically relating to blood tests conducted in other trusts outside the Merseyside area.
- Risk assessments and patient pathways were easily accessible to staff and some were available of the trust's intranet.
- Staff were also able to access policies, protocols and guidance from the trust's intranet site.
- We also found that consent forms were always available on the date of surgery to prevent delays in surgical procedures.

## 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 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 and this was audited on an annual basis.
- All 23 patient records we looked at indicated that staff had sought and obtained verbal or written consent before treatment was delivered.
- The service undertook an audit to measure their compliance with the trust consent to treatment policy. The results of this showed that consent forms were present in 100% of the case notes audited; which was an improvement from 85% in the previous audit. There was evidence that the patient was provided with an information leaflet in 61% of applicable cases which was again an increase on the previous audit. This was below the services target of 100%. The risks and benefits of the operation were explained to 99% of patients. There was a comprehensive action plan in place to address the areas of lower than expected compliance.
- Staff were aware of the legal requirements of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards. Staff were required to undertake mandatory training in this subject and data provided by the service showed that 81% of staff within the surgical services had received this training which was lower than the trusts target of 85%.
- 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.

## Are surgery services caring?

Good



We rated surgical services as "Good" for Caring. This is 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.

# Surgery

- Staff involved patients and their families in decisions about their care.

## Compassionate care

- We observed staff treating patients with kindness, dignity, respect and compassion. Staff took time to interact with patients and communicated with them 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 18 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 surgical wards consistently scored above 95% which was better than the England average, indicating that most patients were positive about recommending the hospital's wards to their friends and family.
- The average response rates for the surgical wards was 38% which was higher than the England average of 32%. This means that 38% of the patients who were discharged from surgical wards completed the test.

## 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 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 staff supported them with their emotional needs.
- The service and trust had recognised that patients often travelled long distances to the centre and therefore their relatives required additional support. We were told of examples where staff had gone above and beyond to provide support to patient's relatives including arranging accommodation and laundry services for them. The wards and home from home centre also had care packages to provide to patients' relatives who had to attend the centre with very little notice. These included tooth brushes and other essential items.
- The wards were also trialling new ways to enable virtual visiting by relatives who could not travel to the centre themselves.

## Are surgery services responsive?

Good



We rated surgical services as "Good" for Responsive. This is because;

- The surgical services were responsive to the needs of patients and 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.
- Access and flow was managed effectively.
- Patients had timely access to consultant led care which met the national referral to treatment indicator of 90% and was better than the England average for the period September 2014 to August 2015.

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- Complaints were well managed and learning from these complaints was evident.

However;

- The service did not meet the national referral to treatment time indicator of 90% from October 2015 until the time of the inspection but this was because the trust had made an agreement with NHS England and Monitor to assist a local hospital with some of their surgery as patients there were experiencing long waits.
- A consistently higher number of planned operations were cancelled than the England average; however most patients received their treatment and were rebooked within 28 days.
- 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

- The service planned its services to meet the needs of the local population.
- One example of this was that the service had taken on additional surgery cases from a local district general hospital as patients there were experiencing long waits for surgery.
- There was also an emergency 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.

## 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.
- Staff told us 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 were living with dementia were provided with care that met their needs on all surgical wards. We observed staff caring for one patient living with dementia and observed that they were caring, kind and delivered care which met their needs. However, there were no designated 'dementia friendly' ward 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.
- A reasonable adjustment flagging system was in place for patients living with a disability and in use in all areas. This alerted staff to any reasonable adjustments that they needed to make to accommodate the patient living with a disability. We saw evidence that this was used in patient records.
- Staff told us they gave patients identified as transgender the option to be treated either in a side room for privacy or in the main bay areas. Where possible staff accommodated these preferences.
- 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).
- Accessibility to all facilities and areas was good.

## Access and flow

- Patients were admitted for surgical treatment and care through referrals from other specialities and hospitals and by GP referral.
- The admission, transfer or discharge of patients from the surgical wards was well managed in all areas. The trust always accommodated emergency referrals and the bed management told us that they had never turned an emergency referral away.
- Patient records showed discharge planning took place at an early stage and there was multidisciplinary input (for example from physiotherapists and social workers).
- Trust data showed that medical and surgical patients were 'outlied' (placed on a ward which was not best suited to meet their needs) due to bed availability issues. However, this was not a regular practice and when patients were outlied they were tracked by the matrons for the divisions and the bed management team. They also received daily medical and surgical reviews.
- Data showed the service performed better than the England average and met the national 18 week referral to treatment standard between September 2014 and August 2015. However, the service had not met this standard from October 2015 until the date of the inspection. This was because they had agreed with

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Monitor and NHS England to breach this standard so that they could support a local district general hospital to treat additional patients who were experiencing long waits.

- NHS England data showed that the number of cancelled operations within the trust remained consistent during 2015 but was worse than the England average for the last three quarters of 2014/15 and the first quarter of 2015/16. 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. We did not see evidence of any action plans to address this but the trust were working hard to increase the number of these patients who were re booked for their surgery within 28 days.
- 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 worse than the England average for two out of two non- elective (unplanned) specialities and was worse than the England average for one out of two elective specialities but better than the England average for the other elective speciality over a twelve month period between September 2014 and August 2015. Managers and consultants within the service told us that this was due to the complex nature of the conditions treated at the centre and the lack of similar trusts in the United Kingdom to benchmark against.
- The theatre areas had an innovative theatre tracking system which allowed the live tracking of patients throughout their theatre journey. This also allowed consultants to view live theatre lists during their clinics. These meant they could book patients into theatre slots in live time in clinic and greatly improved the utilisation of theatres and the general flow of patients within the service. This system also allowed the theatre management team to review information about multiple patient journeys and identify where there were hold ups or areas for improvement. This again improved the flow of patients through the centre.

## 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.
- There were low numbers of complaints for the service and when we reviewed two of these complaints, we 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



We rated surgical services as “Good” for Well-led. This is because;

- The surgical services were well led at local line manager level and at service level.
- The trust’s vision was embedded throughout the service.
- Staff were clear what this vision was and were able to tell us what the trust’s values were.
- There were robust governance frameworks within the service 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 approach them and raise concerns.
- Staff told us the culture within the service was open.
- Staff told us they felt the clinical leaders were open to challenge and willing to make changes to improve patient care but they felt that board level staff were not.
- We found that the board had made efforts to engage with staff through different mediums.

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## Services vision and strategy

- The trust had a clear vision and values. The vision was to provide excellent services based on research and education. The values were caring, dignity, respect, pride and openness. Together these were described as the 'Walton Way'.
- All staff we spoke with were able to articulate these values and vision to us and the values they displayed reflected the trust's vision and values.
- All staff told us they felt proud to work at the centre and most staff mentioned the 'Walton way'.

## Governance, risk management and quality measurement

- There was a robust governance framework within 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 were regular clinical governance meetings held on a monthly basis and a further risk meeting held within the surgical services and we saw minutes from these meetings.

## Leadership of this services

- The leadership within the surgical services at local and service level reflected the vision and values set out by the trust. Staff spoke positively about local leaders within the services.

- Local leaders were visible. All staff told us that they valued and respected their local line managers and felt they were competent in their roles.
- Staff told us that the Head of Nursing and matrons for the service had an open door policy and were available to all staff.
- 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.
- All staff we spoke with were able to identify the Director of Nursing and Chief Executive.
- There were regular emails and updates from the trust board team to all staff.

## Culture within this services

- Staff we spoke with told us they felt respected and valued by their local and service leaders.
- There was an open culture where staff were encouraged to report concerns and incidents. This was demonstrated in the high rate of incident reporting within the service.

## 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.

## 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 frequency of these meetings varied between clinical areas. Minutes from team meetings were made available for staff to access if they were unable to attend.
- 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 trust held the 'wonders of Walton' awards which rewarded staff for excellence and commitment.

# Surgery

## **Innovation, improvement and sustainability**

- Staff and managers within the service were striving to improve the care and treatment patients received and were working to continually improve services.
- The service had a robust business plan for the year in place with clear objectives and progress towards these objectives were monitored.
- The theatre areas had implemented a live tracking system called 'TIMS' to monitor patients' journeys throughout their theatre experience. This was an innovative project which allowed the managerial team to identify delays and issues with patient's theatre

journeys quickly. It also assisted managers in relation to governance and responsibility issues as they were able to identify exactly which staff were in which area at all times.

- There was an innovative education program for theatre staff delivered by a designated practice development practitioner. This included a full mock theatre area where staff could undertake debriefing and simulation training soon after an adverse incident. This simulation laboratory was funded entirely by patient and relative donations.

# Critical care

Safe	Good	●
Effective	Outstanding	☆
Caring	Good	●
Responsive	Good	●
Well-led	Good	●
Overall	Good	●

## Information about the service

The Walton Centre is the only specialist trust in the UK providing neurology, neurosurgery, spinal and pain management services. The critical care service specialised in neuro-critical care and accepted patients from the North West of England, North Wales and the Isle of Man.

The critical care service is located on the Horsley Unit, which is on the ground floor of the hospital with easy access to and from both theatres and radiology. In the main intensive therapy unit (ITU) there are 16 beds for level 3 care to patients, eight of which are in cubicles with doored access. There is a high dependency unit (HDU) and a short stay surgical unit (SSU) which together accommodates up to six patients requiring level 2 care. However, all of the 22 bed spaces are equipped to provide level 3 care if required.

As part of the inspection we spoke to 30 doctors and nurses of different specialities and grades as well as members of multidisciplinary teams. Additionally, we spoke to eight patients and their relatives who were receiving care and treatment. We also reviewed eight patient records, audit documentation, guidance and policies which were provided before, during and after the inspection.

## Summary of findings

Overall we rated critical care services as being 'Good'. This is because;

- There were sufficient numbers of nursing and medical staff to keep patients safe both during and prior to the time of inspection.
- There were robust systems in place to protect patients from avoidable harm. Incidents were reported and investigated with evidence of the outcomes being disseminated to staff and lessons being learned.
- Infections in the unit were kept to a minimum and when they did occur, a full investigation into their cause was carried out so that lessons could be learnt and improvements made.
- The hospital used an appropriate track and trigger system and there was a designated team who responded to deteriorating patients throughout the hospital.
- The unit used best practice guidance when providing care and treatment and submitted regular data to both the Intensive Care National Audit and Research Centre (ICNARC) and the Cheshire and Mersey Critical Care Network (CMCCN) which allowed the service to be compared against similar units both nationally and locally.
- ICNARC data showed that the unit had consistently better outcomes in areas such as emergency neurosurgical admissions.

# Critical care

- Care and treatment was discussed in a number of multidisciplinary team meetings that were held on a daily basis with staff from inside and outside the unit. Care and treatment provided was always led by a consultant intensivist. The unit worked as part of a trust-wide trauma collaborative with a neighbouring trust. This contributed to the positive outcomes experienced by patients who had been admitted to the unit.
- The trust had developed a 'home from home' service which provided short notice accommodation for relatives who wanted to spend time with patients who had been admitted to the unit. This was particularly important as the unit received patients from a large geographical area.
- We saw evidence of patients being treated with compassion and having their privacy and dignity maintained at all times.
- Risks for the unit had been identified and were managed appropriately through the use of a critical care risk register.
- There was a positive culture demonstrated by staff in the unit and this was supported by a highly visible leadership team.

However;

- The unit struggled with meeting the Department of Health 4 hour target in discharging patients. Between April 2015 and March 2016, approximately 70% of discharges from the unit were delayed.
- The unit had an informal vision and strategy. However, the improvements that had been identified were not included as part of the divisional business plan and we were unsure as to how the improvements were to be monitored and measured.

## Are critical care services safe?

Good



We rated critical care services as "Good" for Safe. This is because;

- Staff were able to access the incident reporting system and were able to describe types of incidents that they would report. Staff were also able to give us examples of when there had been lessons learnt from incidents and we saw that there were systems in place to disseminate this to staff.
- We found that there were sufficient levels of staff at the time of the inspection. Nurse staffing was well managed on a daily basis and local inductions were provided for agency staff.
- All care and treatment in the unit was led by a consultant intensivist.
- The hospital used a track and trigger system which was used to identify deteriorating patients. There was also a surgical, medical acute response team (SMART) that followed up patients that had been discharged from the unit and responded to patients who had deteriorated within the rest of the hospital.
- There was a safeguarding system in place that was used to keep people safe and staff had a good understanding of safeguarding issues.
- The unit had robust infection control protocols and procedures in place. If a patient acquired an infection on the unit, a full root cause analysis investigation was instigated so that lessons could be learnt and improvements made.
- Records and risk assessments that we reviewed were completed to a good standard. The unit used an electronic system for identifying if a risk assessment needed completing or updating.

However;

- We found one example of an incident that had not been reported appropriately in line with the serious incident framework developed by NHS England. We raised this with the trust and it was reported appropriately.
- Staff had a limited understanding of the duty of candour and we found one incident of where this should have been instigated. However, there was no recorded evidence of this being undertaken.

# Critical care

- The unit did not always meet the Intensive Care Society (ICS) guidelines in that the resident doctor to patient ratio was exceeded during the night. However, there was always a consultant intensivist on call who was able to attend within 30 minutes.

## Incidents

- The trust had a policy and procedure for incident reporting which could be accessed via the intranet. Staff were aware of its existence and knew how to locate it.
- There was a trust-wide electronic incident reporting system which was accessible to staff and they knew how to use it.
- Staff were able to give us examples of the types of things they would report as an incident and told us that when they reported something, they had received feedback. However, staff were not reporting delayed discharges as clinical incidents. Although the trust recorded delayed discharges through other monitoring systems, this meant that the opportunity to analyse the reasons for these were limited.
- There were no 'never events' reported between January 2015 and January 2016. Never events are serious, wholly preventable incidents that should not occur if the available preventative measures had been implemented.
- In the period January 2015 to January 2016, there was one reported serious incident that related to a period of adverse media coverage about the unit. Serious incidents were investigated using a root cause analysis (RCA) approach. We reviewed a sample of RCA reports from investigations. We found that the appropriate staff had been involved in completing the investigations and that comprehensive actions had been put in place to prevent further occurrences of similar incidents.
- We found one example where an incident had not been reported in line with the serious incident framework developed by NHS England. However, an investigation was carried out and initial actions had been implemented to prevent it happening again. We raised this with the trust who took action to report this correctly.
- We reviewed all other incidents that had been reported in the critical care services between January 2015 and January 2016. There were 241 incidents recorded in that period. The majority of these had resulted in either no

harm or a low level of harm to the patient. Types of incidents that had been reported included medication errors, safeguarding concerns and incidences of infections acquired on the unit.

- Incidents were discussed in monthly governance meetings and were also described in a quarterly 'harm free care' leaflet that was available in the staff area. Staff were able to describe examples of lessons learnt from incidents and told us about instances where practice had changed as a result of investigations being carried out.
- Mortality and morbidity for the unit was discussed as part of minuted divisional meetings that were held monthly.
- We found that most staff across the department had a limited understanding of duty of candour. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. We found that on one occasion the duty of candour should have been instigated and it was unclear if it had been carried out. The management team told us that it had been done. However, they were unable to provide any written evidence to support this as the records could not be found.

## 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.
- Between January 2015 and January 2016 the numbers of reported cases of harm in critical care services was relatively low. There were two incidents of pressure ulcers, one incident of a catheter acquired urinary tract infection and one VTE which had been acquired on the unit. There were no falls reported.
- Guidance from the National Institute for Clinical Excellence (NICE) states that all patients should have a VTE and a risk of bleeding assessment carried out within 24 hours of admission. We looked at eight records and the assessment was completed in all but one.

# Critical care

- Safety thermometer information was displayed in the main corridor on a television screen for members of the public to see.

## Cleanliness, infection control and hygiene

- The trust had a trust-wide infection and prevention control policy that was available on the intranet and staff knew how to locate it when needed.
- The trust had an infection control lead and there was an infection control link nurse who was involved in managing infection control in the unit.
- Patients were screened regularly for infection and we saw that if tests returned positive that they were moved and managed in an appropriate doored cubicle.
- When there were incidents of hospital acquired infections, a full investigation was carried out using a root cause analysis approach so that lessons could be learnt and improvements made. We saw an example of a change in practice following an incident of pseudomonas (microorganisms that live in water). Regular water testing was being undertaken at the time of the inspection and filters had been put on all taps.
- The unit submitted data on a regular basis to the Intensive Care National Audit and Research Centre (ICNARC). The latest validated report for the period June 2015 to September 2015 showed that there had been one incident of methicillin-resistant staphylococcus aureus (MRSA), one incident of clostridium difficile (CDIFF) and five incidents of blood stream infections. These results were slightly worse than comparable units nationally.
- Unit records showed that between April 2015 and December 2015, there had been one incident of unit acquired carbapenemase producing enterobacteriaceae (CPE) colonisation and three incidents of methicillin sensitive staphylococcus aureus (MSSA).
- A housekeeper was available during normal working hours and was responsible for the general cleanliness and upkeep of the unit. We found the unit to be visibly clean and tidy. However, on one occasion we found a resuscitation trolley that had not been cleaned despite the records indicating that it had. We brought this to the attention of management and it was rectified immediately.
- Hand gel dispensers were located at the entrance and exit points to the unit and there were voice recorded reminders for both staff and visitors to use them.

- We found that staff were compliant with 'bare below the elbow' guidance and that personal protective equipment (PPE) was used on a regular basis in line with trust policy. PPE was also provided for visiting relatives when needed.
- Sink units were available in every bed space and we saw staff washing their hands before and after treating patients.
- We saw that bed spaces were thoroughly cleaned when patients had been moved to a different area.
- The unit had access to and had used hydrogen peroxide vapour (HPV) on a number of occasions. HPV eliminates bacteria such as clostridium difficile (CDIFF) from the environment. However, this was a lengthy process and meant that rooms were unavailable for a long period of time.
- The unit also used ultraviolet germicidal irradiation (UVGI) as a cleaning tool. This uses short wavelength ultraviolet light to kill or deactivate bacteria. A number of health care assistants were trained in its use so cleaning could be completed out of hours if required.
- The unit completed hand hygiene audits on a monthly basis. Records indicated that between the periods of January 2015 and December 2015 levels of compliance were high, 100% on most occasions.
- For the same period, the unit also completed a monthly audit of general cleanliness. Records indicated that results from these were consistently high.

## Environment and equipment

- The intensive therapy unit (ITU) was located on the ground floor of the hospital in close proximity to both theatres and radiology. The unit was secured with swipe card access and visitors had to gain access via an intercom.
- The main area of the ITU was open-plan and provided a spacious and light environment for patients requiring level 3 care. The high dependency area (HDU) was a separate four bedded area for patients requiring level 2 care. The short stay surgical unit (SSU) had two beds and was used mainly for patients who had surgery, although they were sometimes used as escalation beds if the unit was full.
- The ITU and SSU areas met HBN-04-02 building standards. These are the building standards for critical care units as designed by the department of health. However, the HDU area fell short of these standards in that the amount of space around the beds was limited.

# Critical care

- There were eight doored cubicles available, three of which had gowning rooms. A general sluice area was used for these. There were also four doored side-rooms and one positive pressure room which was used for patients who had a compromised immune system and were at risk from infection.
- All of the bed spaces had equipment to manage a patient who required level 3 care so the environment could be 'flexed' to meet the needs of the patient. This was in accordance with the Department of Health (2000) guidelines.
- We sampled a range of medical equipment and found that appropriate service and portable appliance test (PAT) stickers were in place and in date. The unit had a medical equipment technician who worked Monday to Friday. They were involved in the maintenance and supported staff in moving equipment when needed. There was a consultant who was responsible for equipment maintenance and the unit worked alongside the electronic biomedical engineering (EBME) department which was based at a neighbouring hospital.
- There was a capital programme in place to ensure the replacement of equipment on a rotational basis.
- The unit had several resuscitation and difficult airway trollies available for use and we found that all equipment was in date. However, records indicated that the resuscitation trolley that was used for the cubicles on the main corridor had not been checked twice a day in line with trust policy on 10 occasions in March 2016. We also found them not to have a tamper tag in place to prevent tampering. This meant that there was a risk of the correct equipment not being available in an emergency. We raised this with a member of staff who rectified it immediately. We saw the difficult airway trolley being used on a number of occasions and being replenished appropriately.
- Clinical waste was managed and stored appropriately. There were bins available for both domestic and clinical waste which were easily identifiable. There was also a separate system for infectious waste which was disposed of in a separate area.
- The unit had designated pharmacy cover during normal working hours, which equated to 1 whole time equivalent (WTE). The intensive care society guidelines recommend 0.1 WTE for each level 3 bed and 0.1 WTE for two level 2 beds which meant that there was a shortfall of 0.9 WTE based on the guidance. There was out of hours support available from a neighbouring hospital when needed.
- The unit used paper prescription cards for recording drug administration. This differed from the rest of the hospital which used an electronic system. Between January 2015 and January 2016 we saw that there were 19 reported medication errors as a result of the transfer of patients to or from the unit. These errors included administration errors and drugs being missed. This risk was highlighted on the critical care risk register and controls were in place to reduce this risk such as nurses checking the electronic system against the paper records on patient handover.
- We found that controlled drugs were stored in accordance with trust policy and legislation. Records indicated that regular checks had been completed. Medicines were kept in lockable cupboards which required swipe card access. Staff details were recorded every time the cupboards were accessed.
- We observed staff administering medication during the inspection and found that consideration was given to policy and procedure when doing this.
- We checked a sample of medications that were stored in three separate fridges within the department. We found these to be in date. Records indicated that fridge temperatures were monitored and found to be within the correct ranges. However, we saw that during March 2016 there were three occasions when daily checks had not been completed.
- We checked a sample of eight prescription cards and found that these had been completed appropriately. Prescription cards were legible, signed and dated.
- The trust had a policy for the administration of antibiotics in accordance with National Institute for Health and Care Excellence (NICE) guidelines. There was daily input from microbiology during the afternoon ward round. This ensured that antibiotics were being given in accordance with trust policy and conditions such as septicaemia were considered and treated appropriately.
- We reviewed an antibiotic point prevalence audit that was completed in April 2015. This showed that from 13

## Medicines

- The trust had a policy for medicines management which was accessible on the intranet. This documented the procedure for stock replenishment, withdrawal, administration and disposal.

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reviewed prescription cards, there was 100% compliance with the correct antibiotic indication being present and for the antibiotic being given by the correct route. However, it was noted on one occasion that an incorrect antibiotic was given despite advice from microbiology.

## Records

- Records were kept electronically and on paper. A system had been introduced within the last month where all risk assessments were completed electronically. Paper based records were still being used for general medical notes, observations and prescription cards.
- Paper records were stored at the end of a patient's bed and it was the responsibility of the staff member assigned to the patient to complete them on a regular basis.
- We checked a sample of eight patient records and found that on most occasions they had been completed to a good standard. However, on one occasion a VTE risk assessment had not been completed and on another occasion, a patient's weight had not been recorded appropriately.
- Paper based records were used to record medication that had been prescribed and administered.
- When a patient was admitted or discharged staff throughout the hospital were able to access the completed risk assessments electronically. There was a television screen in the staff area that highlighted if certain risk assessments had been completed or were overdue and this was used to support staff in ensuring that appropriate risk assessments had been completed.

## Safeguarding

- There was a trust-wide safeguarding policy in place, which was available on the intranet. Staff knew how to access the policy when needed and were able to give us examples of safeguarding referrals that had been made and examples of concerns that would require safeguarding referrals to be made. We were told that if there was a concern then it would be escalated to one of the co-ordinators initially for support.
- There was a trust-wide safeguarding team in place that were available during normal working hours and the unit had a lead nurse who was trained to safeguarding level 3. The unit also had safeguarding link nurses.
- A clear process was in place for out of hours advice and staff were able to locate the relevant contact numbers

for this. The unit had a policy of managing any patients under 18 years of age in side rooms. We saw that this had been reported as an incident on each occasion that it happened for monitoring purposes.

- Level 2 safeguarding for adults and children was included as part of the trusts mandatory training. We saw that 73% of nursing staff including health care assistants were up to date with their safeguarding training for adults and 91% of staff were up to date with safeguarding children.

## Mandatory training

- There were two dedicated practice education facilitators for the unit. They kept a spreadsheet that indicated if a member of staff was overdue for either training or an appraisal.
- Training was available in two ways. Some modules were completed face to face and others on the intranet via e-learning. Staff were required to complete statutory and mandatory training. The trust target for all training was 90%.
- Overall compliance with statutory training was 90%. This included topic such as hand hygiene, fire awareness, manual handling, and health and safety and the requirement for completion was every 12 months.
- Mandatory training compliance was mixed in some areas. 73% of staff were up to date with mental capacity and deprivation of liberty training and 73% of staff had completed infection control training.
- Resuscitation training was delivered by staff from a neighbouring NHS trust. 84% of all critical care staff were up to date with refresher training in basic life support for adults. There were 14 members of staff (co-ordinators and the management team) that had been identified as requiring advanced life support for adults and 71% of these were up to date with it at the time of the inspection. In addition, all members of the surgical medical acute response team (SMART) were up to date with refresher training for advanced life support for adults and were available to respond to emergencies 24 hours a day, 7 days a week.
- Critical care staff had completed immediate life support training. However, refresher training was currently unavailable as courses were not being facilitated by the trust that provided the training. There were no immediate plans in place to solve this problem.

# Critical care

- Substantive medical staff had to provide evidence that they had undertaken all relevant training before they were able to complete their annual appraisal. This meant that their compliance with training was regularly monitored.

## Assessing and responding to patient risk

- There was a trust-wide policy for monitoring and responding to the deteriorating patient, which was available to staff on the intranet.
- An outreach service was available within the hospital 24 hours a day, 7 days a week. This service had recently been redeveloped and was now called the surgical medical acute response team (SMART). The SMART team comprised of advanced critical care practitioners (ACCPs), doctors of various grades and nursing staff, all of whom had a background in critical care or anaesthesia.
- The SMART team had a clear operating policy in place which set out their main responsibilities. They responded to concerns about patients on the wards to assess and prevent further deterioration while also managing emergency admissions and patients who were deemed at risk. This included responding to resuscitation calls across the trust. The SMART team followed up patients when they had been stepped down from the unit and supported staff in managing patients with artificial airways.
- There was no audit data available at the time of the inspection that measured the effectiveness of the SMART team. This included monitoring of the number of patients seen, or compliance with the national early warning (NEWS) system.
- The hospital had a track and trigger system which used the national early warning score (NEWS). The NEWS system used clinical observations within set parameters to determine how unwell a patient may be. When a patient's clinical observations fell outside certain parameters they produced a higher score, which meant they required more urgent clinical care than others. A NEWS score was required as part of the patient's initial assessment, and at intervals for routine monitoring. The trust had a policy which set out the actions and frequency of physiological observations and actions to be taken based on the clinically indicated NEWS.
- When a patient was stepped down from the unit they were monitored by ward staff and if a patient

deteriorated they would escalate this to the SMART team. Regular training days were provided to support all levels of staff that covered recognition and management of the deteriorating patient.

- The unit did not monitor if patients were admitted within four hours of the decision being made. The management team assured us that there were few delays in admitting patients and it was not normal practice for ventilated patients to be managed away from the unit. However, on one occasion when the unit was at full capacity a patient had to be managed by the SMART team on a ward after being transferred from another hospital.
- Staff within the unit monitored patients' physiological signs closely. We observed staff responding to the deteriorating patient in a timely manner on a number of occasions and were able to manage them effectively.

## Nursing staffing

- A bi-annual staffing review was carried out so that the appropriate establishment of nursing staff for the unit was calculated. This was completed in accordance with guidelines developed by both the Intensive Care Society (ICS) and the British Association of Critical Care Nurses (BACCN).
- There were sufficient numbers of nursing staff at the time of the inspection to provide safe care and treatment for patients who required both level 3 and level 2 care. Patients requiring level 3 care needed a patient to staff ratio of one to one and those requiring level 2 care need a ratio of two to one. The unit had been established to provide 19 registered nurses and 3 health care assistants 24 hours a day, 7 days a week.
- There were vacancies for 2.46 whole time equivalent (WTE) registered nurses across critical care services which was as a result of recent recruitment to the newly formed Surgical Medical Acute Response Team (SMART). There was also a vacancy for 0.84 WTE health care assistants. Recruitment for these positions was ongoing at the time of the inspection.
- ITU, HDU and SSU had two supernumerary co-ordinators (staff who were not counted as part of the required numbers of staff so as to co-ordinate or support staff) on duty at all times which meant they were compliant with the Intensive Care Society (ICS) standard, which states that for units with over 10 beds there must be more than one co-ordinator available and they must not be included in the staffing numbers

# Critical care

allocated to look after patients. However, we were told that on a small number of occasions this could not be avoided due to the number of patients that were in the unit.

- On the days of inspection we saw that the unit was at full capacity and both of the escalation beds in the Short Stay Surgical Unit (SSU) had been used for patients requiring level 2 care. As a result of this, the amount of staff on the unit had to be flexed to ensure safe care and treatment was provided. This was done by including the nurse education facilitator in the staff numbers. Since the introduction of the two escalation beds, the Matron for critical care had been given permission to overstaff by 2.5 WTE nurses which also took into account annual leave and long term sickness.
- We saw at the time of inspection that the planned number of registered nurses and health care assistants had been achieved. We reviewed rotas for March 2016 to the time of inspection and found that the planned level of staffing was met on all but two occasions. These shortfalls had been covered by an additional member of staff such as a practice education facilitator.
- We attended a nursing staff handover which we found to be robust and involved handovers between the co-ordinators and between individual staff. There was also a safety huddle where any relevant information could be disseminated.
- The unit filled a high number of vacant shifts with overtime carried out by staff from the trust working additional hours. There was a low use of agency staff which had varied from 1.89% to 4.19% between June 2015 and November 2015. The unit ensured that all agency staff received a local induction and we saw evidence of written documentation being completed for this.
- For the same period the levels of staff turnover was relatively low with the highest monthly figure during the same period being 2.13%. However, the highest monthly sickness rate was 7.74% which was above the trust target of 3.8%.

## Medical staffing

- The trust employed nine consultant intensivists who all had a background in anaesthesia and covered both intensive care and theatres on a rotational basis. The unit had been established to provide two consultants in the daytime between 8am and 6pm Monday to Friday and one consultant between the same time at the

weekend. Outside of these hours a consultant intensivist was available on call and had sole responsibility for the unit. We were told that they were easily contactable and met the Intensive Care Society (ICS) standard of being able to attend within 30 minutes if required.

- On weekdays, the level of consultant cover did not exceed the ICS standard of a staff to patient ratio of between 1:8 and 1:15. However, at the weekend and during the night the ratio was higher at 1:20. Consultants worked on a five day rotational basis which ensured the continuity of patient care.
- We found that at night time the unit could not always ensure compliance with the ICS standard of a resident doctor to patient ratio of 1:8. This was because there was a clinical fellow whose primary responsibility was for theatres and was very rarely available for critical care which meant that a medical trainee had the sole responsibility for 20 patients. The unit had two Advanced Critical Care Practitioners (ACCPs) to help fill this shortfall. However, they were currently only available to cover one in three shifts. ACCPs are experienced nurses who have a critical care background and have undertaken a master's qualification in critical care practice. Two additional ACCPs had been appointed at the time of the inspection and were due to start in July 2016.
- There had been no incidents reported about the level of medical cover and staff told us that they felt that this was being managed safely. Both the medical trainees and ACCP's who were available on the unit during the night were all trained in advanced airway techniques and were competent in managing a deteriorating patient. There was also out of hours support from the surgical medical assessment Response Team (SMART) when needed.
- At the time of inspection and on review of the last four weeks rotas the planned level of medical staff had been achieved on all occasions.
- We observed a handover that took place between medical staff in the morning and an evening. We found that this process was robust and all patients were reviewed. The night time resident registrar took part in the evening handover. The same consultant then remained on call through the night, providing support if required.
- The unit did not use any locum medical staff at the time of the inspection but did have an induction process in place if needed.

# Critical care

- There was a consultant intensivist lead for the unit who was responsible for overseeing all activities and providing supervision for the other eight consultants. All of the consultants had an extra responsibility, for example equipment procurement or delirium management.

## Major incident awareness and training

- Major incident preparedness and business continuity policies were readily available on the intranet and had been developed in conjunction with a neighbouring hospital. The unit held a list of action cards that described key roles for staff to undertake in the event of a major incident.
- The unit had a winter resilience policy and had recently agreed the use of the two available spaces in the short stay surgical unit (SSU) as escalation beds. These were used for patients requiring level 2 care and an extra member of nursing staff was required to facilitate this.

## Are critical care services effective?

Outstanding



We rated critical care services as “Outstanding” for Effective. This is because;

- The unit used best practice guidance when providing care and treatment to patients. There was evidence of the unit submitting regular data and information to both the Intensive Care National Audit and Research Centre (ICNARC) and the Cheshire and Mersey Critical Care Network (CMCCN). This allowed the unit to be benchmarked against similar services both nationally and locally.
- We saw that in some cases that the unit performed consistently better than similar services. An example of this was lower mortality rates for patients who were admitted for emergency neurosurgery.
- There was a well-established multidisciplinary team approach that was seen as integral to the service. There were regular meetings through the day with staff from other departments, internally and externally.
- Staff were given the opportunity to consolidate and develop their skills and knowledge on a regular basis through the in house training that was provided by the clinical education team.

- Staff also showed knowledge of and had consideration for best interest decisions, mental capacity and deprivation of liberty safeguards.

However;

- There was no data available to measure the effectiveness of the surgical and medical acute response team (SMART).
- There were no action plans available following the results of local audits which meant that the opportunity for sustaining current compliance or improving results further was limited.

## Evidence-based care and treatment

- The unit used a combination of best practice and national guidance to determine the care that they delivered. These included guidance from the National Institute for Health and Care Excellence (NICE) and the Intensive Care Society (ICS).
- There was a range of local policies, standard operating procedures and clinical guidelines that were available on the intranet. We reviewed a sample of these and found that these had been referenced against the most recent best practice guidance.
- Compliance with evidence based guidance was measured through a number of audits which benchmarked performance against the required standard. For example, the physiotherapy team had undertaken an audit against NICE guideline CG83 (rehabilitation after critical illness). Results from this were mixed; 80% of patients had a comprehensive rehabilitation assessment completed and 80% of patients had rehabilitation goals clearly documented. However, a full handover of a patient’s rehabilitation needs were took place when a patient was transferred to a ward on only 5% of occasions. A clear action plan had been put in place to make improvements where required.
- The unit met the intensive care society guidelines for the number of respiratory physiotherapists available per critical care bed.
- The unit made regular data contributions to the Intensive Care National Audit and Research Centre (ICNARC). This meant that the unit compared the care delivered and mortality outcomes with similar units throughout the country. The unit had an audit clerk who was responsible for collecting and making data contributions.

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- The unit was also a member of the Cheshire and Mersey Critical Care Network (CMCCN). This meant that they were subject to an annual peer review which assessed a range of standards applicable to critical care.
- The last peer review that had been undertaken was for the last financial year of 2015/16. This report stated that the unit was 95% compliant with the required service specifications. This result was above average when compared to other benchmarked trusts. The review did highlight areas for improvement. These included recommendations to improve flow from critical care, reducing delayed discharges and repatriations, and to address the level of out of hours medical cover as this did not meet the ICS standard at the time of the review. The management team were able to identify the gaps and actions from the peer review. This hadn't been formalised into an action plan at the time of the inspection but it's recognised that the inspection was conducted five days after the end of 2015/16 financial year.
- The unit had completed a number of local audits in the last year which included ventilator care bundles, a nutritional audit and a patient and relatives satisfaction survey. Results from these showed that compliance was to a generally high standard. However, for local audits we did not see any evidence of action plans to sustain or improve levels of clinical performance.
- The unit had been involved in responding to a national confidential enquiry into patient outcome and death (NCEPOD 2015). An action plan had been developed to improve the management of sepsis against best practice guidance in the critical care setting.

## Pain relief

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

## Nutrition and hydration

- Guidelines were available for initiating nutritional support for all patients on admission to ensure

adequate nutrition and hydration. We reviewed a sample of patient records which indicated that nutritional assessments had been completed within six hours of admission.

- There was fluid balance monitoring for patients which included daily totals of input and output. We reviewed eight patient records and found that they had been completed appropriately.
- There was access to a dietetic service. A dietitian was available to attend ward rounds when required during normal working hours. There was a folder available for staff to use at the weekend providing clear guidance and protocols for them to follow including guidelines for the use of prabinec, which was the main nutritional supplement used for patients.
- The unit had two beds that had a weighing function but most patient weights' had been estimated by a dietitian using an appropriate method that was based on best practice guidelines. This was then corroborated through the use of a weighing bed when possible.

## Patient outcomes

- The most recently available and validated ICNARC data (April 2015 to September 2015) showed that the patient outcomes and mortality were similar to benchmarked units nationally. The exception to this was for emergency neurosurgical admissions, where mortality was consistently lower (better) than that of similar units. This was important as it was a key component of the neuro-critical care service that was provided.
- The ICNARC (2013) model mortality was 0.76 for the period July 2015 to September 2015 meaning that the number of observed deaths were less than those predicted. Overall performance was similar to that of other trusts that the unit was benchmarked against.
- In comparison, the mortality ratio for the same period using APACHE 2 (2013) model was 0.69. (APACHE stands for acute physiology and chronic health evaluation and is a severity score and mortality estimation tool developed in the United States of America). This result was again similar to other trusts.
- Between April 2015 and September 2015 the unit mostly performed similar to comparable trusts for early readmissions to the unit (within 48 hours of discharge). The unit's performance for late readmissions (after 48 hours) was consistently similar to other trusts.

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- Records also showed that the number of times patients had received cardiopulmonary resuscitation was consistently lower (better) than that of comparable units.

## Competent staff

- There were two whole time equivalent (WTE) practice education facilitators that were employed by the unit. They were responsible for organising staff training and appraisals.
- All nursing staff that worked in the unit were assigned to a team that had a band 7 lead and were responsible for completing appraisals for their staff. Nursing staff had an appraisal every year so that they had the opportunity to discuss their progress and training needs. We saw that only 69% of nursing staff were up to date with this at the time of the inspection and we were told that the main reason that they had not been facilitated was due to the current demand on the unit. This was below the trust target of 85%.
- The unit had an induction policy and a robust induction programme for new staff to complete. All new staff completed a corporate induction and were assigned a named mentor, had a list of key competencies to complete and were given a 3 month supernumerary period (this meant that they were not included in the daily staffing numbers to look after patients so that they could learn).
- The use of agency staff was kept to a minimum. The unit only used one staffing agency and tried to use regular staff so that they were aware of local policies and procedures. We saw evidence of local induction checklists being completed for agency staff.
- Staff told us that the unit encouraged staff development. A number of staff had progressed into different positions. For example, two nurses had become advanced critical care practitioners (ACCPs) and a number of nurses had recently joined the surgical medical acute response team (SMART). The unit also provided the opportunity for staff to complete a critical care nursing qualification; 60% of nurses had completed this qualification at the time of the inspection. This meant that the unit was compliant with the Intensive Care Society (ICS) guidelines which recommend that a minimum of 40% of staff should have completed this.
- The education team facilitated regular training days for staff that covered topics such as cardiovascular, respiratory and neurological assessment, delirium

management and the duty of candour. There was also a simulation suite that had a patient mannequin. Clinical scenarios took place with observers viewing through a video link in a separate room. A debrief was available for staff when they had completed the scenario.

- Members of the SMART team ran training sessions that included topics such as managing the deteriorating patient and tracheostomy care. Staff from other departments told us that this training enabled them to manage patients that had been discharged from the unit with confidence. This was available to staff of all levels from the unit and throughout the rest of the hospital.
- All staff on the unit completed a medical devices and equipment competency book. We were told that every year staff were asked to complete a self-assessment in using equipment and the unit provided training where needed. Training records showed that 94% of staff had completed this.
- The unit had highlighted a risk on the risk register of staff not being trained in the transfer of patients including the use of transfer equipment. A number of transfer team training days had been facilitated so that this risk was reduced.
- Regular training days for medical staff were facilitated on a rotational basis by the trust wide educational team.

## Multidisciplinary working

- There were a number of multidisciplinary team meetings discussing patient care and staff worked together to agree treatment plans.
- The unit worked as part of the trust-wide 'trauma collaborative' with a neighbouring trust. If a patient suffered multiple traumatic injuries then they were stabilised at the neighbouring hospital before being transferred to the unit. As a result of this, the unit had a trauma lead and members of the neighbouring trauma team visited on a daily basis and had input into patient care when required.
- There was a daily multidisciplinary team meeting. This was attended by all of the medical staff, a physiotherapist and a dietitian. We observed one of these meetings and found that the information covered was comprehensive. Staff used a clear handover sheet that highlighted any areas of patient concern.

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- The unit also held a board round once a week which was attended by all members of the critical care team including the speech and language therapist, physiotherapist, dietitian, pharmacist, microbiologist as well as the medical staff.
- There were three ward rounds per day during the week and two at a weekend. On Monday to Friday, the morning round consisted of a consultant, a clinical fellow, an anaesthetic trainee and the pharmacist. The afternoon round had input from microbiology and the evening round included the anaesthetic trainee who was resident through the night. At weekends, the microbiology and pharmacy teams were available on an on-call basis.
- The unit had pathways in place with other local trusts that provided continuity of patient care, for example if a patient needed transferring to a local spinal cord injury unit there was a weaning pathway available and this was used by staff prior to the patient being transferred.
- There was a clear system in place for stepping patients down for continued care on a different ward. There was a discharge summary that required completing and the patient handover was done on a nurse to nurse basis. We checked five discharge summaries and found that these had been completed appropriately.
- Once a patient had been discharged from the unit they were followed up by the SMART team. Staff told us that this happened on a regular basis. However, there was currently no data available to measure the effectiveness of this.
- There was a daily bed meeting in the hospital. However, a team member from the unit did not normally attend. We were told that this system was being reviewed in an attempt to reduce the number of delayed discharges that the unit currently had.

## Seven-day services

- A consultant intensivist was available seven days a week, including on-call outside of normal working hours.
- There were pharmacy services available between 9am and 5pm on Monday to Friday. Outside of normal working hours, there was additional pharmacy support from a neighbouring hospital. Additionally, dietetic services were available between the same times. Out of hours, staff had access to a file providing advice on nutrition and hydration.

- There was a dedicated physiotherapy team for the unit who worked as part of the wider trust team. There was an outreach service provided by the wider team that included an on call service that covered 24 hours, 7 days a week.
- Staff told us that there were no problems in obtaining diagnostic or laboratory support when required.

## Access to information

- The unit used a combination of paper and electronic recording systems. Patient's physiological signs and medication charts were recorded on paper alongside written medical notes.
- A new electronic system had been recently introduced and documentation such as risk assessments and medical notes had been added to this. This meant that patient information could be accessed by all staff throughout the hospital.
- Staff had access to care bundles and patient pathways to use when needed. There was also access to best practice guidance, along with trust policies and procedures.
- Staff were able to access diagnostic test results such as x-rays and blood test results on the electronic system.
- On discharge from the unit a discharge summary was created for the nursing and medical teams taking over the patient's care.
- The unit used a different prescription chart to the rest of the hospital meaning that when a patient was admitted to or discharged from the unit the current prescription had to be cancelled and transferred to another system.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- There was an up to date trust-wide policy for mental capacity, best interest decisions and deprivation of liberty safeguards available on the intranet. However, there was a file in the staff area which held some paper documentation which staff used and we found this policy was out of date. We informed management of this and they were immediately removed.
- Staff knew how to access the policy on the intranet and nurses told us that if there were any concerns they would always inform the unit co-ordinator to take the necessary actions.
- Staff had an understanding of mental capacity and best interest decisions. Staff also had an understanding of

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deprivation of liberty safeguards and although this did not apply to the unit on a regular basis, staff gave examples of when this had been instigated and how it had been done.

- The unit used a confusion assessment method for intensive care units (CAM-ICU). This was used in association with the Ramsay score (RSS) or the Bispectral index (BIS) which measure the agitation or sedation level of a patient. CAM-ICU is an adaption of the confusion assessment method by Inouye (1990), the most widely used tool for diagnosing delirium by non-psychiatric clinicians. The CAM-ICU tool utilises yes and no questions for non-speaking mechanically ventilated patients.
- Sedation breaks were implemented where appropriate. A sedation break is where the patient's sedative infusion is stopped to allow them to wake and has been shown to reduce mortality and the risk of developing ventilator related complications. The sedative was then re-started if the patient became agitated, was in pain or showed signs of respiratory distress.

## Are critical care services caring?

Good



We rated critical care services as “Good” for Caring. This is because;

- Staff treated patients in a caring and compassionate way; maintaining their privacy and dignity at all times. Both relatives and patients were positive about their time in the unit and spoke highly of the way in which they had been cared for.
- Staff communicated with patients and relatives effectively ensuring that they understood all aspects of the care and treatment that was being provided.
- The trust had funded a memorial tree within the hospital grounds that acted as a reminder of patients who had passed away while in the unit and donated organs. There was a yearly remembrance event that had been well attended by relatives.
- There was an organ donation team who were based within the department and did a lot of positive work with families of patient's whose treatment was withdrawn.

## Compassionate care

- Staff took steps to ensure that patients' privacy and dignity were maintained at all times. We saw that when treating a patient the curtains were fully drawn around the cubicle. The side rooms also had curtains around the bed spaces and were used when required.
- We saw both nursing and medical staff comforting and communicating with patients on a regular basis. The unit tried to ensure that patients' were looked after by the same members of nursing staff and this was done whenever possible.
- We saw examples of patients regaining consciousness and staff managing them in a compassionate way ensuring that they did not become agitated.
- We spoke to a number of relatives who all spoke very highly of the quality of care that their loved ones had received.

## Understanding and involvement of patients and those close to them

- Staff communicated with relatives on a regular basis, discussing treatment plans and allowing them to be involved in their relatives care. Relatives that we spoke to told us that they were aware of their loved ones condition and that this information had been communicated in a clear manner.
- The unit had introduced the use of patient diaries which were used for patients who were sedated. Intensive Care patient diaries are simple but valuable tools which help recovering patients come to terms with their experience of critical illness. The diary is written by healthcare staff, family and friends. Research has shown that patient diaries help prevent depression, anxiety and post-traumatic stress.
- There were two whole time equivalent (WTE) members of the organ donation team that were employed by a different service but were based within the unit. This team provided support to relatives of patients whose treatment was being withdrawn and screened patients using a national database for possible organ donation. They also facilitated visits back to the unit for patients and relatives and had organised a recent memorial service for patients who had had been involved in organ donation.

# Critical care

- The trust had funded a memorial tree within the hospital grounds that acted as a reminder of patients who had passed away while in the unit and donated organs. There was a yearly remembrance event that had been well attended by relatives.
- The unit had completed a patient and relatives satisfaction survey as part of their ongoing audit activity in October 2015. This information was shared with the Cheshire and Mersey Critical Care Network (CMCCN) and was compared to the results of similar services. The results from this showed that patients and relatives were very happy with the level of care that they had received during the stay in the unit and that performance was similar to that of other local units. There were also a few areas that the unit performed better in. This included when being asked if information had been provided about what to expect on their first visit to the unit.

## Emotional support

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

## Are critical care services responsive?

Good



We rated critical care services as "Good" for Responsive. This is because;

- The unit had been designed so that services could be flexed to meet the needs of patients.
- Out of hours discharges were kept to a minimum and the unit's performance was better than comparable services nationally.

- There had only been one reported incident of a mixed sex breach occurring in the last 12 months.
- The unit used IPADs to support patients in being able to communicate with their relatives by video link during their time on the unit.
- The trust had developed a 'home from home' service which provided accommodation for relatives. The accommodation provided was of a high standard and relatives were able to access refreshments.
- Complaints and concerns had been dealt with in a timely manner and we saw evidence of these being disseminated to staff and also being used to improve the service.

However;

- The unit had consistently struggled to meet the NHS England target of discharging patients within 4 hours once they were ready for their care to be transferred to a different ward. We saw that during the financial year of April 2015 and March 2016 approximately 70% of discharges had been delayed. However, only 10% of these had been delayed for longer than 24 hours and that out of hours discharges had been kept to a minimum.
- We were told that generally there were no problems in admitting patients to the unit. However, as a result of capacity issues a small number of elective surgeries had been cancelled.

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

- The unit had been developed in such a way that the environment and facilities could be 'flexed' so that patients received the correct type and level of care. For example, if a patient was being cared for at level 2 and deteriorated, there was the correct equipment available to provide care at level 3.
- Potential mixed sex breaches were managed through the use of side rooms. This complied with the standard set by the Department of Health which states that male and female patients must be accommodated on separate wards or in separate areas. A patient was said to require single sex accommodation in the intensive care setting once they were ready to be transferred to a ward. Records indicated that in the last 12 months there had only been one occasion when this had not been facilitated.

# Critical care

- The unit were able to manage patients in need of long term care and had access to a home ventilation and weaning unit at a neighbouring hospital if needed.
- A monthly follow up clinic was provided for patients who had been discharged after spending time in the unit. We were told that this was offered to all patients but only some chose to attend. The follow up clinics were used to answer any questions that a patient had about the time they had spent in the unit.
- The unit provided three separate rooms for relatives which were used while they were waiting to see a patient or to facilitate a more private environment.
- The trust had developed a 'home from home' service which provided accommodation for relatives. The accommodation provided was of a high standard and had been designed as the catchment area for the unit was large, with patients using the services regularly from the Isle of Man and North Wales. The trust had recognised that relatives may have to visit on short notice and may not always bring what they need. Items such as toothbrushes were provided for relatives to use if this was the case. Access to refreshments was also available.

## Meeting people's individual needs

- Side rooms were utilised to maintain a patient's privacy and dignity and also provided a more suitable environment for managing adolescents using the service.
- The unit used tablets to support patients in being able to communicate with their relatives by video link during their time on the unit. For patients who were unable to communicate verbally a keypad could be used to speak to medical staff and the iPads could be attached to a patient's bed if they were unable to hold them.
- The trust had a nominated lead nurse for patients living with dementia and was available to give advice and support to staff when needed. Additionally, there was a trust-wide dementia strategy which had been designed to improve services throughout the hospital.
- Staff had an awareness of how to manage patients living with a learning disability. There was a system in place for patients to be admitted with a learning disabilities passport and all patients with learning disabilities were referred to the safeguarding team on admission.
- Interpreting services were available for patients and relatives if their first language was not English. Advice leaflets and patient information was only available in English but different languages could be provided on request.
- The trust provided a neuro-psychology service which was available for patients to access when required.
- Staff were aware of the issues around sensory and sleep deprivation in the critical care environment and adjusted the lighting to simulate the difference between day and night time. The unit had a designated quiet time between 2pm and 4pm ensuring that patients were not disturbed.

## Access and flow

- There was a clear admissions and discharge policy that was available on the intranet. Staff had a good knowledge of this and told us that it was adhered to.
- The hospital did not have a post-operative unit available where patients could be managed following surgery. This meant that all patients were managed in the unit and if there was no capacity, surgery could not be undertaken. However, records indicated that between October 2015 and the time of inspection that only a small number (19) of elective operations had been cancelled as a result of a bed not being available.
- We were told that there were no problems in admitting patients to the unit within 4 hours of a decision being made. However, staff could not provide us with any up to date information that indicated compliance with this. If a patient required emergency treatment and the unit were unable to accommodate them there was access to neighbouring units that could provide similar treatment.
- Patients were reviewed by a consultant within 12 hours which was in line with the Intensive Care Society (ICS) guidelines. This was corroborated in eight patient records that we reviewed. Patients also received appropriate risk assessments and a rehabilitation prescription in a timely manner.
- ICNARC data for July 2015 to September 2015 showed that out of hours discharges were kept to a minimum and the unit's performance was better than comparable services nationally. Out of hours discharges are those that occur between 10pm and 7am and we were told that the only reason that this would be done was to facilitate an emergency admission to the unit.

# Critical care

- Records indicated that during the same period there had been no patients transferred out of the unit for non-clinical reasons.
- There was a daily bed management meeting within the hospital but staff from the unit did not attend this all of the time. Contact with the bed manager was only made when a patient was ready to be discharged.
- Critical care bed occupancy between December 2015 and March 2016 was high, ranging from 82.7% to 92%. In the same period the average time that a patient stayed on the unit varied between 6.2 and 8.1 days. It is generally accepted that when occupancy rates rise above 85% it can start to affect the quality of care provided to patients and the orderly running of the hospital.
- The unit had consistently struggled to meet the NHS England target of discharging patients within 4 hours and had performed consistently worse than similar units nationally. The latest data that had been validated by the Intensive Care National Audit and Research Centre (ICNARC) showed that 70% of discharges between April and September 2015 had taken longer than 4 hours. The majority of these waited less than 24 hours. In addition, approximately 10% of patients waited between 24 hours and 6 days. Overall figures for between April 2015 and March 2016 showed a similar picture for the full 12 month period.
- This happened for a number of reasons which included patients requiring high levels of support once discharged to the wards and some patients were repatriated to the service from which they had been admitted.
- The management team had identified the delayed discharge of patients from the unit as an area for improvement. As a result of this a CQUIN (a payment framework that promotes quality and innovation) had been introduced to support the improvements that were needed.
- Staff told us that as a result of delayed discharges and the unit being very busy patients were being moved between bed spaces on a regular basis. Examples of reasons that a patient was moved included if a patient had deteriorated or a patient had an infection that required them to be managed in a doored cubicle.

## Learning from complaints and concerns

- The trust had a complaints policy which was up to date and available on the intranet. Staff knew how to access this when needed.
- Staff were able to give appropriate information to patients and relatives if they wanted to make a formal complaint. However, we did not see any information available for patients and relatives such as posters or leaflets in the unit.
- There had been a low number of formal complaints made about the unit between January 2015 and January 2016. We reviewed these and found that they had been dealt with in a timely and robust manner. A number of complaints had been partially upheld which meant that the unit had recognised the need for improvement in some instances. For example, the unit had recognised the need for better communication with relatives on one occasion and this had been discussed with staff and had been reported to a monthly divisional meeting for improvements to be made.
- There was evidence of learning from complaints and this information was disseminated to staff through team meetings, safety huddles and a quarterly 'harm free care' newsletter.

## Are critical care services well-led?

Good



We rated critical care services as “Good” for Well-led. This is because;

- The unit had a clear leadership structure and staff knew what their roles and responsibilities were.
- There was an up to date risk register that identified risks that the unit currently faced and the management team were able to identify with these.
- The unit held a number of clinical and operational meetings which were well attended. These were used to discuss a variety of issues including incidents and complaints.
- The unit had collated and submitted
- The unit had an audit calendar for 2016/2017. This was based on themes that were of particular interest or areas that required monitoring for improvement.

# Critical care

- The management team had developed a number of business cases to improve and develop the service further.

However;

- There was an informal vision and strategy in place which staff were able to identify with but this was not documented in a way in that progress could be monitored or measured.
- We were unsure of when risks that were listed on the risk register were to be next reviewed.
- There was limited evidence of action plans being developed as a result of local audits that had been undertaken and we were unsure of how current performance would be sustained or improved.

## Vision and strategy for this service

- The trust had a clear mission, vision and values statement. The mission was to provide high quality treatment, care and patient experience in the most appropriate place for the needs of their patients. The vision was to provide excellent services based on research and education. The values were caring, dignity, respect, pride and openness. Together these were described as the 'Walton Way'.
- Staff that we spoke to were able to describe what the vision and strategy was and they felt that they provided an excellent service for patients.
- The unit had an informal vision and strategy to improve critical care services. However, we found that this plan was not documented in either departmental documentation or in the divisional business plan and we were unsure how the strategy was being monitored and measured. This was confirmed by the management team. The strategy for the unit included employing additional advanced critical care practitioners and developing the equipment used for delivering patient care such as the introduction of cinematic ceilings to the unit.

## Governance, risk management and quality measurement

- There was a risk register for the division of neurosurgery as well as a separate risk register for critical care services, both of which had been reviewed in January 2016. The risk register listed all risks that the unit currently faced and the management team were able to identify with these. Risks were measured appropriately

and controls were put in place to manage the risk. Additionally, gaps in current assurances were listed. However, on the critical care risk register there was no evidence of dates that these risks were to be reviewed.

- The unit held a number of risk assessments which we sampled. We found that these had been reviewed and were up to date.
- Any clinical incidents in the department were reviewed by an appropriate member of staff. For example, if there had been an equipment failure, the consultant who was responsible for looking after equipment was assigned to complete the investigation and implement improvements when required. Incidents were discussed in monthly meetings and learning was disseminated to staff when needed.
- The unit held several divisional and departmental meetings every month which discussed a variety of topics. For example, there was a monthly critical care group meeting that was attended by the divisional team and discussed things such as infection control and current policies and guidelines. There was also a monthly operational group that was attended by all of the consultants and the pharmacist in which clinical issues such as nutrition, medication and weaning were discussed.
- Morbidity and mortality were discussed at divisional level on a monthly basis and included any lessons learned.
- The unit had an audit lead and we saw an audit calendar for the years 2015/16 and 2016/17. Most of the local audits that had been planned leading up to the inspection had been completed such as ventilator care bundle and nutritional audits. Despite the results of the completed audits being positive, there was limited evidence of any action plans that had been implemented to sustain or improve these areas.
- Additionally, consultant intensivists were responsible for completing clinical audits. We found that these had clear action plans to inform areas of improvement and detailed how the improvement was to be measured.
- Delayed discharges had been identified as an area for improvement and the clinical lead had recently completed a 3 month audit for this. While the audit had not identified areas for improvement, we were told that ideas had been discussed to improve the number of delayed discharges which included more involvement with the bed management team.

# Critical care

## Leadership of the service

- The unit operated under the division of neurosurgery and anaesthesia within the trust. There was a clear leadership structure for this including a clinical lead and an operations manager.
- The unit had a matron who was responsible for overseeing the unit who was from a critical care background and had worked in the unit for a number of years. The matron also ran the Surgical Medical Acute Response Team (SMART) who were responsible for responding to emergencies and following up patients that had been discharged from the unit.
- There was a designated lead consultant for the unit who specialised in both critical care and neuro-anaesthesia. The lead also had clinical oversight for the SMART team.
- The unit had two designated practice education facilitators who were both from a critical care background and were responsible for overseeing training and development within the department.
- Two supernumerary co-ordinators were responsible for managing the operational aspects of the unit on a daily basis. This was in line and with and met the Intensive Care Society (ICS) Guidelines.
- All leaders for the unit were visible during the inspection and staff told us that management were both approachable and supportive.
- Staff had clear responsibilities and defined roles. For example, a number of band 7 nursing staff had been tasked with things such as service improvement and infection control. Consultants in the department also had extra paid responsibilities such as equipment maintenance and updates, trauma and the management of delirium.
- Both nurses and consultants attended external meetings such as those facilitated by the Cheshire and Mersey Critical Care Group (CMCCN). This meant that the unit had the opportunity to be involved in shared learning alongside other trusts.

## Culture within the service

- Staff told us that there was an open and honest culture within the service and that there was a real sense of teamwork between staff on the unit.
- Staff said that patient care was their priority and that they felt this view was shared through the department by all staff, including management.

- We saw that both nurses and doctors worked well together and that there was a pleasant environment in the unit. We observed staff communicating well, helping and supporting each other on a regular basis.
- Between January and December 2015 results from the trust-wide friends and family test showed that 96% of staff that completed the survey would recommend the critical care unit as a place to work.

## Public engagement

- The unit had undertaken patient and relative satisfaction surveys in the hope of being able to use their views and ideas to improve the services that were provided. This data was submitted to the Cheshire and Mersey Critical Care Network (CMCCN) on a bi-yearly basis. The results from a survey undertaken in October 2015 showed positive results in all areas. Questions that had been asked as part of this survey included 'were you kept up to date with your relatives condition' and 'did you feel that your relatives' privacy and dignity was maintained'. There were also a number of positive comments about the unit that had been made by patients and relatives.
- The trust held listening weeks which members of the public could attend and provide either positive or negative feedback. The results of these weeks were disseminated to staff and information received was used to help drive service improvement.
- Between January 2015 and December 2015 NHS Friends and Family Test (FFT) trust-wide records indicated that an average of 96.6% of people said that they would recommend the trust to other people.

## Staff engagement







- Information was cascaded to staff through a number of different methods. It was done by email, information in staff areas, daily huddles, team meetings and appraisals.
- We were told that there was a monthly nurses meeting but this had not been facilitated regularly due to the unit being at full capacity. However, a large amount of information was communicated to staff through the use of notice and bulletin boards and quarterly newsletters.
- The trust held 'Berwick' sessions, which were open to all staff to discuss what they are proud of and what keeps them awake at night. The trust considered this a key component of their open and honest culture and staff speaking out. We were told that this was well attended and as a result staff felt part of the 'trust-wide team'.

# Critical care

## Innovation, improvement and sustainability

- The trust had developed a 'home from home' service which provided accommodation for relatives. The accommodation provided was of a high standard and had been designed as the catchment area for the unit was large, with patients using the services regularly from the Isle of Man and North Wales. The trust had recognised that relatives may have to visit on short notice and may not always bring what they need. Items such as toothbrushes were provided for relatives to use if this was the case. Access to refreshments was also available.
- A number of nursing and medical staff from the unit had key responsibilities such as infection control or service improvement. They had regular involvement with the Cheshire and Mersey Critical Care Network (CMCCN) so that shared learning was facilitated and improvements to the service were made.
- The trust had developed an electronic system that the unit used to monitor if patient risk assessments had been completed and provided a visual reminder for staff if they had not or required updating.
- The unit had established strong links with medical deaneries including Merseyside and North Wales (deaneries are education facilities that train medical staff). The unit had identified this as a key area for development due to the regular turnaround of staff. As a result there was a full establishment of clinical fellows who had an interest in neuro-intensive care and remained with the trust for a longer period of time.
- The unit had agreed a business plan to develop an outdoor space for patients to use and the introduction of two rooms with cinematic ceilings that would simulate day and night. This would be the first of its kind nationally and staff believed that it would promote recovery and improve the level of overall patient experience.
- Shortfalls in the number of trainee anaesthetists had been identified as had the need for more medical cover during night shifts. As a result there were two Advanced Critical Care Practitioners (ACCPs) in position at the time of inspection. ACCPs were practitioners who were from a critical care nursing background and had undertaken a masters qualification that provided them with extended skills. The unit had plans to develop six of these positions in total so that an extra level of medical cover could be provided.

# Outpatients and diagnostic imaging

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

## Information about the service

There are two buildings at The Walton Centre, the main outpatient department (OPD) with 22 rooms and the Sid Watkins building with 12 rooms. There is also a satellite service at the Royal Liverpool University hospital where some routine tests are performed. There were 6500 attendances per month. OPD services were also provided at 13 sites across the North West of England and North Wales in hospitals and community venues.

The centre offers one of the most comprehensive neuroradiology services in the country. There are four magnetic resonance imaging scanners (MRI), one computed tomography (CT) scanner, two biplane intervention suites and one single plane fluoroscopy suite. There are also four mobile image intensifiers, three mobile x-ray machines, one general x-ray room and one ultrasound machine which allow the directorate to undertake highly complex procedures. In the period from 1 April 2015 to 31 March 2016 the department provided 24,759 MRI scans, 7990 CT scans and 1198 angiograms.

The neurophysiology service undertakes a range of routine and specialised investigations to help in the diagnosis of a number of neurological conditions. The service had 7739 patient attendances from April 2015 to March 2016.

There is a neuropsychology department that does assessments of cognitive function and provides differential diagnosis for a range of conditions.

We visited the trust between 5 and the morning of 8 April 2016 as part of a comprehensive inspection and we visited the radiology services in the OPD in the main building and

neurophysiology services in the Sid Watkins building. We also visited a satellite centre at a neighbouring NHS hospital. During the inspection we spoke with three administration assistants, 11 health care assistants, one staff nurse and two agency nurses, eight patients and seven carers and family members, two volunteers, a neurosurgeon and the ward manager and matron of the OPD.

In radiology we spoke with a band 8A radiographer, five band 7 radiographers, three band 6 radiographers and a band 4 radiography assistant, we also spoke with the radiology manager, a consultant radiologist, a consultant neurologist, the divisional manager and six patients. We also spoke with a band 7 neurophysiologist two band 6 neurophysiologists, a student neurophysiologist and the neurophysiology manager. In neuropsychology we spoke with the neuropsychology manager.

As part of the inspection we reviewed information and data from the trust before, during and after the visit. We also reviewed policies and patient records during the visit and we received 38 “tell us about your care” comment cards from patients.

# Outpatients and diagnostic imaging

## Summary of findings

We rated the outpatient department (OPD) and diagnostic imaging services as good overall at The Walton Centre and we rated caring as 'Outstanding'. This is because;

- Governance structures were robust, risks were well managed and there was evidence of strong leadership.
- Incident reporting was good; staff knew how to report incidents and this was fed back to staff.
- Mandatory training levels were at 100% and the environment was visibly clean.
- Staffing was adequate in the OPD and good in radiology and neurophysiology for staff and consultants.
- Services were effective and there was a comprehensive audit programme and excellent multi-disciplinary working.
- In diagnostic services, staff worked closely with medical staff and there was good training and continuing professional development.
- Throughout our inspection we witnessed exemplary patient centred care being given. Services were delivered by caring, committed, and compassionate staff who treated people with dignity and respect.
- Staff knew some of the patients who had been attending the trust for many years and there were caring interactions between them. Staff greeted patients like old friends.
- Patient satisfaction surveys were consistently positive and the results were used to improve.
- Staff were willing to be flexible with patients and recognised that patients regularly travel to the trust from far away. For example, one patient arrived at the hospital OPD at 6pm; staff rang the consultant who agreed to see them.
- The diagnostic services were innovative and in radiology there were a range of different scanners to accommodate different patient needs and new techniques were being used in the diagnosis and treatment of patients that were undertaken in very few trusts in the country.

- In neurophysiology, a service had been developed that could be undertaken in patients homes and so patients did not always have to stay in hospital for a prolonged period of time.
- The trust was meeting the referral to treatment times.

However;

- Record keeping in the OPD was poor and a number of records that we looked at were illegible, some were not signed and others did not have the designation of the doctor.
- There were sometimes long waiting times for patients once they arrived in the OPD.

# Outpatients and diagnostic imaging

## Are outpatient and diagnostic imaging services safe?

Good



We rated the outpatients department (OPD) and diagnostic service as 'Good' for Safe. This is because;

- There had been no never events and no serious incidents in the past year. Incident reporting was good, staff knew how to report incidents and there was feedback to staff through regular meetings.
- Staff were aware of the meaning of the duty of candour.
- Staffing was adequate in the OPD and was good in radiology and neurophysiology for medical staff and for radiographers and neurophysiologists.
- There was full compliance with mandatory training in all the services that we inspected.
- The OPD and diagnostic departments were visibly clean and there were regular environmental audits and hand washing audits with full compliance. Hand gel was available in all departments and there were systems in place for infection control.
- In radiology and neurophysiology equipment was serviced regularly and was repaired in a timely manner if there was a problem.
- Policies and procedures were in place to keep people safe and staff knew how to manage patients who became unwell in the department.
- Medicines were stored securely in line with legislation.
- Staff were aware of their roles and responsibilities in relation to safeguarding patients.

However;

- Some of the patient records were not fully completed, but following the clinical consultation, clinicians completed a detailed letter to the referrer which was kept as part of the electronic record.

### Incidents

- There were no never events (serious, wholly preventable incidents that should not occur if the available preventative measures had been implemented) and no serious incidents in the period February 2015 to January 2016.
- In the same period there were 91 incidents in the outpatient department (OPD) recorded on the

electronic trust system which were level zero or level one, indicating that there was no harm or insignificant harm to patients. Incidents were mainly communication issues, records being unavailable for clinic or patients suffering seizures in clinic. There were examples of incidents where apologies had been made to patients and following a number of incidents where patients arrived at the wrong site the appointment letters were changed.

- There was a trust-wide incident and near miss reporting policy that included information on the grading of incidents.
- The health care assistants (HCAs) in the outpatient department that we spoke with said that they would inform the nurse in charge of any incident who would report it on the trust system as they didn't have access to the electronic trust system for recording of incidents. They were confident about raising concerns and would have no hesitation in raising a concern. They felt that their opinions would be valued, listened to and acted upon. The ward manager was aware of the duty of candour and explained how it was applied in the department. Some of the HCA's did not know what the duty of candour meant but they knew about apologising to patients if anything went wrong. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- There was a positive approach to the management of risk in radiology and staff (including consultants), were aware of incident reporting and there was a good open culture of reporting. Senior staff supported more junior staff in incident reporting. The manager was informed of all incidents as they were reported. Incidents were generally at level one indicating that there was no harm or insignificant harm to patients. There was feedback to staff by email and at monthly staff meetings. Staff we spoke to were aware of the duty of candour and when to apply it. There had been a recent incident in radiology in which a procedure was ordered by mistake and the person who ordered the procedure rang the department to cancel it but there was a failure to cancel the procedure. The system for the requesting of radiology scanning and procedures would not allow the requester to cancel the procedure. This was a software issue with the system and was being addressed. The patient

# Outpatients and diagnostic imaging

received a minimal dose of radiation and was given an apology. This incident had been appropriately reported to the ionising radiation (medical exposure) regulations IR(M)ER team at CQC.

- The quality, risk and governance meetings in radiology included incident reviews (including radiation incidents) as agenda items. This included any greater than intended radiation exposures under the (IR(M)ER) regulations. There was a clinical imaging operator checklist for staff.
- In neurophysiology and neuropsychology there was good incident reporting and feedback was through the monthly staff meetings. Staff knew how to use the trust reporting system and said that there was a good reporting culture. Some of the incidents reported were of when a patient had had a seizure during treatment and how the staff dealt with it and any learning from it.
- There were trust quality board meetings at which the neurology directorate was represented, where mortality and morbidity reviews were agenda items and this information were fed back to managers.

## Cleanliness, infection control and hygiene

- The OPD was visibly clean and tidy and there was 100% compliance to hand washing audits in the period July 2015 to December 2015. There had also been environmental spot checks and cleaning audits by the infection control team. A patient led assessment of the care environment (PLACE) had been completed and actions had been put in place to address any issues.
- Patients described the environment as “spotless” and “clean and hygienic.”
- Records indicated that the OPD rooms were cleaned and restocked with personal protective equipment (PPE) and other items in the mornings before clinics started. The rooms were cleaned and restocked periodically throughout the day. Domestic staff cleaned the rooms in the evening.
- Procedures were in place to deal with patients with a suspected communicable disease and staff could contact the infection control team for specific advice if required. Strategies included patients with known infections being booked at the end of the clinic if possible and they were seen in the treatment room which was easier to clean. Staff would then take the necessary precautions and clean the room

appropriately. OPD staff would not accept inpatients who had an infection into the department as this could lead to clinic delays while staff cleaned the room; consultants saw these patients on the wards.

- Hand washing stations and hand gel were readily available in the hospital. There was hand gel on the wall at the entry to the department and on the department desk in the Sid Watkins building. Patient and visitor leaflets were available about hand hygiene and methicillin-resistant staphylococcus aureus (MRSA).
- There were regular environmental and hand washing audits in radiology with 100% compliance. Rooms were visibly clean and tidy and in each of the scanning rooms were laminated cards with information about different types of infection and how to clean the room following a scan of a patient with an infection. PPE was plentiful. Long sleeved gloves and gowns were available for staff and linen was disposed of appropriately. Any spinal fluid samples that could possibly be infected were taken to the laboratory by porters instead of using the pod system.
- There was an infection control link radiographer who attended the trust infection control meetings on behalf of the department and fed back to the manager about infection control. They organised the environmental and hand washing audits and did weekly checks on the sharps boxes. There was 100% compliance with the environmental and hand washing audits.
- Clinical rooms in neurophysiology were visibly clean and PPE was plentiful. Sharps boxes were dated and there was 100% compliance with environmental and hand washing audits. Patients with an infection were treated last in the schedule and all electrodes were disposable.

## Environment and equipment

- There was a large seating/waiting area in the OPD; clinical rooms were visibly clean and tidy, bright and organised. Patients we spoke with said that the environment and the facilities were very good. In the Sid Watkins building there was a private reception area and a large comfortable seating area.
- Staff told us that equipment was serviced and faulty machinery could be referred to biomedical engineering though some equipment was serviced by outside contractors.

# Outpatients and diagnostic imaging

- Portable equipment was portable appliance tested (PAT) and dated. The equipment we looked at had been tested within the month prior to the inspection.
- The resuscitation trolley in OPD was not sealed correctly and could have been opened or tampered with, there would have been no signs of this. Several items in the trolley were out of date. The weekly checks were carried out by operating department practitioners and the last check was dated 30 March 2016. There was a grab bag in the OPD that could be used for any emergencies in the department or in the adjacent areas. It was not sealed correctly but this was addressed by staff before the end of the inspection.
- There was a main waiting room in radiology and then other waiting rooms for the different scanning. Following patient comments the waiting areas had been improved, there was comfortable seating and relevant information was displayed on the walls. In the MR waiting areas there were lockers for any metal objects so that the patients could store these securely. The scanning rooms were large to accommodate monitoring equipment if necessary. The computerised tomography (CT) room had a picture on the ceiling for patients in the scanner.
- There was a log book for all the scanning equipment, these contained information from the manufacturers about the equipment, services dates and logs of completed services with dates.
- The CT scanner required planned downtime every three months, this was done on a Saturday and the equipment service plan was available a year in advance. The downtime lasted from 9am until 2.30pm and everybody was informed on the Friday about the downtime. Extra patients were accommodated if necessary and staff would see patients until 9pm on the Friday.
- The trust used an outside company to provide radiation protection advice. The department had supplied data for the patient dose audit and had established local diagnostic reference levels for compliance with ionising radiation (medical exposure) regulations (IR(ME)R) 2000 and was compliant. This would be reviewed in October 2016. There was also a radiation protection audit report from January 2016 with an action plan. Information was fed into the board through the radiation protection committee. There was a trust radiation safety policy.
- In neurophysiology there was a comfortable, well decorated, airy waiting area with artwork on the walls. Information was available for patients including the performance turnaround time for the issuing of the report and the outcomes of the patients' survey.
- Equipment was regularly checked and serviced and this was recorded. Staff said that there were good relationships with manufacturers who would send out replacement parts on the same day or visit the following day if a piece of equipment was faulty.
- Neuropsychology was based in the Sid Watkins building, the waiting room was very comfortably furnished and had a calm, relaxing atmosphere.

## Medicines

- The medicine cupboard, the controlled drugs cupboard and the fridge in OPD were checked and all medicines were found to be in date. Prescription pads were available in clinic and were securely stored.
- Medicines prescribed under patient group directives (PGDs) were used in the OPD for the Botox clinic. They were also used in radiology and we saw the correct paperwork had been completed with appropriate signatures.
- There were two angiography suites that were connected by a central anaesthetic room. There was an anaphylaxis kit due to the risk to patients of anaphylaxis during the administration of contrast dye. We checked this and the adrenaline was found to be in date. There was also a warmer in the room to keep the contrast media at 37°C before being administered to patients this was monitored, recorded and checked daily.

## Records

- The trust used a hybrid system of electronic and paper records. We reviewed 48 paper patient records during the course of the inspection and found that although all records were dated 39 had no record of the time that patients were seen. Exactly half of the records were illegible, 29 did not have the designation of the doctor who saw the patient and nine had no signature; 28 of the records did not record the allergy status of the patient. Two sets of records did not record the next of kin. This did not follow General Medical Council and Nursing and Midwifery Council guidelines. However, following a consultation, clinicians contemporaneously completed a detailed letter to the referrer which was typed and kept as part of the electronic record.

# Outpatients and diagnostic imaging

- Medical records were stored on site and selected and stored securely for the following days listing. Staff collected the notes and placed them in the appropriate consultant's room ready for the clinic. Case notes were returned to the consultants' secretaries following the consultation and letters and other information was scanned into the record.
- The availability of records was audited and in the period 1 October 2015-30 December 2015 99.7% of records were available for the OPD. If patient records were unavailable a temporary record was created with a front sheet, labels and previous correspondence. All test results were available electronically and the temporary folders were a different colour to distinguish them from the permanent records.
- Patients attending the Clatterbridge clinic had two sets of records, the notes were kept at Clatterbridge hospital and were sent by courier in time for the clinic, the notes were then married up with The Walton centre notes.
- Radiology reporting was electronic and was done by voice recognition software which was audited. There was also an audit of documentation in the medical records of radiological procedures. Images were stored on the electronic system and were available to appropriate staff as necessary.

## Safeguarding

- In the OPD 92% of staff had completed level one safeguarding training and 92% of staff had completed level two safeguarding training for children and young people. There had been 96% attendance at a safeguarding training day for vulnerable adults, this had included training on PREVENT and domestic violence.
- Level two training for children and young people was the minimum level required for non-clinical and clinical staff that have some degree of contact with children and young people and/or parents/carers. There were low numbers of young people attending the clinics, usually transition patients from the local specialist children's trust.
- In the main OPD there was a safeguarding board for staff with information about safeguarding in the trust and useful contacts, there was a laminated flowchart in the Sid Watkins OPD reception with information about the safeguarding processes for children and vulnerable adults. This included information about what to do out of hours.

- The HCA's we spoke to had completed safeguarding training for vulnerable adults but were unaware of the level of the training.
- Safeguarding policies for adults and children were available on the intranet and a nurse told us that if they had any queries, they could refer to the trust's safeguarding nurse.
- The radiology department did not see any children on site and the radiographers had undertaken level two in safeguarding children; however some staff went to a nearby children's trust and had completed the level three for safeguarding children. The staff had an update on safeguarding at a recent mandatory training day.
- The neurophysiology service did not see any children or young people under the age of 18 on site and all the staff had undertaken their level two for adults and safeguarding children and young people.

## Mandatory training

- The trust provided mandatory training days with updates in clinical and non-clinical issues.
- The trust's learning and development team produced a document that informed managers of the mandatory training status of all their staff, this was colour coded, amber indicated that training was due and red indicated that training was overdue. In OPD staff received emails to inform them that training was due.
- Staff we spoke with said that they had completed mandatory training. Mandatory training included infection control, medicines management, safeguarding, manual handling, fire and health and safety.
- The radiology manager booked all staff onto mandatory training ensuring that everyone was up to date with training. The department was at 100% compliance apart from those on long term sick. In neurophysiology there was 100% compliance with mandatory training for all eligible staff
- All the neurophysiologists and neuropsychologists had completed their mandatory training.

## Assessing and responding to patient risk

- In the Sid Watkins OPD there was a flow chart with guidelines for staff in the event of patients having a cardiac arrest. Deteriorating patients were transferred to the A&E of the adjacent acute trust.

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- If patients with diabetes had hypoglycaemia (low blood sugar) staff gave them a biscuit and a cup of tea; their blood sugar levels were monitored and if necessary intravenous glucose was administered.
- Staff in the epilepsy service worked with women taking certain medicines to reduce the risk of congenital malformation and development disorders in pregnancy.
- Risk assessments were available in radiology for all areas and activities and had review dates. Local rules were available on the trust intranet and there was a non-medical prescribing list in each room.
- There was information available to female patients about informing staff if they were pregnant or there was any possibility that they could be pregnant, we saw this throughout the department and staff also checked with appropriate patients.
- In the event of emergency downtime for the CT scanner, patients could be seen at the adjacent acute hospital trust.
- If a patient suffered a cardiac arrest in the MR area, they were taken into the anaesthetic area where there was a defibrillator and appropriate medicines. Piped oxygen and other gases were available in the MR scanning rooms. Oxygen was also available in the CT scanning room.
- There was information about pacemakers and other metal implants for patients going to MR scanning. Patients who worked with equipment that could cause very small pieces of metal to be present in their eyes had them x-rayed before being put into a scanner. Staff completed a check list with patients, which was signed before the patient went into the scanning area.
- In neurophysiology HCA's continuously monitored patients undergoing video telemetry. There was a risk of sudden death in epilepsy from patients who were withdrawn from their anticonvulsant therapy.
- Assistant neuropsychologists would make qualified staff aware of patients with suicidal and negative thoughts.

## Nursing staffing

- There had been no increase in staffing since the Sid Watkins building opened. An external consultant had undertaken a review of the OPD in November 2015 but there was no review of staffing. The divisional nurse lead and the divisional director of operations were to look at staffing levels.
- There was a vacancy in the OPD nursing team and the planned numbers were for four registered nurses

although at the time of the inspection there were two staff nurses and an agency nurse. The actual numbers of HCA's was greater than the planned numbers and there were over eighteen staff. There had been a 16% rise in activity in the OPD which had led to an investment in an extra nurse.

- There was a registered nurse in both the main OPD and in the Sid Watkins building at each clinic though sometimes they were agency staff. The nurses managed clinic bookings, undertook migraine and Botox treatments and conducted visual field tests. They were there to support patients who needed clinical input. There were usually ten HCA's in the main OPD, one for every three rooms. The band three staff HCA's provided a phlebotomy service and an ECG (electrocardiogram) service as necessary while the role of the band two HCA's was mainly as a chaperone if necessary.
- Staffing was adequate but any sickness in the department had an impact on staffing and only four staff were allowed on annual leave at any time, some of the HCA's said that sometimes staffing was not appropriate for the workload. There was some use of agency staffing for the nurses and the HCA's and there was an induction process for agency staff.
- There were few opportunities for flexible working and staff sometimes had to stay late if clinics were running late. The trust had recently agreed to pay overtime to staff that stayed late.
- Some of the health care assistants had other jobs and worked flexibly to fit in with other commitments. Overtime was available for staff in the evenings and on Saturdays.

## Radiology staffing

- There had recently been a restructure in the department and one member of staff had been promoted to the deputy post to support the manager. There were just over five whole time equivalent (WTE) posts for band 7 radiographers and just over 25 WTE posts for band 6 radiographers. There were ten WTE band 3 assistants and picture archiving and communication system (PACS) assistant who worked four days per week.
- During normal working hours the neuro-radiographers had a rotational rota for general, theatre, fluoroscopy,

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MRI, CT and intervention. There were core trainers in each area so the rotating radiographers were supported and updated in all areas of the department. Rotas were flexible to meet the daily demands of the department.

- There was an extended hours, out of hours/on call rota. This involved radiographers and assistants working longer days within the five day period. The radiographer on call for weekdays worked 12.30pm to 8pm on site and then on call from home. If the radiographer was called out after midnight they did not attend work the following day.
- At weekends, radiographers were on site 9am-9pm. There were two radiographers on site between 11am and 5pm; between 9pm and 9am there was a radiographer on call from home. On call could be busy and there was a local agreement with staff about pay and lieu time for on call. There were facilities for the staff to sleep in the department if necessary. Staff said that they liked the shift system and that it worked well.
- There were radiographic department assistants who rotated through CT, MR, fluoroscopy, and general areas of the department.
- There were no problems in the recruitment of radiographers and the department had a full complement of staff.

## Neurophysiology staffing

- There was full staffing in the department and good use of skill mix.
- Historically there has been a national shortage of healthcare scientists' (HCS) and the department had struggled to recruit qualified staff. The department has recently offered staff the choice of working their hours over four days which had proved popular with some staff. It was not compulsory and some staff said that they preferred five day working.

## Neuropsychology staffing

- The service had a manager and another two staff were the management team. There were also three psychologists and there was funding for three assistant posts. The assistants rarely stayed for longer than six to nine months as they needed to gain experience to get onto the clinical course.

## Medical staffing

- Medical staffing was adequate in the OPD and clinics were covered by consultants and registrars.

- The medical vacancy rate for the directorate was below the trust target of 6% in October, November and December 2015.
- In neuroradiology, there were nine consultant neuro-radiologists and one neuro-radiology fellow; one three year intervention post had just been recruited to. These posts were supervised by the consultants.
- The consultant neuro-radiologists had a rota for the radiologist of the day who was the first point of contact for referrers and radiology staff.
- There were three call consultant interventional radiologists as first on call from home for all out of hours. The trust was concerned that this was not enough to cover the rota but the radiologists said that there were probably not enough procedures to merit four radiologists and they would become deskilled. One of the radiologists was due to retire in a few years but due to the recruitment of the interventional fellow the radiologists felt that this succession planning was sufficient for the future.
- In neurophysiology there were 2.7 whole time equivalent consultants and one full time vacancy and a full time registrar.

## Major incident awareness and training

- There were clear instructions for staff to follow in the event of a fire or other major incidents.
- Staff were aware of what they would need to do in a major incident and knew how to find the trust policies, key documents and guidance.
- There was only one CT scanner and a plan was in place if there was unplanned downtime. Most patients could have alternative imaging as the MR scanners would produce a basic CT scan. There were arrangements with the adjacent acute trust, which had three scanners, to take patients if necessary.

## Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate



We are currently not confident that we are collecting sufficient evidence to rate effectiveness for Outpatients & Diagnostic Imaging but we saw examples of outstanding practice in the radiology and diagnostics department.

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- Staff were working in line with evidence-based guidelines and quality standards, such as those from the National Institute for Health and Care Excellence (NICE).
- There was a comprehensive audit schedule in radiology which was reviewed regularly and all staff in neurophysiology was working on an audit.
- Multi-disciplinary team (MDT) working was good across all the departments. In diagnostic services consultants and staff described excellent partnership working with mutual respect for the different staff roles.
- There was robust training for radiography staff to enable them to work on the on call rota.
- There was investment in training for radiology staff enabling them to attend national and international conferences.
- Processes were in place to quality assure radiology reporting
- In neurophysiology the manager worked closely with local universities to provide training for health care scientists, they had also introduced career development to aid recruitment and retention.
- There was good training for specialist registrars and there was good continuing professional development sessions for all staff including the lower graded staff.

## Evidence-based care and treatment

- All guidelines and trust policies were available on the trust intranet.
- The epilepsy specialist nurses were using the NICE quality standard for epilepsy that provided guidance for a range of conditions and interventions for people with epilepsy. One of the nurses had recently audited against part of this quality standard as patients with epilepsy should see a specialist nurse every three months. Almost every patient had been reviewed; there were extenuating circumstances for those who had not had a review. The quality standard included treatment of epilepsy in pregnancy and the trust was working with a nearby specialist women's trust to implement the quality standards. One of the specialist nurses was doing research on the transition of young people from a nearby specialist children's trust to The Walton centre.
- In the multiple sclerosis service (MS) they were generating evidence (GEMS), this was a service analysis that was used to support NICE guidance and services were evaluated for compliance to NICE standards.

- Staff in the outpatient department (OPD) followed patient pathways for the treatment of migraine in the pain clinic.
- Staff in the radiology department were working to national and royal college guidelines and audited against this. This included the Royal College of Radiologists and the British Medical Ultrasound Society.
- In neurophysiology protocols were evidence based but due to the research being undertaken in the department consultants were developing new protocols.
- Good practice was shared with the health care scientist (HCS) staff and the nursing staff and health care assistants (HCA's) who were undertaking the telemetry observations on the ward.

## Pain relief

- Patients attending the OPD could have their medicines changed by their consultant if necessary. Some patients were attending pain clinics at the trust.

## Patient outcomes

- In the trust, 33% of appointments were for new patients and 55% were for follow up patients. This was better than the England average and meant that patients were discharged appropriately and new patients were given appointments.
- The government has committed to sequencing 100,000 whole human genomes by the end of 2017. Patients with rare or inherited diseases for inclusion in the project will benefit from a conclusive diagnosis and diseases for inclusion the project could include inherited neurological conditions including epilepsy and muscular dystrophy. Staff in the OPD participated in the recruitment of patients for the genome project.
- The epilepsy service was developing outcome measures for patients following surgery. They said that appointments would need to be lengthened to be able to complete the necessary assessments.
- The radiology department had a comprehensive audit programme which was managed by a radiographer who was also the clinical governance lead for the department. She was a member of the trust audit committee and attended meetings every three months to approve audit applications. She also met with the audit lead for the trust every three months to agree an audit forward plan for the department and to agree the outcomes of any audits needed to be included on the risk register.

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- There were 23 ongoing audits in the department (not including trust-wide audits) and meetings were held every three months to review them and to track progress.
- The radiology service audited the turnaround times for reporting of all modalities. There was also a peer review of reporting/double reporting quality assurance where one percent of all reports were reviewed. Radiologists reviewed the reporting of other radiologists and that of reporting radiographers, sometimes the wording of the report was changed through the review and in the last six month period one report had the wording changed through the peer review process. This had no impact on outcome for the patient. The radiologists agreed with the findings in all the other reports reviewed. There was an audit to support this.
- As the picture archiving and communication (PACS) system was shared with other trusts the radiologists would feed back to other consultants about discrepancies in reporting, this was also shared with the trust medical director. The radiologists were happy to give advice to consultants as necessary.
- The trust was doing functional magnetic resonance (MR) scanning which was only usually done as research, only three or four trusts in the country were using the technique for diagnosis and treatment. This technique measured brain activity and this was used in the planning of neuro-surgery and other treatments. Some patients were referred from Ireland for this type of scanning. The scanner was also used to identify and grade different types of tumours without the need for a biopsy and work had been done to compare results between the scanner and the biopsy to ensure confidence in the process.
- There were a number of other research projects and clinical trials involving the use of the scanners, one was for a PhD project and others were funded by pharmaceutical companies for the treatment of conditions including multiple sclerosis.
- There were plans for a fifth magnetic resonance (MR) scanner and building was underway at the time of the inspection. It will be a wide bore high resolution scanner that will be attached to an operating theatre allowing patients to be scanned during surgery; this will provide better outcomes for patients and will reduce length of stay.
- The neurophysiology manager had attended a workshop for the first level of improving quality in physiological services (IQIPS) accreditation scheme and had put forward their self-assessment.
- In neurophysiology, there were regular quality audits every three months, these were shared with the team and changes were implemented as necessary. Each member of the neurophysiology team was working on an audit.
- Following a visit to a neighbouring trust, the department suspended one of their services as staff felt that they needed to review the evidence to improve the service. This was a service for sleep studies and patients were referred to the neighbouring trust for this service in the interim period.
- There was a research lead for the neuropsychology team and they had a national profile. They only supported research that had a clinical outcome and were looking at research interventions that were clinically effective. When the intervention service was commissioned the service would be able to develop outcome measures for patients. They were currently using friends and family and patient satisfaction surveys.

## Competent staff

- Clerical staff in OPD were offered the opportunity to pursue training and development in any appropriate interest that they had.
- Appraisal rates were 100% for the nurses and HCA's in the OPD. A nurse said that she had appraisals with her line manager that supported her development. Some of the HCA's in OPD said that appraisals were a paper exercise and felt that they were a waste of time.
- The manager in OPD participated in clinical supervision with a colleague and said that they supported each other. We were told supervision was also offered to the OPD staff but there had been little take up.
- A nurse we spoke to was a link nurse for student nurses and arranged development opportunities and visits to other departments.
- In the radiology department recruitment of staff was at band six and above as all staff covered the on call rota in all specialities. Following recruitment staff undertook training for 12-18 months with competency assessments

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for each of the specialities. One of the band three staff had recently undergone training and a competency assessment to become a band four working on the picture archiving and communication system (PACS)

- Each piece of equipment in radiology had a training log to ensure that all staff were competent in the use of the equipment and there was a core trainer for each piece of equipment. Staff were asked every year if they required further training or support on any piece of equipment and appropriate training was given if required.
- Appraisals in radiology were done by the manager for the band 8A and band 7 staff. The band 7 staff did the appraisals for the staff grades below them. They took place from January to March and were 100% compliant apart from a new radiographer. Appraisals linked into benefits and areas of development for the department and the trust.
- One of the radiographers was an advanced practitioner who worked in the ultrasound department and was able to report her own scans. She was supported by a consultant radiologist and there were discrepancy checks and spot checks to ensure the accuracy of her reporting. She taught the radiology registrars and also nurses and medical students.
- There was excellent additional funding to support training and further education in radiology. Some of the staff had a post-graduate degree which was funded by the trust and staff attended national and international conferences. There were continuing professional development days which covered a wide range of topics and training.
- In 2015 the radiology department had 15 publications in peer reviewed journals.
- In neurophysiology the specialist training for the specialist registrars (SpR) was organised between the consultants in the department, the SpR's were assigned an educational supervisor and a clinical supervisor during their placement. The service had strong networks across the North West to ensure that all SpR's in the region could develop a comprehensive range of skills.
- The neurophysiology service had an excellent track record of successfully training healthcare scientists' students. The service worked with two local universities to support the delivery of both the graduate and undergraduate healthcare scientist programme, they delivered clinical lectures and courses, competency

assessments and clinical placements. The programme leader for healthcare science at Manchester Metropolitan University quoted "the team is indispensable to the running of the BSc (Hons) degree providing a highly professional, comprehensive and effective programme of study".

- The neurophysiology department had established band 5/6 development posts to address problems in recruitment. They advertised for qualified staff and confirmed that they would progress to band 6 once they had demonstrated that they had met the competencies of the band 6 role and completed a training programme that was delivered and supervised by senior HCS' and lasted for 12-18 months. This has been successful as it negated the need to recruit to a band 6 post at a later date. Six to eight staff had been through this programme.
- There was a monthly continuing professional development session for consultants and HCS' in neurophysiology; there were presentations and case studies, undergraduate and postgraduate projects and dissemination of information from information from scientific conferences and courses. Staff were given the opportunity to observe and learn skills of other more senior HCS roles to provide a broader knowledge and to potentially enable further career progression. The sessions have been beneficial for staff who wanted to refresh their skills or for tests that are specialised and of low volume and therefore difficult for staff to maintain their competency. There were also case reviews, teaching sessions and joint reporting sessions.
- The neurophysiology services worked well with other local centres in the North West and there were regional meetings, study days and presentations from staff at all levels, including the HCA's.
- The department worked with the deanery to train medical staff the HCS were working with a nearby specialist children's trust to train some of their staff.
- All the neurophysiologists had appraisals except for a new member of staff. The appraisal was scheduled for the week following the inspection.
- Training for neuropsychologists was good and the assistants were supervised by the qualified member of staff.

## Multidisciplinary working

- There was good multidisciplinary team (MDT) working in the OPD with physiotherapists, occupational therapists,

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speech and language therapists and the specialist nurses. Staff said that the relationships with doctors were good and that everyone worked together as a team.

- The multiple sclerosis nurse specialist had reviewed service provision in the OPD and has produced a report showing positive feedback from staff. A presentation has been produced for the trust.
- There was a weekly MDT meeting every Thursday in the trust for oncology patients, patients admitted as an emergency and all elective surgery. The radiology staff ensured that all reports and imaging were available for the meeting; 40 to 50 patients were reviewed at each meeting.
- The advanced practitioner in ultrasound reported excellent MDT working with medical staff.
- Radiographers who worked in the plain x-ray area undertook ward rounds and covered theatre. The radiographers said that they had good relationships with the theatre staff and their manager was part of the theatre user group.
- In neurophysiology they worked with ward staff, neurologists and surgeons. Staff attended the monthly epilepsy surgery meeting ensuring good continuation of treatment. Patients undergoing video telemetry on the ward needed 24 hour observation as they were withdrawn from anticonvulsant therapy. This was done by the HCA's on the ward from the dedicated nurses' station for telemetry; they would monitor the patients and respond when they began to convulse. The neurophysiology team had done a lot of training with the HCA's so that they understood the importance of the observation. The department audited events missed, the response times for staff to get to the patient and the appropriateness of the responses; this was done monthly and was fed back to staff and had improved patient safety.
- MDT working in neuropsychology was excellent. Referrals to the service came from neurologists within the trust; staff also attended MDT meetings including epilepsy service meetings. Staff worked with occupational therapists and physiotherapists in areas such as neural oncology and motor neurone disease.

## Seven-day services

- Plain film, theatre, MRI and CT services were covered on a 24 hour on call system

- There were radiographers on site 9am to 9pm on Saturday and Sunday and there was an on call service to cover for the rest of the time.

## Access to information

- Staff had patient information on electronic devices that informed them of the status of the patient in clinics.
- Staff in OPD could access the computer system at a nearby specialist cancer trust if necessary to make follow up appointments for patients attending clinics at both sites.
- HCA's in the OPD and some of the new agency nurses did not have access to any of the trust IT systems.
- A consultant told us that the new computer system had created more clerical work for clinical staff as the system to request diagnostics was more time-consuming than the previous paper based system that was completed by clerical staff. The changes had not been factored into the working day and doctors were spending time on computers instead of listening and observing patients. He also said that there was a lack of flexibility to amend or change the allocated doctor and clinic lists which meant that the registrars were not always given the most appropriate patients to develop their learning.
- There was an electronic system for appropriate staff to order radiological tests; staff logged into the system and account usage could be monitored. The department was responsible for setting up accounts for new staff. There was a new picture archiving and communication system (PACS) that was shared by ten other local hospitals.
- There were restrictions on the PACS system put on by the IT department at the trust, one of the radiographers was frustrated by this and said that much more could be done with the system without the restrictions.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Training for consent, mental capacity and deprivation of liberty safeguards were part of the safeguarding study day.
- There was a trust consent policy which included consent from patients who had undergone video telemetry to consent to their videos being used for training purposes.
- There were flow charts for deprivation of liberty safeguards in the reception areas of the main OPD and in the Sid Watkins building.

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- Some HCA's in the OPD did not understand mental capacity and what impact that it could have for patients in the department. They said that they would speak to whoever the patient came to clinic with or their next of kin to gain consent.
- Staff in radiology were aware of the mental capacity act and the deprivation of liberty safeguards.
- All patients undergoing testing in neurophysiology had their consent taken by the referring consultant, staff checked this verbally with the patient before conducting the test.

## Are outpatient and diagnostic imaging services caring?

Outstanding



We rated the outpatients department (OPD) and diagnostic service as 'Outstanding' for Caring. This is because;

- Throughout our inspection we witnessed exemplary patient centred care being given. Services were delivered by caring, committed, and compassionate staff who treated people with dignity and respect.
- Staff knew some of the patients who had been attending the trust for many years and there were caring interactions between them. Staff greeted patients like old friends.
- We received 38 "tell us about your care" cards and all except one was positive.
- Patients with epilepsy and multiple sclerosis said that the telephone support line was invaluable to them.
- In the NHS family and friends test in November 2015 and December 2015, 95% of patients said that they would be extremely likely to recommend the service to friends or relatives.
- In the OPD, patient comment cards were left on chairs in the waiting room for patients to complete. The comments from these were fed back to staff.
- There was a patient survey twice a year in radiology in each area of the department. In the patient survey in neurophysiology (July to December 2015) 95% of patients said the care that they received was good and 100% said that they were treated with dignity. The department received 223 responses to the survey. There was evidence that changes were made to services in response to patient comments and feedback.
- We spoke with patients who said that they were involved in making decisions about their own treatment and felt listened to.
- Staff were willing to be flexible with patients and recognised that patients regularly travel to the trust from far away. For example, one patient arrived at the hospital OPD at 6pm; staff rang the consultant who agreed to see them.
- There were specialist nurses who supported patients and their carers in a number of specialities.
- Patients who had a seizure were looked after and supported by staff in a manner that protected their dignity.
- Carers were allowed to stay and support patients undergoing video telemetry.

## Compassionate care

- We received 38 "tell us about your care" cards and all except one was positive about the OPD, one patient described how they had rung up in the morning and was given an appointment on the same day; another patient visiting for the first time said they were very impressed with the department. There were no negative comments about waiting times. The negative comment was about a delay in receiving an appointment for a review.
- Throughout our inspection we witnessed exemplary patient centred care being given. Services were delivered by caring, committed, and compassionate staff who treated people with dignity and respect.
- Some patients had been attending the trust for many years and knew the staff very well; some of these patients were living with learning disabilities. The staff, including consultants, were very caring and greeted patients like old friends. We observed good caring interactions between staff and patients.
- Interactions between the reception staff and some of the patients, were respectful and polite. Staff were calm and explained processes to patients and their carers.
- In the NHS family and friends test in November 2015 and December 2015, 95% and 94.5% of patients respectively, who responded to the survey said that they would be extremely likely to recommend the service to friends or relatives.
- In the local OPD survey 2015/6, patients were asked the question "did you find someone within the hospital to talk to about your worries and fears" and in the period January 2015-December 2015 for three months the

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score was 100% and the lowest score for one month was 90%. For the question “overall were you treated with dignity the score for seven months was 100% and 98% for two months.

- We saw a frail, older lady being shown to a seat and staff explaining the process of waiting and how she would be called into the clinic. This was a particularly caring interaction.
- Staff were willing to be flexible with patients and recognised that patients regularly travel to the trust from far away. For example, one patient arrived at the hospital OPD at 6pm; staff rang the consultant who agreed to see them.
- In OPD comment cards were left on chairs for the patients to complete and the comments were fed back to staff.
- There was a patient survey twice a year in radiology in each area of the department. In the patient survey in neurophysiology (July to December 2015) 95% of patients said the care that they received was good and 100% said that they were treated with dignity. The department received 223 responses to the survey.
- Staff in neuropsychology helped patients to retain their dignity and privacy during a seizure.

## Understanding and involvement of patients and those close to them

- Staff actively involved patients and those close to them in all aspects of their care and treatment. Patients were positive about the way staff looked after them.
- A patient and carer we spoke to said that staff were kind and considerate, that they listened to their views and that that they were included in decision making. A patient said that his symptoms had been thoroughly explained and another discusses his condition in terms that he could understand.
- During the inspection a patient was unhappy following their consultation, they said that the consultant hadn't listened and hadn't taken account of their symptoms, staff asked the consultant to see the patient again and the issues were resolved.
- Carers were encouraged to stay with patients undergoing tests in neurophysiology to support them as some of the tests could be painful.
- Carers could stay with patients undergoing telemetry in the hospital for the duration of the treatment.
- Staff in the OPD were offered training in conflict resolution and violence and aggression.

## Emotional support

- The phone line for patients with epilepsy and multiple sclerosis was used if patients needed to be seen urgently but also to provide emotional support for patients, nurses would ring the patients back if required, and a patient we spoke to said that this was invaluable. Specialist nurses provided emotional support for patients and carers in a number of specialities.
- Patients we spoke with said that the service met their needs holistically and that consultants tried to solve their problems. One patient was offered advice about relaxation methods after going through a traumatic time. Another said that she was given information and support regarding stress and the effect it had on her.
- The multiple sclerosis society attended the trust every week to offer support and advice to patients and their carers.
- The neurophysiology staff and the nursing staff who supported patients undergoing video telemetry on the ward were very caring. Some patients had to remain on the ward and were confined to bed for up to 14 days. Some patients found this difficult and the staff supported them to allow them to get a diagnosis of their condition.

## Are outpatient and diagnostic imaging services responsive?

Good



We rated the outpatients department (OPD) and diagnostic service as 'Good' for Responsive but we saw examples of outstanding practice in the radiology and diagnostics department. This is because;

- Patients were sent an appointment in a timely manner and the trust were meeting targets for referral to treatment times.
- Diagnostic waiting times were good and the reporting turnaround times in December 2015 showed that over 50% of reports were available in five days and over 90% were available in 14 days. In neurophysiology in the same period over 70% of reports were available in five days.
- There was good care for patients living with a learning disability and appointment slots could be altered to accommodate these patients in OPD and diagnostics.

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- There was a telephone help line available for patients with multiple sclerosis and epilepsy and a nurse would call patients back with help and advice or with an appointment.
- There were a range of magnetic resonance (MR) scanners available, one had a wider bore and could accommodate bariatric patients and there was one open scanner that could be used for patients who were unconscious.
- The radiology department had won funding to run a clinic for patients with claustrophobia to help them to overcome their fears, this had been successful and the clinic had continued after the funding had run out.
- Staff in neurophysiology had introduced ambulatory telemetry for patients; this was in response to waiting list pressures but was more suitable for patients who could not undergo a long stay in hospital.

However;

- Many clinics started late and some patients waited over 30 minutes to see a doctor. The average wait was just over 15 minutes.
- We did not see any leaflets for patient in languages other than English and the information on how to request a leaflet in additional languages was also in English.
- The visual field testing was conducted in the waiting room where other patients and staff could hear and some patients undergoing the test were anxious because of this.

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

- In the main OPD there was a snack bar in the area adjacent to the clinical areas. The area was comfortable and there was information available for patients. Voluntary organisations, including the Multiple Sclerosis Society, used this area to provide support and information for patients attending clinics. In the Sid Watkins building there was a cold water machine and biscuits were available, there was no snack bar though the adjacent main building had a snack bar. Patients were aware of delays in clinics and could go over to the main building for refreshments.
- There were patient leaflets available in the OPD but only in English and there was no information on the availability of leaflets in other languages. Some of the leaflets were out of date. However, in radiology and

neurophysiology leaflets were available in English with information on the back in a number of languages informing patients how to request information in another language.

- The trust operated a daily “advice line” where GPs could contact a consultant during a one hour time slot to discuss any queries about referrals. There was a weekly emergency clinic for any urgent neurology referrals and a rapid access epilepsy clinic for patients experiencing their first seizure. Neurosurgery had reserved slots on clinic for urgent referrals and cancer two week wait patients. There was a pre-operative surgery clinic and patients had a range of tests completed on the same day.
- The multiple sclerosis service had OPD clinics in other hospitals and community venues for patients within the trust catchment area.
- In radiology a great deal of research and planning went into the purchase of new scanners to meet the changing needs of the service. When a business case was submitted for a new piece of equipment it included costs for the staffing of the equipment.
- Most of the CT scanning was for patients from intensive care and these patients were usually scanned frequently. There was good communication and multi-disciplinary team working with the staff on the intensive care unit.
- There was a rapid access clinic for ultrasound Doppler for patients who might have had a transient ischaemic attack (TIA)
- The neurophysiology manager had been approached by other trusts to provide services in their trusts.

## Access and flow

### OPD

- There was a patient access policy and a patient access centre with an administration team with referral management of booking to the first appointment in the department. While GP patients could use the choose and book system this was not used for referrals from inside the hospital, consultants from other trusts and for more complex patients. The trust sent out a confirmation letter, a leaflet with a contact phone number, a point of contact and any other relevant information to patients for their first appointment.
- From September 2015 to December 2015 21.3% of patients waited more than 30 minutes to see a clinician.

# Outpatients and diagnostic imaging

The average wait was 15 minutes. In the same period, 75.7% of clinics started late. Four percent of clinics were cancelled within six weeks of date and nine percent of clinics were cancelled over six weeks from date in December 2015. The main reasons for cancellations were annual leave, service reconfiguration and study leave. Clinics were Monday-Friday 8am to 5.30pm. There were also clinics on Saturdays and in the evenings. These clinics were usually to address waiting lists though there were some dedicated evening clinics.

- The did not attend (DNA) rate at the trust was 10%, which was worse than the England average of 7%.
- The referral to treatment for the incomplete pathway was higher than the England average and the standard. These are the waiting times for patients waiting to start treatment at the end of the month. The department was better than the England average (92%) from the period October 2015- March 2016 and consistently scored above 96%. This meant that patients were treated in a timely manner.
- Since April 2014 the percentage of people seen by a specialist within two weeks following urgent GP referral was mainly at 100% and always above (better than) the England average and the standard. The percentage of people waiting less than 31 days from diagnosis to first definitive treatment was also 100%. However, for the percentage of people waiting less than 62 days from urgent referral to first definitive treatment in the period October to December 2015 the trust scored lower (worse) than the England average. This was because the trust took 92 patients from another trust that had already breached this target. They had previously been at 100% in the achievement of this target. There had been a review of referral to treatment times by external management consultants as part of the trust's governance review.
- There was good clear signage around the hospital to the department and an automatic check in for patients in the OPD foyer, though patients could also check in in the clinic at the reception desk. A full time member of staff was available to assist patients checking in and they also provided other advice and signposting. A patient said that the person who greeted them was always there with a smile and a chat. Reception staff had noticed that when this staff member was

unavailable there was congestion at the reception desks. Patients scanned a barcode and were informed about the clinics that they were booked into and the waiting time for each clinic.

- The reception area of the clinic was located a suitable distance from the nearest seating with privacy screens between each window. Following their consultation patients were given an outcome slip which informed the reception staff of the time interval for their next appointment. The consultant dictated notes for the referrer which went remotely to the secretaries and was typed up almost immediately. Patients who needed an appointment to return in two to three weeks were not given an appointment when leaving the hospital. This was in response to high did not attend (DNA) rates. The appointment department rung patients following their appointment to arrange a follow up, this had reduced DNA rates. Some patients had reported that they struggled to get another appointment in the appropriate time frame.
- In the Sid Watkins building there was an automatic check in, patients we spoke with said that they preferred the automatic check in as they didn't have to queue for a long time at the desk. A television screen in the clinic area informed the patients when it was their turn with their name and the relevant room number. The screen also informed patients about any delays in their clinic.
- We spoke with a patient and carer who were regular users of the service who said that clinics did not always run on time. Another patient had travelled four hours to the hospital to see a specialist pain consultant as there was no treatment available in the area where they lived. They thought that the facilities and the environment were very good. Another patient we spoke to, who attends a nurse led clinic, said that the clinic always ran on time and that they liked the automatic check in as there were previously long queues at the desks.
- There had been waiting lists for Botox injections and the nurse manager and other nursing staff had volunteered to undertake training, this had reduced the waiting list time and enhanced the clinical skills of staff.

## Radiology

- The four magnetic resonance imaging (MRI) scanners were in operation from 7.50am to 8.10pm, Monday to Friday; one of these was an open scanner for patients who were unconscious.

# Outpatients and diagnostic imaging

- The computerised tomography (CT) scanner was in operation 8am to 5pm, Monday to Friday. The two interventional suites were in operation 9am to 5pm, Monday to Friday, as were the plain film imaging and ward mobile service, the ultrasound service and the four mobile image intensifiers in theatre.
- The diagnostic waiting times for this trust were lower (better) than the England average and in November and December 2015 the trust achieved 100% in the cancer two week referral rates.
- The reporting times for radiology were good. In December 2015, 2,646 investigations were reported; 31.9% of reports were completed on the same day, 20.1% were completed in five days, 38.6% in 14 days and 9.4% in over 14 days. In addition, 65% of inpatient reports were completed on the same day. Waiting list initiative funding was available if there was a backlog in reporting.
- Outpatients were booked in for 30 mins for their scan although the process usually took less time; this allowed inpatients to be slotted in as necessary. Urgent scans were prioritised and this was explained to patients who were waiting.
- On one of the OPD clinics, patients generally needed high levels of radiology input and this was factored into the schedule for that day.
- The demand for the open MR scanner had increased by 10-12% over the last year. The open scanner was used to scan patients who were unconscious and the department would scan unconscious patients from the neighbouring acute trust. Additional services were provided at weekend to meet demand as necessary. There was no outsourcing of MR services; this helped to keep costs down.
- All requests for radiological testing were vetted by the radiologists on a daily basis. This allowed radiologists to alter the request if it was appropriate and to allocate the request to a particular scanner. Once vetted, clerical staff knew how long to allocate to each procedure and patients would be sent a booking letter. They would then ring the department to make an appointment and they could ask questions about the procedure. Text reminders were also sent to patients. The partial booking system had reduced the DNA rate and the vetting of the requests had helped the access and flow through the system.
- There was increasing demand for imaging, particularly MR scanning. This was due to a 9% increase in

neurology, a 4% increase in neurosurgical referrals for MI and an 11% increase in referrals from intensive care and inpatients. An increase in complex scanning equated to an average of ten hours MR scanning every week. A 20 hours increase in MR scanning was achieved in November 2015 by extending the hours on all scanners and the recruitment of two radiographers. The radiologists managed the demand for the service through the vetting process and knew the usage of radiology testing requested by each consultant, there were some outliers and the information was used in consultant appraisals.

- The assistants were mainly involved in patient care, they greeted patients and helped to position the patients in the scanners, this helped the flow through the department as the radiographer could set up the scanner while this was happening. In MR scanning there would be a patient in the scanner, one changing and one in the waiting area. One of the radiographers had produced a step by step guide for the HCA's to enable them to correctly position patients for scanning.
- The radiographers doing the plain x-rays were very busy and they tried to do all the inpatient x-rays on the day that they were referred.
- There were some non-medical referrers to the service; they were mainly specialist nurses and physiotherapists. There was a trust policy and they were sponsored by a consultant radiologist. Training was undertaken by the radiology manager and included the ionising radiation (medical exposure) regulations (IR(ME)R). Following training, staff worked to protocols and had follow up training every three years. There was a list of staff who were non- medical referrers and the interventions that they could request. There was an audit of non-medical referrers in relation to IR(ME)R.

## Neurophysiology

- The department was located in The Walton Centre building and was open Monday to Friday 8.15am to 6.30pm; services were provided for inpatients and outpatients. There was also a satellite service at a neighbouring NHS hospital for outpatients and inpatients, for some neurophysiology tests and this was available four days a week. Video telemetry testing could take one to two weeks, the test was undertaken on the ward and the data was analysed in the department. As the test was continuous staff worked over the weekend if necessary.

# Outpatients and diagnostic imaging

- Demand for electromyogram tests was high and there were clinics at weekend to meet demand. Some electromyogram (EMG) testing was outsourced to the independent sector to meet demand.
- All clinics including the satellite clinics were booked six weeks in advance by the administration team in the department. The booking clerk had the schedule of clinic slots and the appointments were booked accordingly. This was a partial booking system and patients were contacted to agree appointment times and dates. DNA rates were low. The health care scientists planned their own clinic rotas and timetables and liaised with the administration team. Minimum staffing levels and skill mix were agreed for each day dependant on the tests being undertaken.
- Reporting times were good. In December 2015, there were 458 tests undertaken in the department. 29.3% of tests were reported on the same day, 43.9% within five days and 24.2% were reported within 14 days.

## Neuropsychology

- All the referrals for the service came from neurologists in the trust and were prioritised.
- There were 36 clinics a week and urgent cases could be fitted in as necessary. The assistant psychologists were doing assessment clinics.
- The service could only see outpatients and the service manager was keen to develop an inpatient service. A pilot had demonstrated the need for such a service following an audit, the manager wanted the service to become more responsive than assessment based but they needed more evidence to support a business case.
- Many patients referred to the service were very complex and the current improving access to psychological therapies (IAPT) provided in primary care did not meet their needs due to patients having memory problems. DNA rates had increased in the service and reception staff telephoned patients to remind them of appointments.

## Meeting people's individual needs

- Information at the check in desk was only available in English and the height of the check in could not be adjusted for people with mobility problems.
- A television screen in the clinic area informed the patients when it was their turn with their name and the relevant room number; the screen also informed

patients about any delays for their clinic. We noticed that one patient had appointments at three clinics in one afternoon. There were also verbal announcements for patients who could not see the screen.

- Dementia awareness and learning disability awareness for staff were part of the safeguarding study day.
- There was very good individualised care for patients with a learning disability, many had been attending the trust for many years and staff were aware of their likes and dislikes and accommodated these appropriately.
- If patients were booked in with the registrar but wished to see the consultant, the OPD staff would speak to the consultant who usually agreed to see the patient.
- There was a dedicated phone line for patients with multiple sclerosis or epilepsy who could ask for advice or make an appointment over the telephone and were seen in a few days. Patients would speak to a receptionist and a specialist nurse would call them back. Patients we spoke to said that this was a good service and they had positive experiences of using the phone line.
- There was good pre-conceptual counselling for women of child-bearing age who had epilepsy and there was a joint neurology obstetric clinic at a nearby maternity hospital that was attended by a neurologist.
- There was no designated area for patients on stretchers who had arrived by ambulance or from the wards and they were not prioritised as the doctors did not allow this.
- Refreshments were provided to patients who had been waiting a long time.
- There was dedicated parking close to the building for those with mobility problems.
- There was a quiet room in the OPD for breaking of bad news. Patients could remain there until they wished to leave the department.
- Previously patients had to go to another department for visual field testing but the nurses had received training on the visual field equipment and were now undertaking the tests in the department. The visual field testing was conducted in the waiting room where other patients and staff could hear and some patients undergoing the test were anxious because of this.
- Interpreters were available and were booked through the medical records department. If patients arrived and no interpreter had been booked this was recorded as an incident. Telephone translation could be offered if necessary.

# Outpatients and diagnostic imaging

- Clerical staff in OPD were offered training in sign language.
- The epilepsy service was working with a group of young people with epilepsy using animation to provide information to support the transition from adolescent to adult services. The animator was incorporating the ideas from the group and they hoped that one of the group would provide the voice-over. It was hoped that this group would evolve into a patient public involvement group. In neuropsychology there was also a transition services for neuro-muscular patients including those with muscular dystrophy.

## Radiology

- There were four MR scanners of different strength, some were slower and one was an open scanner. The more powerful scanners produced better images. Patients were allocated a scanner by the radiologist ensuring that they received the most appropriate scan. Patients who might become agitated were allocated into the faster scanners as they had to remain still. Patients were not sedated during the procedure though patients could visit their GP for an oral muscle relaxant before attending the department. One of the newer scanners had a 70cm bore and could accommodate some of the larger patients; other scanners had a 60cm bore. The maximum weight that could be accommodated was just over 220kg.
- One of the radiographers had won some funding support patients with claustrophobia who were concerned about MR scanning. Scanners are narrow tubes that are open at each end but patients can feel claustrophobic and sometimes the scan can take a long time. A clinic was set up and patients were invited in for a chat and could look around the scanner, lie in it while it was turned off and discuss coping strategies. In the first year, 86 patients were referred and six did not have a scan. This prevented these patients from having a general anaesthetic to go into the scanner. Although the funding has now run out, the clinics have continued and other radiographers have been identified to develop the service. Non- neurological patients were referred to the clinic from other trusts. The open scanner has somewhat reduced the need for this service but does not provide the image clarity necessary for some patients.

- The diagnostic angiography suite had two cameras one was at the side of the patient that gave a three dimensional image to assist in diagnosis and interventional treatment.

## Neurophysiology

- Prior to 2013, long term electroencephogram (EEG) which is long term recording of brain activity consisted of ward based telemetry EEG recordings and video time synced together and ambulatory EEG without video. In 2013 the department evaluated home EEG monitoring systems with a high definition camera. This technology enabled the recordings to be undertaken in the patient's home. The system needed be easy to use to capture clinical changes that occur during a seizure and there must be no loss of clinical quality. The introduction of this service had reduced the waiting list as ward based telemetry could only accommodate three patients at any one time, six patients can undergo ambulatory telemetry in addition to the three ward based patients. The patient attended the department to have the electrodes set up and the health care scientist (HCS) explained to the patient and/or carer the requirements in terms of setting the camera up. The technical quality was comparable to that of the ward. The department audited those who used the ambulatory telemetry and all said that they preferred to have the test at home instead of in hospital. It was useful for people whose social circumstances might have made a prolonged stay in hospital difficult and for people who may have found it difficult to remain in bed for long periods of time including those with a learning disability. It was not suitable for all patients as some patients needed a reduction in their anticonvulsant therapy which required a hospital stay.
- Appointments for people with learning disabilities could be tailored to meet their needs. All appointments were triaged in the department and the length of the appointment was agreed with staff. The department had pictures of the procedures that they could use with people with learning disabilities. Sign language and translators were booked as necessary.
- Staff worked with patients on the intensive care unit (ICU) that were in an induced coma, they could observe patients from their base using video cameras and staff in the ICU found this very supportive.

# Outpatients and diagnostic imaging

## Learning from complaints and concerns

- As part of the directorate risk and governance report there was a section on patient experience. In December 2015 there were nine complaints in the neurology directorate and 24 concerns. Each of these was reviewed with outcomes, actions and lessons learned. Most complaints in the OPD were about waiting times in the department. The manager was supported by the patient experience team when dealing with complaints
- The radiology department had very few complaints and these were mostly informal and were dealt with quickly. Following a number of complaints about the waiting rooms in radiology the trust provided funding to improve the environment.
- We saw leaflets about complaints that were in English but had information about their availability in other languages in the radiology and neurophysiology departments.

## Are outpatient and diagnostic imaging services well-led?

Good



We rated the outpatients department (OPD) and diagnostic service as 'Good' for Well-led. This is because;

- There was a neurology divisional dashboard that was produced monthly to inform managers about national and local targets and compliance with these targets.
- Governance structures were robust and there were regular meetings that were effective and information was shared with staff.
- Risk registers were reviewed regularly and risks were well managed.
- There was good staff engagement and regular patient surveys.
- Leadership in the OPD was good and managers had tried to make the work in the department more varied
- Leadership in radiology, neurophysiology and neuropsychology was effective and robust. The service managers were committed to service improvement and development and were supported by their staff and the clinicians.

- Staff in radiology, neurophysiology and neuropsychology liked working for the trust and were motivated; consultants had worked with managers to develop new roles for staff and were providing support for staff in these roles.
- Staff in radiology and neuroradiology said that the board and the executive team were very visible in their departments and were responsive to emails.

However;

- There was a vision and strategy for the department but not all staff were aware of it.
- In the OPD some staff said that the board and the executive team were visible but others said that they had never seen them and felt that the department was overlooked.
- There were some relationship issues highlighted to us in the outpatient areas.

## Vision and strategy for this service

- There was a five year business plan for the neurology directorate with different sections for each service. The plans were comprehensive and linked into the overall plans for the trust.
- The staff in radiology, neurophysiology and neuropsychology were aware of the trust vision and strategy.
- The nurse manager was aware of the trust vision and values though some of the HCA's said that they were unaware of them. Nursing staff said that they felt that information was drip fed and that they were never fully informed of the strategy.

## Governance, risk management and quality measurement

- Outpatient department (OPD), radiology, neurophysiology and neuropsychology were part of the neurology directorate. The OPD matron and manager attended the monthly ward manager's governance risk and quality meetings, agenda items at these meetings included complaints and compliments, incidents and trends and feedback from the family and friends test.
- There were monthly team meetings in the OPD, attended by the matron and the manager said that it was difficult to get people together. The meeting agenda included items at both organisational and local level from the governance meetings. An issue that had been

# Outpatients and diagnostic imaging

raised by patients was about uniforms and compliance with uniforms was discussed at the meetings. Minutes of the meetings were circulated to staff and were available in the staff room.

- There was a trust quality board meeting and the neurology department were members of the meeting. The meetings included mortality and morbidity reviews.
- There was a monthly neurology divisional dashboard with training and workforce data, reporting turnaround times, access target information and activity and productivity data.
- There was a risk register for the OPD department and a directorate risk register. The risks identified were performance related with a clinical risk about needle stick injuries. There were review dates on the register. Staff we spoke to were unaware of the risk register.
- Governance in the radiology department was extremely effective; there was a designated radiographer for clinical governance who was also the audit lead. There were quarterly quality risk and governance meetings attended by the lead and the service manager with agenda items including health and safety, complaints/complaints, audit and risk. There was also a quarterly risk review meeting which was also attended by the consultants to review all the risks on the risk register.
- There were monthly directorate meetings that included radiographers and radiologists and monthly staff meetings for the radiography staff where staff were given feedback from other governance meetings and raise questions and issues. This included patient survey feedback. There was a monthly radiology consultants meeting that included the radiography staff.
- Radiology had participated in the NHS National Radiology benchmarking exercise and had provided information from the period 2014/2015. The benchmarking exercise had allowed comparison of reporting turnarounds, quality, governance, equipment and staffing levels. This exercise identified that the radiology department is performing well against the other hospitals in the teaching hospital group. Previous benchmarking had previously been undertaken with other neuroradiology sites. This identified comparable staff levels, with added value per member of staff at The Walton Centre. The Walton Centre achieved a higher level of examination throughput compared to the other sites

- There were monthly quality, governance and safety meetings in neurophysiology and all departmental staff were invited. The agenda covered directorate feedback, risk management, audit, mandatory training figures and incident feedback. The risk register was discussed and the main issues were in access and flow as referrals could be clustered at particular times of the year and many were very time consuming. All referrals were validated by the consultants.
- In neurophysiology governance meetings were held monthly and there were regular staff meetings.

## Leadership of service

- Administration staff in OPD said that the trust was a great place to work, that managers were supportive and that teamwork was good.
- The manager of the OPD said that the executive team were visible and had visited the department, however some of the Health Care Assistants (HCAs) said that they had not seen anyone from the executive team in the OPD department.
- The matron and the OPD manager had identified that nurses in the department were becoming deskilled and that there was a lack of direct patient care for these staff. Training was provided for the vision field equipment and also to undertake the Botox injection clinics. The ward meetings were also used to get ideas and suggestions and to involve the staff in the efficiency savings. A lean programme was undertaken in the OPD to try to better understand why clinics were running late and to streamline services.
- The leadership of the radiology and neurophysiology services effective, robust and forward thinking. Both services had developed significantly over the last few years to meet the demands of the services. In radiology, the manager was well supported with senior staff having specific responsibility for areas of work or pieces of equipment. This meant that staff always knew who to go to for information and support. Training was robust giving staff confidence to work on the on call rota following a competency assessment. The audit programme was extensive and the audit lead was part of the trust audit committee. There was good career progression in radiology and there had been a restructure in the department and a deputy post had been established to support the manager and a number

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of new band seven posts had been developed. The trust had agreed to fund a new MR scanner and building work was underway to house the scanner. This would provide development opportunities for the staff.

- In neurophysiology, the manager had worked to retain staff by providing career development opportunities. The manager had worked closely with local universities to develop training for under-graduate and post-graduate staff.
- The manager in neuropsychology was forward thinking and keen to develop the service. She had worked in the trust as a volunteer before being offered a job in the trust.

## Culture within the service

- Administration staff in OPD said that there was good multi-disciplinary working, good teamwork and that the work was interesting and diverse. They also said that there were good relationships with the doctors and that there was no hierarchy.
- Sickness levels in the OPD were over 8% above the directorate target of 3.7% in January 2016. This was due to a number of staff on long term sickness absence leave. In the period before this, sickness absence was on or about the directorate target.
- Concerns had been raised by members of the HCA staff about the culture in the OPD, these were historical and the trust had addressed these and were continuing to monitor any staff concerns raised in the department.
- A nurse who we spoke with said team working was good and there was a lot of support and a good team spirit. She said that they tried to respond to the concerns and ideas of the HCA's and to implement these as much as possible and to be sensitive to the needs of staff.
- A consultant said that the relationship with the trust board and the executives was good but that there was sometimes too much emphasis on targets, processes, guidelines and performance indicators.
- Staff in radiology liked working in the trust. The variety of work encouraged recruitment as staff needed to be experienced in all modalities for the on-call rota. Staff said the board and the chief executive (CE) were visible and that the CE often visited the department.
- All the radiographers said that the radiologists were approachable and that they had good support from other clinicians including those on the wards. The consultant radiologists said the radiographers were providing a good service.

- The health care scientists' (HCS) in neurophysiology said that they had good relationships with the consultants and that they respected the work that they did, they said that they were approachable and supportive. Staff were enthusiastic and said that they enjoyed their work. A new member of staff had been waiting for a vacancy so that she could apply for a post.
- The manager in neuropsychology was proud of the development of her service and her staff. There was good clinical supervision for all staff members and the manager received supervision from her line manager at her monthly one to one meetings.
- There was a counselling service and a member of staff told us that they had been supported by human resources when they were off sick.

## Public engagement

- The OPD had "answers on a postcard" with a post box located in the waiting areas. The questions were OPD specific and the cards were left on the chairs in the waiting areas. We observed patients completing them and posting them into the box. Patients had fed back that OPD staff were disengaged and "sat round", changes had been made and the staff had become more positive and engaged with the patients.
- In the family and friends test from January 2016 for the OPD, there was a response rate of 19% and 93% of people said they would recommend the trust. The main issues raised were car parking and waiting times.
- There were patient listening weeks when the executive and nonexecutive team spoke to patients about what changes could be made and issues that they had.
- There was a biannual patient survey in radiology, 30 questionnaires were given out in each part of the department dependent on the scanning provided. Most of the comments were about the waiting areas and following these comments the department had been given some funding to upgrade the areas.
- Staff in neurophysiology visited schools to promote the service and the profession. There was a trust open day where the public could visit the trust to see what they did.
- Every neurophysiology patient attending the department was asked to complete a patient survey. In the period July to December 2015, 223 responses were returned.

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## Staff engagement

- There were staff listening weeks when the executive and nonexecutive team spoke to staff about what changes could be made and issues that they had.
- There was a scheme called the 'Ivan Idea' where staff were encouraged to come up with ideas to improve the service; if an idea couldn't be implemented then managers explained to staff the reason for this. One of the suggestions was an outside staff courtyard. Other suggestions had included a waste bin for wheelchair users and a quiet area for staff to take phone calls.
- A consultant said that they did not get a break in the four hour clinic and if they did they were expected to take breaks in the coffee shop adjacent to the OPD, the consultant did not think that this was appropriate.
- Staff undertook fundraising including cake bakes and sponsored walks to raise money.
- There was a counselling service for staff and a nurse who we spoke to said that she was supported while off sick. Some staff commented that the sickness policy was unfair as there was no discretion to distinguish between staff having planned treatment and staff having self-certified sick leave.
- There was an annual trust award ceremony, staff we spoke to said that it was a good event and they looked forward to attending.
- The radiography team had won trust team of the year and were proud of their achievements.
- Staff in radiography said that there was a newsletter called Walton weekly that they received by email. The radiology manager compiled a monthly brief of all information, unless it was urgent, to try to reduce the number of emails received by staff. Staff thought this was useful

- There was a lone worker policy for the radiographers who came into the hospital on call. They were allowed to park at the front of the building and reported to security on arrival. They were issued with walkie-talkies to communicate with security staff.
- Staff in neurophysiology received three to four compliments a month and in one month a student on placement had received ten positive comments and had been nominated for the trust "good catch award".

## Innovation, improvement and sustainability

- The radiologists said that there were opportunities to develop the roles of the radiographers; they felt that there was a role for the radiographers in x-ray guided lumbar punctures for patients who were difficult to lumbar puncture.
- Strategic development in neurophysiology involved the further creation of an advanced healthcare scientist roles to support an area that was previously consultant led. This role was the specialist healthcare scientist and they undertook aspects of theatre monitoring that would have previously been the remit of a consultant neurophysiologist. Clinical supervision was provided by the consultant but the HCS worked independently in theatre, liaising with the consultant to plan the technical aspects of the cases in advance and then reviewing them afterwards. They also supported the consultant in monitoring cases that were particularly complex. The specialist HCS also supervised band seven HCS' in theatre for a range of interventions. Since commencing in post the HCS has presented studies nationally and internationally.

# Specialised rehabilitation

Safe	Good	●
Effective	Outstanding	☆
Caring	Good	●
Responsive	Outstanding	☆
Well-led	Good	●
Overall	Outstanding	☆

## Information about the service

Specialised rehabilitation services were managed through the neurology services at the Walton Centre providing specialist rehabilitation. For this inspection we have used the following definition of rehabilitation as defined by the British Society of Rehabilitation medicine:

“Rehabilitation is an active time limited collaboration of a person with disabilities and professionals, along with other relevant people, to produce sustained reductions in the impact of disease and disability on daily life. Interventions focus on the individual, on the physical or social environment, or a combination of these.”

The Walton Centre hosted the Cheshire and Merseyside Rehabilitation Network, a regional service providing specialist assessment and rehabilitation for people who have suffered traumatic injury or illness. The Rehabilitation Network is a “Hub and Spoke” model that provides services based at The Walton Centre (Hub) on Lipton Ward (specialist hyper acute rehabilitation) and Complex Rehabilitation Unit (CRU). The network offers an integrated co-ordinated pathway to meet the patient’s clinical needs regardless of diagnosis as they progress through their rehabilitation journey and the patient can access any of the rehab levels at any given time.

For the purposes of the inspection we restricted our inspection to services based in the Complex Rehabilitation Unit in the Sid Watkins building. We reviewed how the in-house services liaised with the other parts of the network both internally and with other external providers in the network.

The Walton Centre has 40 specialist rehabilitation beds for patients with intensive rehabilitation needs. The Walton Centre provision consists of ten specialist hyper acute rehabilitation and 30 specialist rehabilitation beds for patients with intensive rehabilitation needs. The hyper-acute Lipton ward is reported under the medicine core service

A multidisciplinary team, made up of different professionals including consultants, specialist rehabilitation nurses, physiotherapists, occupational therapists, speech and language therapists, and dieticians all work collaboratively to help patients recover.

The hospital provides services to a population of 465,000 extending as far as the Isle of Man and North Wales.

We visited The Walton Centre as part of our announced inspection on 5, 6, 7 and the morning of 8 April 2016.

We reviewed the environment and staffing levels and looked at 20 care records and medication records. We spoke with 16 patients and family members, 59 staff of different grades, including nurses, doctors, therapists, ward managers, matrons, domestics, ward hostesses and senior managers who were responsible for rehab 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.

# Specialised rehabilitation

## Summary of findings

Overall we rated specialist rehabilitation services as “Outstanding”. This is because;

- We found that the service provided a wide range of services to meet the needs of its population across a wide geographical area. The service had worked within its commissioning arrangements to implement a complete service redesign of specialised rehabilitation services operating a hub and spoke model to make best use of resources and provide high quality responsive care for people requiring specialist rehabilitation.
- The complex rehabilitation was within the newly opened Sid Watkins building with facilities on the ground floor with easy access to an outdoor area for patients. The CRU had a large purpose built gym with access to various pieces of equipment. Facilities also included a dedicated occupational therapy gym, kitchen, and a speech and language therapy treatment area.
- An independent living flat was available for the use of patients prior to discharge. This was a purpose built rehab facility within the complex rehabilitation unit (CRU), away from the main ward area to enable patients to prepare for returning to living in a home environment but with access to support and assistance if required.
- Staff provided care to people based on national guidance, such as those from the National Institute for Health and Care Excellence (NICE), and were aware of recent changes in guidance. There was clear evidence of local and national audit practice.
- There was a strong multidisciplinary team (MDT) approach to care for patients undergoing rehabilitation. There was a joined-up and thorough approach to assessing the range of people’s needs and a consistent approach to ensuring assessments were regularly reviewed by all team members and kept up to date.
- Outcomes for patients throughout the service were above or in line with the expected national averages. For example, data submitted to the UK Rehabilitation Outcome Collaborative showed that, in comparison to similar rehabilitation units nationally, the complex rehabilitation unit (CRU) had a shorter length of stay than other units, with fewer episodes exceeding the national rehabilitation target at 180 days.
- Patients’ had a comprehensive assessment of their needs throughout their rehabilitation period and data showed that 75% of patients fully achieved their individual goals. Examples of individual goals included activities of daily living, recreational activities and mobility. In addition, the unit was more efficient in terms of referral to assessment and assessment to admission.
- Staff were competent and confident in their roles. The service had a culture of learning and staff had regular access and opportunities for training and development to enhance their skills and knowledge, such as post-graduate training.
- Staff also had access to training and development sessions from the wider rehabilitation network to share learning and outcomes for patients undergoing complex rehabilitation.
- There were systems for reporting actual and near miss incidents across services. Staff were familiar with and encouraged to use the trust’s procedures for reporting incidents. We saw evidence where findings from incidents were discussed and learning was shared. The service had a positive culture of reporting incidents.
- Harm-free care was monitored and we saw patient risk assessments completed and management plans were in place for patients where a risk had been identified. There was clear evidence of local and national audit practice within specialised rehabilitation services.
- People we spoke with during the inspection were complimentary about the staff that cared for them. Patients received compassionate care and their privacy and dignity were maintained.
- Patients were involved in their care, and were provided with appropriate emotional support. The NHS Friends and Family Test (FFT) showed the majority of patients who responded would recommend the service to their friends or relatives.

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- Staff morale was good overall and the neurology division leadership were visible and working hard with to engage with staff and work towards developing the network and developing the culture and ways of working within the new building.
- People were supported to raise concerns or complaints. Complaints were investigated and lessons learnt were communicated to staff.
- All staff knew the trust vision and values of “The Walton Way”. Staff felt part of the wider trust and were established as an integral part of the wider regional rehabilitation network.
- There was a clear governance structure and learning was discussed and disseminated at key meetings.
- There was a risk register for rehabilitation services which was being managed proactively by managers in the division. Staff were aware of key risks and felt informed about key issues affecting the service such as staffing and development of the network.
- The majority of staff said they felt supported and well led. The service was proactive in promoting research and innovation and there was a culture of supporting post graduate education and striving to improve service delivery.

However;

- The trust had reviewed the complexity of the patients and increased care required to meet the patient’s needs but during our visit we noted that there was a lack of visibility of staff on the complex rehabilitation unit (CRU) which had been identified by the service, partially due to the layout of the new building.
- The staff sickness rate was above the target set by the trust.

## Are specialised rehabilitation services safe?

Good



We rated specialist rehabilitation services as “Good” for Safe. This is because;

- Systems and processes were in place for the support of vulnerable adults and children. Staff clearly understood their responsibilities and roles to escalate any safeguarding concerns.
- There were systems for reporting actual and near miss incidents across services. Staff were familiar with and encouraged to use the trust’s procedures for reporting incidents. We saw evidence where findings from incidents were discussed and learning was shared.
- Harm-free care was monitored and we saw patient risk assessments completed and management plans were in place for patients where a risk had been identified. The service had developed a “falls action plan. For the period 2014/15 the trust achieved a 17% reduction in falls compared to the previous year’s figures and a 51% reduction in harm.
- Records we reviewed were completed appropriately and we were able to follow and track patient care and treatment easily.
- The areas we visited were visibly clean and adapted to meet the needs of patients with neurological conditions. The trust had scored high in the patient-led assessments of the care environment (PLACE) scores for cleanliness in 2015.
- The trust had invested in a new system using ultra-V technology to decontaminate ward areas.
- Staff were aware of the need to be open and transparent under the duty of candour regulation. The service had a positive culture of reporting incidents.
- The neurology division overall was achieving the trust target in relation to adherence to mandatory training.
- The trust had reviewed the complexity of the patients and increased care required to meet the patient’s needs.

However;

- At the time of our visit we noted that there was a lack of visibility of staff on the complex rehabilitation unit (CRU) which had been identified by the service, partially due to the layout of the new building.

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- The staff sickness rate was above the target set by the trust.

## Incidents

- There were systems for reporting actual and near miss incidents across specialised rehabilitation services. Staff were familiar with and encouraged to use the trust's procedures for reporting incidents. Staff understood their responsibilities to raise concerns and record safety incidents.
- There were no never events reported for the period February 2015 to January 2016. Never events are serious, wholly preventable incidents that should not occur if the available preventative measures had been implemented.
- From February 2015 to January 2016 specialised rehabilitation services at the trust reported three incidents within the category of moderate harm. One of these was reported as a serious incident which was fully investigated by senior staff. We looked at the root cause analysis which was robust and had clear recommendations, including extra training for staff in the care of diabetic patients. The report also identified clear lessons learned which was cascaded to staff on the unit. We observed that an example of a root cause analysis for an incident was available for staff to read on the staff notice board.
- From April 2015 to March 2016, 299 incidents were reported on the complex rehabilitation unit (CRU); 74 related to violence and aggression from patients and 70 were reported as general accidents on the unit. Staff told us that the complexity of patients had changed since the move to the new building and the senior staff had introduced different ways to support the staff when a patient required close one to one observation. Managers responsible for the running of the service undertook root cause analysis (RCA) of incidents.
- Incidents were discussed at the monthly governance, risk and quality meetings. Lessons learnt from incidents was discussed during team meetings, sisters meetings and divisional meetings. A governance bulletin was also circulated monthly.
- All serious incidents had been investigated and action had been taken to prevent recurrence. The other reported incidents were rated as low or moderate harm.
- Weekly harm meetings took place to discuss incidents and share learning across the division.

- Staff were aware of the need to be open and transparent as part of the duty of candour regulation. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person.
- Multidisciplinary mortality and morbidity reviews were held monthly and rehabilitation services had identified key themes, for example delays in escalation and delayed discharges.

## Safety thermometer

- The trust submitted data as part of the NHS 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 (VTE)), was monitored on a monthly basis. The service achieved over 98% of patients receiving harm-free care with an average of 97% over the period April 2015 to Dec 2015. In April 2016, nationally 93.9% of patients received no harm.
- Results of the safety thermometer were displayed on every ward and area we visited. The results related to that individual ward or area.
- Ward managers had actions in place for improvement when there had been a reduction in performance against previous months. The service had developed a "falls action plan. For the period 2014/15, the trust achieved a 17% reduction in falls compared to the previous year's figures and a 51% reduction in harm. A falls prevention steering group has been set up to analyse any falls that have happened to seek out patterns and risk areas and utilise the learning across the service. This meant that staff on the rehabilitation unit, were proactive in utilising safety information to improve the care patients received.
- Between January 2015 and January 2016, the unit had a low number of reported incidents of patient harm. There were no reported pressure ulcers on the CRU between October 2015 to March 2016. In the same period the service reported only two catheter related urinary tract infections.

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- Guidance from the National Institute for Health and Care Excellence (NICE) states that all patients should have a VTE and a risk of bleeding assessment carried out within 24 hours of admission. This was the case in all the records we reviewed.

## Cleanliness, infection control and hygiene

- The wards we inspected were visibly clean and well organised.
- Staff consistently followed hand hygiene practice and 'bare below the elbow' guidance. Personal Protective Equipment (PPE) such as aprons and gloves were readily available and in use in all areas. There were sufficient hand washing sinks and hand gels. Hand towels and soap dispensers were adequately stocked.
- The unit used 'I am clean' stickers to inform colleagues at a glance that equipment or furniture had been cleaned and was ready for use.
- Between April 2015 and February 2016, the trust overall reported a total of eight cases of clostridium difficile and one incident of Methicillin-Resistant Staphylococcus aureus (MRSA) infection meaning the trust was on plan to meet its locally set target. This information was trust-wide and not specific to specialised rehabilitation services.
- Side rooms were used as isolation rooms for patients identified as an increased infection control risk. During our inspection there was a carbapenemase-producing enterobacteriaceae (CPE) positive patient. CPE is a strand of bacteria that has developed resistance to a number of strong antibiotics. Staff were adhering to strict barrier nursing with this patient. Plans were in place to ensure the patients room was cleaned appropriately and specific deep cleaning regimes were in place.
- It is important there is clear signage for isolation rooms so that staff and visitors are aware of the increased precautions they must take when entering and leaving the room. We observed staff adhering to the necessary precautions to minimise the risk of cross infection. However, one door did not have clear signage indicating that the patient was identified as an increased infection control risk. We raised this with senior staff who rectified the situation immediately.
- Cleaning schedules had been completed regularly to indicate that cleaning had taken place and cleaning materials were securely locked away.

- Patients on the ward reported that they were happy with the overall cleanliness of the wards and said that staff always washed their hands before any care or treatment was given.
- Hand hygiene audits were completed in line with the world health organization (WHO) 'five moments of hand hygiene' which describes the key points at which hand hygiene should be completed by health care staff. Hand hygiene results were generally around 100% but nothing less than 97%.
- Infection, prevention and control audits were also carried out on a monthly basis on the unit. These identified good practice and areas for improvement. Key actions were identified to be implemented by staff, for example ensuring that clear signage was in place on individual rooms to alert staff and visitors of an infection present.

## Environment and equipment

- In order to maintain the security of patients, visitors were required to use the intercom system outside wards to identify themselves on arrival before they were able to access the ward and staff had access codes.
- There were systems in place to maintain and service equipment. Stickers indicated that regular portable appliance testing had been carried out in all cases and electrical safety certificates were in date. Records indicated that hoists had been serviced appropriately. We checked a range of equipment including vital sign monitors, defibrillators, and hoists.
- Resuscitation equipment was available to CRU. Resuscitation trolleys were locked with tamper seals in place. Records indicated that checks of the equipment had been completed on a regular basis.

## Medicines

- Controlled drugs were appropriately stored in line with legislation. Access was restricted to authorised staff and accurate records were maintained. The storage and monitoring of medicines and intravenous fluids was largely managed according to trust policy. We reviewed fridge temperature records, which we found to be up to date and staff were recording the range as well as current temperature. Staff told us how they would raise concerns if the temperature was outside the maximum or minimum range. However we found one medicine which was open, past its expiry and could still be used as it hadn't been destroyed. We raised this with the unit manager and it was addressed immediately. One

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respiratory medicine did not state the date removed from the original packaging and therefore it could not be guaranteed as safe for administration as there was no clear batch number or tracking information on the individual medicine.

- We checked the medicines and equipment for emergency use and found emergency drugs were available and were found to be within the expiry date.
- The trust used an electronic prescribing and medicines administration (EPMA) system, which had a number of benefits in terms of the safety and quality of services provided for patients such as reducing medication errors due to reducing the need for transcribing records and issues of legibility of records.
- The pharmacy provided a medicines reconciliation and discharge service. On one day during our visit, 68% of patients had their medicines reconciled within 24 hours.
- Ward staff and managers were able to describe how to report incidents involving medicines and we saw examples of how learning from incidents was shared.

## Records

- The trust had recently introduced an electronic records system to record care and treatment for patients. The service was using a hybrid of paper and electronic records. We looked at 15 sets of records in total. All of them contained entries that were dated; there was evidence that care plans were completed for patients as appropriate and documentation that consent had been obtained when needed. These records were clear, and up to date.
- Records included fully completed risk assessments, such as for nutrition, pressure relief and pain management control. Risk assessment forms completed by the nursing teams were complete and easily accessible. The documentation for the intentional observation rounds were in paper format and kept in each individual patient's room. This allowed staff to carry out their required clinical activities for patients.
- The units we visited had lockable medical notes trolleys. However, on one unit the trolley had not been locked. This increased the potential for patient confidentiality to be breached.

## Safeguarding

- The trust had a safeguarding policy and staff knew where to locate a copy if required. The policy covered a range of issues, which included domestic and sexual abuse.

- Safeguarding procedures were in place and staff knew how to refer a safeguarding issue to protect adults and children from abuse. Flow charts were available in staff areas for easy access to information if required. A staff member was able to describe a recent safeguarding case for the unit including a child safeguarding concern. There was a trust-wide safeguarding team in place that were available during normal working hours and the unit had a lead nurse who was trained to safeguarding level 3. Staff had access to advice out of hours and at weekends.
- Safeguarding training was included as part of the trusts mandatory training programme. Data, provided by the trust, showed the service had achieved 92% for level one safeguarding which was above the trust target of 85% for safeguarding adults. Data provided by the trust also showed that the service had achieved the trust target for Level one children's safeguarding and was just below the level two children's safeguarding at 80%.

## Mandatory training

- Staff received mandatory training on a rolling programme in areas such as infection control and medicines management, safeguarding, manual handling and fire. Mandatory training was delivered both as face to face sessions and via e-learning. Training included core clinical skills training as part of the mandatory training requirements. Mandatory training included; safeguarding falls, health and safety, and fire.
- Data provided by the trust showed in January 2016, the neurology division had achieved 88% compliance with mandatory training which was better than the trust target of 85%.

## Assessing and responding to patient risk

- A modified early warning score system for neurological patients called neurological early warning system (NEWS) was used throughout the trust to alert staff if a patient's condition was deteriorating. This involved monitoring a basic set of observations such as respiratory rate, temperature, blood pressure and pain score, to alert staff to any changes in a patient's condition. The service monitored all patients using the NEWS system. Data provided by the trust showed 97% compliance with the trust standard for observations of patients.
- Records we reviewed indicated that early warning indicators were regularly checked and assessed. When

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the scores indicated that medical reviews were required, staff had escalated their concerns. There was access to an outreach service available within the hospital 24 hours a day, seven days a week the surgical medical acute response team (SMART). Repeated checks of the early warning scores were documented accurately.

- Upon admission to the CRU, staff carried out risk assessments to identify patients at risk of harm. 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, use of bed rails, pressure ulcers and nutrition (Malnutrition Universal Screening Tool (MUST)).
- At the time of our inspection, all risk assessments for patients had been completed in the records we inspected. We reviewed 15 patient records and found that care plans contained the necessary information to ensure that patients were not at risk and care was managed safely.
- We reviewed 15 patient records and found that care plans contained the necessary information to ensure that patients were not at risk and care was managed safely.
- The falls team were involved in undertaking pro-active ward visits to review patient risk assessments and work with staff to increase knowledge, understanding and ownership of the risk reduction strategy for falls.
- Intentional observation rounds were carried out by nurses every two to four hours depending on individual need to assess patient risk on an ongoing basis. These observation rounds helped to ensure that vulnerable patients were provided with regular help and support and ensure early response time to a patient's changing condition.

## Nursing staffing

- Data provided by the trust showed that staffing levels were in line with expected staffing establishments set by the trust. However, we compared the service staffing levels with specialised Neuro-rehabilitation Service Standards (2015) for minimum staffing for inpatient rehabilitation services for level 1a and 1b beds. We looked at one month's staff rotas for March 2016 and compared these with the national standards for both Health Care Assistants (HCAs) and qualified nursing staff. We found in the CRU they failed to meet the standards for HCAs by one member of staff on each day time shift for the time period looked at. A shift coordinator was in

place to offer support and overview of the unit. The lack of appropriate staff may affect the ability of staff to meet the needs of the complex patients accommodated on the unit.

- During our visit we noted there was a lack of visibility of staff on the complex rehabilitation unit (CRU) which had been identified by the service partially due to the layout of the new building.
- Data showed that an incident form had been submitted the day before our unannounced inspection when a patient had missed their therapy appointment due to the pressure on nursing staff on the ward to attend to the patients in the morning.
- We found the staff sickness rate was above the target set by the trust.
- Data provided by the trust showed the sickness rates for the CRU as of December 2015 were 9.9% for qualified staff and 10.5% for health care assistants, which was much higher than the trust target of 3.8%.
- Senior managers confirmed that, because of the need for good privacy and clinical reasons, the ward was laid out as single rooms, this meant that it was not always possible to have line of sight of staff and it could take a visitor or relative, on occasions, a few minutes to find a member of staff. The trust had previously trialled different staffing approaches to address this and plans were in place to pilot a 'meet and greeter' role to welcome and orientate relatives/ visitors to the ward and ensure greater visibility.
- Data provided by the trust confirmed that staffing on CRU had been increased on three occasions from 2014. Once in 2014, in response to the increased acuity of the patients cared for following changes in service delivery and the implementation of the wider rehabilitation network; in early 2015, when the service relocated to the Sid Watkins Building in recognition of the ward's layout of single rooms and large foot print; and at the start of the financial year 2015/16 when the trust was commissioned to open additional beds.
- Staffing levels were reviewed bi-annually as part of the trust's safe staffing reviews. This was an evidence based tool which allows nurses to assess patient acuity and dependency and to determine the recommended number of staff.
- In quarter four of 2015/16, the trust had received 'high assurance' from its internal auditors, the highest level of assurance possible, for both its daily escalation/staffing actions and the bi-annual reviews.

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- Within the service due to dependency levels of patients and the complex investigations, treatment and behaviours the recognised safe staffing levels were 1:8 ratios on the Complex Rehabilitation Unit (CRU).
- We noted that adjustments were made for patients requiring one to one support or close observation. For these patients, the trust expected that the minimum number of non-qualified staff should be six on day shifts and five at night. The unit was achieving this.
- The staff fill rate data supplied from the trust, which showed the planned versus actual levels of staff on the wards, identified that the majority of shifts were being covered by the correct number of nursing staff.
- The average percentage of qualified nursing and unqualified nursing shifts filled during January 2016 ranged from 104% to 78% for qualified staff and up to 130% for unqualified staff. This figure included staff allocated to the ward to meet the needs of patients requiring one to one support above the established staffing levels.
- Senior managers met daily to discuss staffing and ensure there was adequate cover and skill mix of staff across rehabilitation services. Each ward had a planned nurse staffing rota and any shortfalls in staff numbers were reported on a daily basis to senior managers.
- Wards displayed nurse staffing information on a board at the unit entrance. This included the planned and actual staffing levels. This meant that people who used the services were aware of the available staff and whether staffing levels were in line with the planned requirements.
- There were 26.45 whole time equivalent (WTE) therapies staff covering this service.

## Medical staffing

- Consultants provided an on call rota for both Hub and Spoke units within the rehabilitation network, which provided 24 hours, seven days cover. The service had 4.2 WTE consultant cover for the CRU and a consultant was available on call from home between 10pm and 8am.
- Junior doctors were available through the neurology division medical rota. The information we reviewed showed that medical staffing on the medical care wards was appropriate at the time of the inspection.
- A night team was available all week between 9pm and 9am, which included medical staff and advanced nursing practitioners.

- The percentage of consultants working in the hospital was 54%, which was above the England average of 39%. The percentage of registrars was 41 % which was higher than the England average of 38%.

## Major incident awareness and training

- There were major incident plans within specialised rehabilitation service areas and these listed key risks that could affect the provision of care and treatment.
- There were clear instructions for staff to follow in the event of a fire or other major incidents.
- Staff were aware of what they would need to do in a major incident and knew how to find the trust policies, key documents and guidance.

## Are specialised rehabilitation services effective?

Outstanding



We rated specialist rehabilitation services as “Outstanding” for Effective. This is because;

- Staff provided care to people based on national guidance, such as those from the National Institute for Health and Care Excellence (NICE), and were aware of recent changes in guidance. There was clear evidence of local and national audit practice.
- Outcomes for patients throughout the service were above or in line with the expected national averages. For example, data submitted to the UK Rehabilitation Outcome Collaborative showed that, in comparison to similar rehabilitation units nationally, the complex rehabilitation unit (CRU) had a shorter length of stay than other units, with fewer episodes exceeding the national rehabilitation target at 180 days.
- Patients’ had a comprehensive assessment of their needs throughout their rehabilitation period and data showed that 75% of patients fully achieved their individual goals. Examples of individual goals included activities of daily living, recreational activities and mobility. In addition, the unit was more efficient in terms of referral to assessment and assessment to admission.

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- A variety of local audits were also carried out by different professional groups. For example, speech and language therapy audits for communication and swallowing disorders and physiotherapy practice audits. The results were used to sustain and improve practice.
- On admission, patients typically presented with a diverse range of medical, physical, sensory, cognitive, communicative, behavioural and social needs and required specialist multidisciplinary care. Patients generally had higher rehabilitation complexity (for example patient categorisation and rehabilitation complexity scale) and greater functional gain (motor and cognitive) on discharge from the service.
- There was a strong multidisciplinary team (MDT) approach to care for patients undergoing rehabilitation. There was a joined-up and thorough approach to assessing the range of people's needs and a consistent approach to ensuring assessments were regularly reviewed by all team members and kept up to date. The trust had carried out its own review of the MDT working and actions were put in place to engage all professional groups including nursing staff to create a fully effective MDT.
- Fortnightly MDT goals were set on the complex rehabilitation unit (CRU) for each patient. These were discussed by the MDT to review whether they had been achieved. MDT meetings took place regularly and were attended by the ward manager, nursing staff and therapy staff such as a physiotherapist and occupational therapist.
- Staff had access to the information they needed to deliver effective care and treatment to patients in a timely manner including test results, risk assessment and medical and nursing records. An electronic version of MDT documentation had also been developed, which was being reviewed by the lead consultant for possible implementation.
- The service had a number of link nurses who had been given additional training to offer advice and guidance to other staff in areas such as infection control, pressure ulcer care, tissue viability and end of life care. The service also had access to a number of clinical nurse specialists for advice and support for areas such as falls and discharge planning.
- Discharge processes were effective. The service had a dedicated discharge co-ordinator and social worker to facilitate the discharge process and they were linked in closely to the goal setting meetings so that they could start the discharge processes when the patient was ready for that to happen.
- Patients' discharged from the service were able to take their rehabilitation plans with them for continuity of care, including a one page profile with an overview of key information for the patient to take with them to the service that would continue the delivery of their rehabilitation service.
- Staff were competent and confident in their roles. The service had a culture of learning and staff had regular access and opportunities for training and development to enhance their skills and knowledge, such as post-graduate training.
- Staff also had access to training and development sessions from the wider rehabilitation network to share learning and outcomes for patients undergoing complex rehabilitation.
- Patients were well supported in meeting their individual nutritional and hydration needs. Nutritional assessments were regularly completed and appropriate onward referrals were made to support patients at risk of malnutrition.
- Pain scores were completed regularly in the records we reviewed and there was appropriate access to pain relief when required. Staff had access to information they needed to support patients.
- Staff knew the principles of consent and we saw written records that consent had been obtained from patients prior to procedures. All staff we spoke to knew about the key principles of the Mental Capacity Act (MCA) 2005, the associated Deprivation of Liberty Safeguards (DoLS) and how these applied to patient care. We saw clear documentation for best interest decisions for people who lacked capacity to make their own decisions and we saw examples of correctly completed DoLS paperwork.

## Evidence-based care and treatment

- Staff provided care to people based on national guidance, such as National Institute for Health and Care Excellence (NICE) guidelines, and were aware of recent changes in guidance. There was clear evidence of local and national audit practice within specialised rehabilitation services. Outcomes throughout the service were above or in line with the expected national

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average. We were provided with the service clinical audit report which demonstrated regular auditing (and reporting back) of services throughout the division to deliver high quality effective care.

- The trust monitored adherence with national standards through regular audit and monitoring of quality standards such as the quality standards for unscheduled care acute neurology by the Association of British Neurologists.
- The trust contributed to all the national clinical audits it was eligible to participate in.
- Data provided by the trust showed a variety of local audits carried out by different professional groups for example speech and language therapy audits for communication and swallowing disorders and physiotherapy practice audits.

## Pain relief

- Pain relief was reviewed regularly for efficacy and changes were made as appropriate to meet the needs of individual patients.
- We saw that the level of pain patients were in was recorded on early warning scores documentation.
- The service had access to the pain management team for support and guidance through the week.

## Nutrition and hydration

- Fluid balance charts were fully completed and records showed that patients' had an assessment of their nutritional needs using the Malnutrition Universal Screening Tool (MUST) and were referred to a dietician where necessary. The MUST is a validated nutritional screening tool with five simple steps, designed to identify adults at risk of malnutrition. The tool allows patients to be categorised as being at low, medium or high risk of malnutrition and enables care plans to be designed to address any risks of malnutrition.
- A coloured tray and jug system was in place to highlight patients' that needed assistance with eating and drinking. Smaller trays were used for patients requiring a special diet.
- When we arrived for the unannounced inspection, we found cold food on a tray outside a patient's room and it was not clear if the patient had missed their meal, how this was being recorded or what system was in place to make sure that the individual would not miss a meal. We raised this with the nurse in charge who confirmed that the patient would be provided with another hot

meal. It is important to make sure systems are in place to ensure that patients receive appropriate nutrition particularly when they have an enhanced nutritional need.

- All but one patient we spoke with said they were happy with the standard and choice of food available.

## Patient outcomes

- The CRU generally performed better than average for patient outcomes when compared to similar units. A full data set of rehabilitation outcome measures was submitted monthly to the UK Rehabilitation Outcome Collaborative. We reviewed the summary benchmarking report for the last three years. The results for the complex rehabilitation unit (CRU) showed that, in comparison to other comparable units nationally, the CRU had a shorter length of stay than other units with fewer episodes exceeding the national rehabilitation target at 180 days.
- The unit was more efficient in terms of referral to assessment and assessment to admission.
- Patients on the unit were defined as having highly complex rehabilitation needs (for example patient categorisation and rehabilitation complexity scale). They also were shown to have greater functional gain (motor and cognitive) on discharge.
- The trust was involved in a project to produce specialist trust mortality indicators, which were due for completion in March 2017.
- Data showed that 75% of patients fully achieved their individual goals, for example activities of daily living, recreational activities and mobility.
- Patients had an individualised care plan, with goals that were regularly reviewed and updated in the records we reviewed.

## Competent staff

- The service held monthly planned sessions which was attended by all the different professionals working on the CRU. The medical staff attended a monthly teaching session.
- Staff told us they were well supported with training and appraisals. The use of appraisals is important to ensure that staff have the opportunity to discuss their development needs or support required to help them carry out their job role. The CRU balanced scorecard for

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February 2016 showed that 78% of staff on CRU had access to an appraisal in the previous twelve months prior to our inspection. This was below the trust's target of 90%.

- There were systems in place to ensure that staff were enabled to deliver effective care and treatment. Local managers held the training needs analysis and were aware of the skills and knowledge required to ensure that the staff were able to care for their patients.
- The SMART team comprised of advanced critical care practitioners (ACCPs), doctors of various grades and nursing staff, all of whom had a background in critical care or anaesthesia and held current Advanced Life Support Certificates to ensure that they were skilled to manage emergency care appropriately.
- The CRU had a number of link nurses, these were nurses trained to offer advice and guidance to other staff in areas such as infection control, pressure ulcer care, tissue viability and end of life care. The service also had access to a number of clinical nurse specialists for advice and support for areas such as falls and discharge planning.
- Staff also had access to training and development sessions from the wider rehabilitation network to share learning and outcomes for patients undergoing complex rehabilitation.
- Qualified staff told us there were formal systems for clinical supervision and they felt well supported to develop their clinical skills and knowledge. Data provided by the trust confirmed this. 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 service had a culture of learning and staff had regular access and opportunities for post-graduate training and development to enhance their skills and knowledge.
- Newly appointed staff said that their inductions had been planned and delivered well. Managers confirmed that there were systems in place to allow staff to work as unqualified staff until the necessary training and induction had been completed.
- The service had practice education facilitators to act as mentors to newly qualified staff. They were also involved in arranging and monitoring training and staff development.

## Multidisciplinary working

- A multidisciplinary team, made up of many different professionals including consultants, specialist rehabilitation nurses, physiotherapists and occupational therapists, speech and language therapists, dieticians all worked collaboratively to help patients recover.
- We observed practice, reviewed records and discussed with staff, which confirmed that there were effective multidisciplinary team (MDT) working practices in place. There was a joined-up and thorough approach to assessing the range of people's needs and a consistent approach to ensuring assessments were regularly reviewed by all team members and kept up to date.
- The therapies, neurophysiology, radiology and neuropsychology services all sat within the division of Neurology but delivered services for patients across both neurology and surgical divisions. Allied Health Professionals (AHPs) were seen as integral to the multidisciplinary care provided. MDT working is a process that includes, professional meetings; ward round, goal setting and liaison with family and carers that is facilitated by the rehabilitation co-ordinators. Where MDT actions were not being met, the co-ordinator would prompt the appropriate profession and feedback will be given at the next MDT.
- Fortnightly MDT goals were set on the complex rehabilitation unit (CRU) for each patient. These were discussed by the MDT to review whether they had been achieved. MDT meetings took place regularly and were attended by the ward manager, nursing staff and therapy staff such as a physiotherapist and occupational therapist. However, we observed that nursing staff did not always attend.
- The trust audited the attendance at MDT meetings over a six week period between October and November 2015. This results showed that there was an over representation of therapy staff. As a result, the MDT was reorganised into two teams to make it more effective. The service was currently looking at how effective the MDT meeting was operating as well as the overall MDT processes.
- An electronic version of MDT documentation had been developed and was being reviewed by the lead medical consultant for possible implementation.

# Specialised rehabilitation

- The service had a dedicated discharge co-ordinator and social worker to facilitate the discharge process. They were linked in closely to the goal setting meetings so that they could start the discharge processes, if required.
- We observed handovers, which included healthcare assistants, nurses and medical staff. There was effective communication and were well structured. We also observed a daily therapy nursing handover as well as the weekly MDT meeting.
- The trust had a local agreement in place which enabled them to have 24 hour access to a local NHS trust for a mental health consultant. The service also had access to psychology services for patients when required.

## Seven-day services

- Consultant cover was available on site from 8am to 9pm, seven days a week with on call provision out of hours.
- Diagnostic services were available 24 hours a day, seven days a week
- Access to pharmacy services were available 24 hours a day seven days a week.
- The nursing team provided 24 hours, seven days per week cover.
- The therapy service was provided Monday to Friday 8.30am to 4.30pm and the Rehabilitation Co-ordination Service (Clinical Nurse Specialists) was also available Monday to Friday, 8.30am - 5.30pm. Emergency on call therapy was available for respiratory conditions.

## Access to information

- Trust policies were regularly reviewed and covered most aspects of clinical and operational management. These were accessible via the hospital intranet to all staff. Policies and protocols were kept on the hospital's intranet which meant all staff had access to them when required.
- Staff had access to the information they needed to deliver effective care and treatment to patients in a timely manner including test results, risk assessment and medical and nursing records.
- There were computers available on the wards we visited which gave staff access to patient and trust information.
- A new electronic system had been recently introduced for nursing and therapy records. Health care assistants (HCAs) did not have access to the electronic system at the time of our inspection. Paper charts and individual care plans were available to enable HCAs to update the

regular observations. The medical notes were still in written format and staff acknowledged that further work was required for a fully integrated system. Staff were very positive about the initial benefits of the system with improved access to information, such as risk assessments and therapy plans.

- On discharge from the rehabilitation units, patients were able to take with them their rehabilitation plans for continuity of care, including a one page profile with an overview of key information for the patient to take with them to the service that would continue the delivery of their rehabilitation service.
- When patients were discharged, communication was sent to the patients GP with a copy of the letter sent to the patient. In December 2015, the neurology division achieved 98.5%, which was above the trust's target of 90% for a copy of the letter to be sent to patients within fourteen working days.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- There was an up to date trust wide policy for mental capacity, best interest decisions and deprivation of liberty available on the intranet. Staff knew how to access the policy on the intranet and had access to support from the rehabilitation coordinators.
- All staff knew about the key principles of the Mental Capacity Act (MCA) 2005 and how these applied to patient care. Staff understood the application of considering capacity, consent and deprivation of liberty and ensuring adjustments such as access to specialist support and carer support are applied.
- Staff had knowledge and understanding of procedures relating to the Deprivation of Liberty Safeguards (DoLS). DoLS 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.
- We saw examples of DoLS paperwork and found consistent compliance with appropriate deprivation of liberty documentation.
- We also saw clear documentation for best interest decisions for people who lacked capacity, including written evidence of involvement of nominated advocates for individuals with no next of kin. This was also reviewed at the weekly MDT meetings.

# Specialised rehabilitation

- Staff knew the principles of consent and we saw written records that consent had been obtained from patients prior to procedures.

## Are specialised rehabilitation services caring?

Good



We rated specialist rehabilitation services as “Good” for Caring. This is because;

- Patients told us staff were caring, kind and respected their wishes. We saw staff interactions with people that were person-centred.
- People we spoke with during the inspection were complimentary about the staff that cared for them.
- Patients received compassionate care and their privacy and dignity were maintained
- Patients were involved in their care, and were provided with appropriate emotional support.
- The NHS Friends and Family Test (FFT) showed the majority of patients who responded would recommend the service to their friends or relatives. FFT response rates were in line with the national average.
- A “My Rehab Folder” had been produced in response to relatives request for more information to include all the necessary information patients need regarding their rehabilitation.
- The staff had introduced the use of e-diaries so that a patient received a video on discharge and had a visual record of the progress they had made during their period of rehabilitation.
- The service worked very closely with the neurological charities and many of the staff contributed to these in their own time, lecturing to patient groups and delivering education.

### Compassionate care

- Staff assisted patients with kindness and with patience, showing them respect and protecting their dignity by closing doors and curtains. All care was delivered in side rooms or in bays. However, we witnessed one person being transferred from the bathroom not covered up to protect their dignity.
- All the patients and families we spoke with were positive about their care and treatment.

- The NHS Friends and Family test (FFT) average response rate for the service was 45%, which was higher than the England average of 33%. The friends and family test asks patients how likely they are to recommend a hospital to friends and family after treatment. Data provided by the trust showed for the period January 2015 to December 2015 that performance at ward level was generally good and 98% of patients/carers would recommend the rehabilitation services to their friends and relatives. In addition, 94% of patients/carers rated their overall satisfaction of the rehabilitation service as very satisfied or satisfied.
- The service carried out care, comfort and communication checks (three C’s) at least every two hours, on every patient to make sure that they were supported and their needs met appropriately.

### Understanding and involvement of patients and those close to them

- Patients had a named key worker as well as nurse, therapist and consultant.
- Staff communicated with patients and families on a regular basis, discussing treatment plans and allowing them to be involved in their care.
- Several groups were run by therapy staff on a rolling programme to provide individuals with specific training, such as cognitive education and upper limb work. Individual invites were made to relatives to attend groups to support their family member.
- A “My Rehab Folder” had been produced in response to relatives request for more information to include all the necessary information patients need regarding their rehabilitation.
- Patients confirmed they had been involved in their care and were aware of their rehabilitation plans.
- Data provided by the trust in the 2014/15 Cheshire and Merseyside Rehabilitation Network annual report patient feedback survey, showed that 100% of patients/carers strongly agree/agree that staff involved them in setting their goals and decisions about their rehabilitation care.
- The majority of patients except one we spoke with said they had received good information about their condition and treatment.
- Additional support was available, including signposting to other agencies and local charities to involve patients and families in safe discharge or transfer from hospital.

# Specialised rehabilitation

- The staff had introduced the use of e-diaries so that a patient received a video on discharge and had a visual record of the progress they had made during their period of rehabilitation.
- The service worked very closely with the neurological charities and many of the staff contributed to these in their own time, lecturing to patient groups and delivering education.

## Emotional support

- The majority of staff said they had sufficient time to spend with patients when they needed support. However, other staff felt that recent pressures on workload meant this did not always happen.
- Chaplaincy services were available for patients 24 hours a day, seven days a week.
- Assessments for anxiety and depression were recorded to recognise if a patient required additional emotional support.
- Nurse specialists would provide specific support for patients, for example the nurses offered additional emotional support for patients and their families.
- Psychological support services were available to patients to support them to come to terms with their condition.

## Are specialised rehabilitation services responsive?

**Outstanding**



We rated specialist rehabilitation services as “Outstanding” for Responsive. This is because;

- We found that the service provided a wide range of services to meet the needs of its population across a wide geographical area. It was noted that the service had worked within its commissioning arrangements to implement a complete service redesign of specialised rehabilitation services operating a hub and spoke model to make best use of resources and provide high quality responsive care for people requiring specialist rehabilitation.
- The single point of access provided a network wide service to referrers which ensured that patients had timely admissions to the appropriate levels of

rehabilitation. The specialist rehabilitation multidisciplinary team included all the relevant specialities who worked together to support patients along a coordinated pathway of care.

- The rehabilitation network offered an integrated co-ordinated pathway that met the patient’s clinical needs regardless of diagnosis as they progress through their rehabilitation journey and the patient could access any of the rehabilitation levels at any given time.
- The complex rehabilitation unit (CRU) was within the newly opened Sid Watkins building with facilities on the ground floor with easy access to an outdoor area for patients. The CRU had a large purpose built gym with access to various equipment. Facilities also included a dedicated occupational therapy gym, kitchen and speech and language therapy treatment area.
- An independent living flat was available for the use of patients prior to discharge. This was a purpose built rehab facility within CRU away from the main ward area to enable patients to prepare for returning to living in a home environment but with access to support and assistance if required.
- Staff were focussed on patient-centred care, supporting the development and use of one page profiles for each patient. This gave staff information at a glance to show the patient’s likes, dislikes and what was important to them. Patients were able take this with them on discharge or to future rehabilitation at services closer to their own home, which provided continuity.
- We found a range of individual assessments and programmes were in place to meet the needs of patients and their families. For example, a self-management programme had been developed to enable patients start self-management earlier in the rehabilitation process.
- Individual treatment goals were set and reviewed at the weekly multidisciplinary team (MDT) meeting. There were also four weekly goal setting meetings to which relatives were invited. This involved reviewing progress and agreeing new goals to work towards, with the ultimate aim of discharge.
- The service had used animations to produce patient and staff experience films which were available on the internet. For example, a cognitive education programme for patients and their carers to have a better understanding of cognitive impairments and inappropriate behaviour.

# Specialised rehabilitation

- The service had a purpose built rehabilitation flat accommodation within the rehabilitation unit to enable them to access cognitive education and develop their skills and plan for discharge. This also supported patients to live semi-independently in an environment where they could also access support and allowed them to trial what it would be like if they were living at home independently before discharge.
- The service was in the process of recruiting an activity coordinator for the unit to help respond to individual needs whilst patients are on the unit.
- People were supported to raise concerns or complaints. Complaints were investigated and lessons learnt were communicated to staff.

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

- We found the complex rehabilitation unit provided a wide range of services such as therapy support to meet the needs of its population across a wide geographical area.
- The service had worked within its commissioning arrangements to implement a complete service redesign of specialised rehabilitation services. The service operated a hub and spoke model to make best use of resources and provide high quality responsive care for people requiring specialist rehabilitation.
- The rehabilitation network offered an integrated co-ordinated pathway that met the patient's clinical needs regardless of diagnosis as they progress through their rehabilitation journey and the patient could access any of the rehabilitation levels at any given time.
- The trust provided specialised rehabilitation at the hub of the regional rehabilitation network including complex rehabilitation for patients following severe illness or injury, regardless of diagnosis. The trust also provided the administrative/coordinating function for the entire network.
- The single point of access provided a network wide service to referrers which ensured that patients had timely admissions to the appropriate levels of rehabilitation. The specialist rehabilitation multidisciplinary team included all the relevant specialities who worked together to support patients along a coordinated pathway of care.

- Due to the very large geographical catchment area, including the Isle of Man and North Wales, the trust had a dedicated discharge coordinator to facilitate discharge back to a trust in the patient's local area once specialist treatment was completed.
- The service had used animations to produce patient and staff experience films which were available on the internet. For example, a cognitive education programme for patients and their carers to have a better understanding of cognitive impairments and inappropriate behaviour.
- Throughout our visit we found that way finding around the ward was not always easy. Individual areas such as toilets were not signed by gender which would be difficult for someone with cognitive impairment to negotiate.

## Meeting people's individual needs

- Following referral to the service, patients were reviewed and triaged by the single point of contact (rehabilitation co-ordinator/clinical nurse specialist). The patient was then discussed at a weekly allocation meeting with the consultants. This was to determine the most appropriate place of rehabilitation, such as hub, spoke, extended rehab, community. Once the decision had been made, the patient was medically accepted.
- On admission the patient had a full multidisciplinary assessment. They were introduced to their co-ordinator whose role was to facilitate the patient through their journey through the pathway from admission to discharge.
- Individual treatment goals were set and reviewed at the weekly multidisciplinary team (MDT) meeting. There were also four weekly goal setting meetings to which relatives were invited. This involved reviewing progress and agreeing new goals to work towards, with the ultimate aim of discharge.
- A self-management programme had been developed to help patients start self-management earlier in the rehabilitation process and support them to manage their complex long term conditions in early inpatient rehabilitation settings.
- There were individual programmes and sources of support that included the routine presence of local support groups on the ward. However, we found that information about the programmes were not easily visible to families and visitors. For example, contact numbers for the local support group.

# Specialised rehabilitation

- Staff informed us patient information was available, upon request, in various different languages. However, we found few signs informing relatives and patients that they could access this information.
- Staff had access to translation services if the patient's first language was not English. Staff confirmed they knew how to access these services. Staff knew how to access information in an accessible format, for people living with dementia or learning disabilities, and in braille for patients who had a visual impairment.
- Staff were focussed on patient-centred care, supporting the development and use of one page profiles for each patient. This gave staff information at a glance to show the patient's likes, dislikes and what was important to them. Patients' were able take this with them on discharge or to future rehabilitation at services closer to their own home, which provided continuity.
- The service had a purpose built rehabilitation flat accommodation within the rehabilitation unit to enable them to access cognitive education and develop their skills and plan for discharge. This also supported patients to live semi-independently in an environment where they could also access support and allowed them to trial what it would be like if they were living at home independently before discharge.
- The trust had developed a 'home from home' service which provided accommodation for relatives. The accommodation provided was of a high standard and relatives were able to access refreshments. This was particularly valuable for families who had travelled a long distance as the catchment area for the service extended as far as North Wales and the Isle of Man.
- The service was in the process of recruiting an activity coordinator for the unit to help respond to individual needs whilst patients are on the unit.
- Patients said if they used the call bell, nurses attended to their needs promptly, and were checked regularly by staff.
- The trust used assistive technology, such as communication applications and sophisticated switch systems to maximise independence for individuals with specific communication impairment.
- The rehabilitation service piloted therapeutic one to one care before it was cascaded and implemented across the trust. The service had introduced the concept of therapeutic one to one care for some patients because they are, for example, at risk of falling. Therapeutic one to one care sees staff learn more about

the patient, their hobbies and interests in a structured way, and take part in activities they like. The aim was to make it more constructive, leading to better patient experience and enhancing the patient's rehabilitation.

- There was a nominated lead nurse for patients living with dementia or a learning disability. Staff could access them for advice and training if required.
- The trust had an agreement with a local NHS trust which enabled them to have 24 hour access to a mental health consultant. The service also had access to psychology services for patients when required.
- The trust had had no mixed sex breaches in the twelve months period prior to our inspection.
- The service had used animations to produce patient and staff experience films which were available on the internet. For example, a cognitive education programme for patients and their carers to have a better understanding of cognitive impairments and inappropriate behaviour.

## Access and flow

- There was a clear admissions and discharge policy that was available on the intranet. Staff had a good knowledge of the policy and told us that it was adhered to.
- For the period April 2014 to March 2015, 52% of patients met the criteria for referral. This was less than the previous financial year (2013/14), when 68% of referrals met the criteria. Patients who did not meet the criteria for the service were signposted to other appropriate rehabilitation services, for example stroke rehabilitation, spinal cord injury rehabilitation and intermediate care. The service was being proactive to ensure that stakeholders were aware of the admission criteria to the unit.
- In prioritising individual patients, beds were allocated according to the level of rehabilitation needs and complexity. The service also aimed to optimise flow of patients through the system, for example patients requiring admission direct to a spoke for multidisciplinary active rehabilitation were not delayed at times of high demand. Waiting times were monitored and were part of the prioritisation process.
- Patients who had been discharged from the hub or spoke units as a result of a clinical interruption such as acute illness exceeding 14 days were prioritised for admission within seven days following medical acceptance.

# Specialised rehabilitation

- Data showed that the unit did not routinely move patients after midnight.
- Referral to treatment (RTT) times were within 18 weeks were achieved on 100% of occasions for all medical specialities in December 2015, which was above the trust target of 90% and above the England average. This included rehabilitation.
- During the period September 2015 to December 2015, bed occupancy for the Complex Rehabilitation unit ranged between 97.7% and 94.7%. Evidence has shown that when bed occupancy rises above 85% then it can start to affect the quality of care to patients and the orderly running of the hospital.
- There was a daily bed management meeting within the hospital but staff from the unit did not attend this all of the time. Contact with the bed manager was only made when a patient was ready to be discharged. Complex discharges were supported by the discharge coordinator.

## Learning from complaints and concerns

- Staff understood the process for receiving and handling complaints and were able to give examples of how they would deal with a complaint effectively. Managers discussed information and learning from complaints during staff meetings to facilitate learning. Information was also disseminated to staff through a quarterly 'harm-free care' newsletter.
- Patients and those close to them told us they knew how to make a complaint or raise a concern if they needed to. 'Patient information' leaflets were available explaining the complaints procedure and how to access the Patient Advice and Liaison Service (PALS). We were told that written information was available in a number of different languages however we did not see any of these available on the CRU.
- The trust recorded complaints on the trust-wide system. Data showed there had been four complaints from August 2015 to November 2015 raised related to the CRU compared with the trust total of 152 in the period 2014/15. In response to a complaint about a point of contact on arrival the service was in the process of reviewing the use of a receptionist on the unit to meet relatives and visitors. The service had also introduced the rehabilitation "one page profiles" in response to requests from patients and relatives for greater orientation on the units.

- All the wards we visited displayed the compliments they received on information boards.
- The trust had also introduced a listening line for patients and their families. This enabled them to speak directly to a senior nurse on duty and respond to respond to concerns in a timely manner.

## Are specialised rehabilitation services well-led?

Good



We rated specialist rehabilitation services as "Good" for Well-led. This is because;

- All staff knew the trust vision and values of "The Walton Way". Staff felt part of the wider trust and were established as an integral part of the wider regional rehabilitation network.
- There was a clear governance structure and learning was discussed and disseminated at key meetings.
- There was a risk register for rehabilitation services which was being managed proactively by managers in the division. Staff were aware of key risks and felt informed about key issues affecting the service such as staffing and development of the network.
- The majority of staff said they felt supported and well led. The service was proactive in promoting research and innovation and there was a culture of supporting post graduate education and striving to improve service delivery.
- However in discussion with senior managers they confirmed that further work was required to have greater public engagement.
- Workshops had been held to facilitate the multi professional working in the service.
- Staff acknowledged that the move into the new building had brought new challenges with regards to staff working together more effectively.

## Vision and strategy for this service

- The service followed the trust vision and mission statement. The mission was to provide high quality treatment, care and patient experience in the most appropriate place for the needs of their patients. The

# Specialised rehabilitation

trust vision was to provide excellent services based on research and education. The trust's objectives were based on this vision and strategic goals, which were cascaded down to the individual services.

- Staff at all levels within specialised rehabilitation services were able to tell us about the trust values. The values of the trust were caring, dignity, respect, pride and openness. Together these were described as the 'Walton Way'.
- The specialised rehabilitation services were part of the newly formed regional rehabilitation network which had produced its own strategy which was closely aligned to the values of The Walton Centre.

## Governance, risk management and quality measurement

- There was a clear governance structure, and meetings were held on a monthly basis to discuss service performance. Monthly ward and board balanced scorecards were produced.
- The service used performance dashboards to measure key quality indicators and standards such as patient's safety, clinical effectiveness and patient experience. Improvements in performance were ongoing and the managers of the service were clear of the work needed to improve performance, such as reduction of falls.
- We reviewed the division of neurology dashboard report for January 2016 which indicated the majority of quality indicators for the Complex Rehabilitation Unit (CRU) were better than the internal targets set by the division.
- The neurology division and the regional rehabilitation network used a risk register to monitor risks, and mitigation actions, which were recorded with progress and review dates. Items on the register reflected those highlighted by the senior staff. For example, the reduction of referrals to the CRU was identified as a risk and an action plan including open days to promote the service was on going to address the issues. Senior staff knew that there was a risk register and ward managers were able to tell us what the key risks were for their area of responsibility.
- Staff were able to tell us how their ward performance was monitored through the nursing assessment and accreditation system (NAAS). This included reviewing patient's experiences and outcomes. The trust undertook a modern matron ward round every month where the allocated matron visited the ward area to look at leadership, documentation, patient safety and

nutrition and infection control. Matron rounds compliance for 'putting patients first' was 89% for CRU. A monthly quality report had also been introduced which shared good practice and improvements in quality as well as highlighting any improvements requiring further focus to enhance patient care.

- Incidents classified as "moderate harm" were presented to the weekly harm meetings and a root cause analysis was completed and shared.
- Safety huddles took place daily across neurology and neurosurgery to manage staffing levels, bed occupancy and to communicate other issues of concern.
- Ward meetings were held monthly. We observed minutes from a meeting in January 2016 which included feedback from an incident, training and feedback on the matron rounds. Staff had access to the minutes by email or could access them in the staff rest area.
- The monitoring of complaints, incidents, audits and quality improvement projects were raised at board level. The trust had a clinical audit programme for 2015/16, which included both local and national audits. Clinical audit is defined as a quality improvement process that aims to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change.

## Leadership of service

- The unit operated under the division of neurology, as well as the regional rehabilitation network.
- Staff reported there was very clear leadership from managers of all levels. Staff could explain the leadership structure within the trust and within specialised rehabilitation services.
- The majority of nursing staff spoke positively of the ward managers on the CRU and matrons, and told us that they received good support.
- In the 2015 national NHS staff survey, staff scored being supported by their managers out of five. The Walton Centre scored 3.9, which was better than the national average of 3.7 for specialist acute trusts. This information was trust-wide and could not be disaggregated specifically for specialist rehabilitation services.
- Doctors told us that senior medical staff were accessible and responsive and they received good leadership and support.

# Specialised rehabilitation

## Culture within the service

- Staff said they felt supported and able to speak up if they had concerns. They said there had been challenges with staffing and adjusting to the new building but felt that things were improving. Workshops had been held to facilitate the multi-professional working in the service. Some staff felt that more work was required to share knowledge of other staff roles and engage all staff groups in developing greater collaborative working on the unit.
- In the 2015 NHS staff survey, the trust scored 4.2 (out of 5) for staff recommending the organisation as a place to work or receive treatment. This was above the national average of 4 for specialist trusts. The survey also showed 91% of staff felt that their role made a difference to patients, which was in line with the national average. This information was trust-wide and could not be disaggregated specifically for specialist rehabilitation services.
- Staff said they felt supported and able to speak up if they had concerns. They said that staff were busy but morale was good. We noted that the national NHS staff survey for 2015 showed that staff motivation at work had reduced compared with the previous survey to 3.73 (out of 5) and was lower (worse) than the national average of 3.85. However, the percentage of staff reporting good communication between senior managers and staff was 46% which was significantly better than the national average of 35%. This information was trust-wide and could not be disaggregated specifically for specialist rehabilitation services.
- The percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months was 23% and the trust was ranked third highest out of seven local trusts. However, it was recognised that it was not a like for like comparison due to the acuity and prognosis of patients who were accepted by the trust. Positively, information provided by the trust showed the change in approach to managing patients with cognitive impairments and inappropriate behaviour by clinical staff, which encouraged early intervention and de-escalation of potential conflict situations.

## Public engagement

- In discussion with senior managers they confirmed that further work was required to have greater public

engagement. The service was in the process of reviewing public engagement and identifying patient/patient groups to attend both operational and research committee meetings.

- Trust board meeting minutes and papers were available to the public online which helped them understand more about the hospital and how it was performing.
- The hospital participated each month in the NHS Friends and Family (FFT) test giving people who used services the opportunity to provide feedback about care and treatment. The FFT showed that the majority of wards scored over 95% of patients, in the period July 2014 to June 2015, who would recommend the hospital to friends or a relative.
- The trust achieved a 45.5% response rate for the FFT from July 2014 to June 2015, which was better than the national average of 33.7%.
- The trust held listening weeks which members of the public could attend and provide either positive or negative feedback. The results of these weeks were disseminated to staff as part of the process of continuous learning.
- The service had strong links with the local head injury charity with local representatives regularly visiting the service.

## Staff engagement

- Staff participated in the staff survey. This included how staff felt about the organisation and their personal development.
- Staff we spoke to felt that they were equipped for their role and had clear roles and responsibilities.
- Staff told us they were well supported with mandatory training, clinical supervision and staff appraisals. However, some staff told us that it had been difficult to get time to complete training recently due to the pressure on staffing.
- Information was cascaded to staff through a number of different methods. The intranet hosted a newsletter and blog to ensure that staff were aware of the current priorities and what was happening within the trust.
- The trust held 'Berwick' sessions, which were open to all staff to discuss what they are proud of and what keeps them awake at night. The trust considered this a key component of their open and honest culture and staff speaking out. However, whilst staff welcomed the sessions some staff (particularly nursing staff) felt that they had not been able to attend due to workload.

# Specialised rehabilitation

## **Innovation, improvement and sustainability**

- The regional network had received a national award for the redesign of specialist rehabilitation services.
- An innovation award had been presented to a senior member of staff for an innovative approach to the provision of 1:1 care for supervision of patients.
- The service had used animations to produce patient and staff experience films which were available on the internet. For example, a cognitive education programme for patients and their carers to have a better understanding of cognitive impairments and inappropriate behaviour.
- An analysis of the 2015 staff survey results showed 75% of staff at the trust, who responded, felt they were able to make suggestions to improve the work of their team/department. This was better than the national average of 73%.
- The service had introduced a “Big Book of Best Practice 2015-2016” to share experience and learning across the pathway and with the wider NHS.
- The trust was a member of the Liverpool Health Partners (LHP) which aimed to create a strategic partnership for improving health and pursuing excellence in delivery of care research and education.

# Outstanding practice and areas for improvement

## Outstanding practice

- In medical services, we found examples of outstanding care where patients' individual needs were met using alternative approaches to rehabilitation pathways which involved patients and their families. This included developing a garden area where family were encouraged to attend and garden with the patient.
- The trust had received a Certificate of Recognition Excellence for the National Institute for Health Research (NIHR) for their work in promoting the benefits of clinical research, and encouraging recruitment of patients into clinical trials. In 2014 to 2015 the trust increased their proportion of NIHR studies from 39 to 56 studies compared to the previous year which was more than any other trust in the region.
- The use of functional magnetic resonance (MR) scanning in the diagnosis and treatment of patients. It was usually used for research purposes in other trusts but the trust was developing a range of applications that would improve diagnosis and outcomes for patients.
- The MR claustrophobia clinic was very supportive for patients and following the service winning funding to develop a service the trust had agreed to continue funding to support the service. Other members of staff were now involved in the further development of the service.
- The development of the advanced healthcare scientist role in neurophysiology to support an area that was previously consultant led. The role involved the healthcare scientist undertaking aspects of theatre monitoring that would have previously been the remit of a consultant neurophysiologist.
- The critical care service used an electronic system which identified the need for appropriate risk assessments to be undertaken for patients. This helped to ensure that patients were assessed in a timely manner by providing a visual aid to staff via a television screen in the main area of the unit. This tool was available throughout the hospital.
- The critical care service had introduced a memorial tree for patients who had passed away in the unit and donated organs. A yearly memorial service was held for relatives, which had been well attended.
- The trust had developed a 'home from home' service which provided accommodation for relatives. The accommodation provided was of a high standard and had been designed as the catchment area for the unit was large, with patients using the services regularly from the Isle of Man and North Wales. The trust had recognised that relatives may have to visit on short notice and may not always bring what they need. Items such as toothbrushes were provided for relatives to use if this was the case. Access to refreshments was also available.
- There was a well-established multidisciplinary team approach that was seen as integral to the critical care service. There were regular meetings through the day with staff from other departments, internally and externally.
- The introduction of the nationally recognised rehabilitation network was found to be outstanding practice due to the focussed approach to rehabilitation and ability to move a patient to the most appropriate setting for care in a timely manner across the hub and spoke model.
- The interactive 'TIMS' theatre live tracking system was an innovative system which allowed live tracking of patients through their theatre journey. This system also allowed consultants to book their own patients on to theatre lists while in clinic. A number of other organisations had visited the centre to benchmark against this system.
- The trust took part in the Multiple Sclerosis Trust 'Generating Evidence in Multiple Sclerosis Services' (GEMS) 2014/15. This report documented an extensive service analysis which informed the national GEMS project which in turn was used to support NICE (National Institute for Health and Care Excellence) guidance. The services are then evaluated for compliance with NICE standards.
- The trust participated in the international Spine TANGO program which benchmarked their surgical outcomes against other services across Europe.
- The trust were rated as the overall top acute NHS trust in England in relation to the patient-led assessments of the care environment (PLACE) in 2015. The trust

# Outstanding practice and areas for improvement

scored 99% for cleanliness; 98% for the food it served; 97% for privacy, dignity and wellbeing; 98% for condition, appearance and maintenance and 95% for patients living with dementia, an average of 97%.

- The trust had been named as an NHS vanguard site after applying for the status in September 2015. The new model of care, the neuro network, should provide additional and more effective support for people with long-term neurology conditions outside the trust hospital site; this should enable patients with spinal conditions across the region to receive more effective

and timely care. The network models led by the trust aim to provide a high quality, cost effective and sustainable neuroscience service, working in partnership with other acute trusts and primary care.

- The trust had introduced a listening line that patients and their families could call and speak directly to the senior nurse on duty so that the trust could respond to concerns in a timely manner particularly for those patients on the ward at that time.
- The trust held 'Berwick' sessions, which were open to all staff to discuss what they are proud of and what keeps them awake at night. The trust considered this a key component of their open and honest culture and staff speaking out.

## Areas for improvement

### Action the hospital MUST take to improve

#### In medical care

- Ensure all equipment is available and in date on the resuscitation trolleys on Lipton and Chavasse wards.

### Action the hospital SHOULD take to improve

#### Trust-wide

- Review the numbers of staff required to undertake level three children's safeguarding training.

#### In medical care

- Schedules for cleaning should be updated and completed.
- All medical consultants should have a completed job plan annually.
- There should be access to lockable boxes for syringe driver pumps.
- Relevant staff should receive training to operate a syringe driver pump.
- The processes in place to request deprivation of liberty safeguards (DOLS) should be reflected in the trust's policy.
- Training compliance for Mental Capacity Act 2005 (MCA) and DOLS training should be improved to meet the trust target.
- Bed occupancy on Chavasse ward remains within the limits to enable quality of care to be delivered.

- Information should be available for patients and relatives about making formal complaints so that they are aware of the correct process to follow.
- Audit processes should be able to benchmark patient outcomes with other specialist neurology services.

#### In surgery

- The service should make sure that all areas used to store medications are locked securely.
- The service should improve compliance with all areas of mandatory training.
- The service should improve the numbers of staff that have received their annual appraisal.

#### In critical care

- The unit should make improvements to the number of delayed discharges from the unit and ensure that all occurrences are reported as clinical incidents in line with trust policy so that improvements can be made.
- The unit should take into consideration the escalation beds that are available in the Short Stay Surgical Unit (SSU) when completing the next staffing review.
- The unit should complete staff appraisals in a timely manner so that they are able to address any requirements for support and development.

# Outstanding practice and areas for improvement

- The unit should make sure that staff complete all mandatory training updates when required.
- The unit should consider increasing the number of pharmacists for the unit so the intensive care society guidelines are met.
- The unit should monitor fridges to make sure they are checked on a daily basis and temperatures are recorded in line with trust policy.
- The unit should make sure that resuscitation trolleys are checked in line with trust policy and that tamper tags are replaced when required.
- The unit should collect data to monitor the effectiveness of the surgical, medical acute response team (SMART) team and the use of the track and trigger system.
- The unit should monitor if patients are admitted to the unit within four hours of the decision being made.
- The unit should improve access to information about how to make a formal complaint so that patients are aware of the correct process to follow.
- The unit should ensure that the review dates for risks identified on the risk register are clear.
- The divisional team should make sure that plans for development of the critical care service are clearly documented as part of the plans for divisional service improvement so that progress can be monitored and measured effectively.
- The unit should make sure that staff have a full understanding of the duty of candour and know when this should be applied.

- The unit should consider ways in which to meet the HBN-04-02 standards in the high dependency unit (HDU).
- The unit should consider ways in which to provide immediate life support training to all critical care staff.
- The unit should ensure that the timetable for the planned recruitment and training of advanced critical care practitioners (ACCPs) is met so that the correct staff to patient ratio is met out of hours.

## **In specialised rehabilitation services**

- The service should continue to continuously review its caseload acuity to enable the service to accurately assess the staffing levels required for the provision of specialised rehab services in line with national guidance.
- Review how it proactively supports families and patients to access information on local support organisations and care of the patient requiring specialised rehabilitation

## **In outpatients and diagnostic imaging**

- The outpatient department (OPD) should improve the quality of written patient records.
- The trust should reduce the waiting times for patients in the OPD.
- The trust should consider moving the visual field testing in the OPD from the waiting room to a private area.
- Senior staff in the OPD should have level three safeguarding training for children and young people as some young people in transition between children's and adult services use the department.

## 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
Treatment of disease, disorder or injury	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p><b>How the regulation was not being met:</b></p> <p>The provider did not do all that was reasonably practicable to mitigate risks. This is because:</p> <p>At the time of our inspection there were pieces of equipment that had exceeded the 'expiry date' on the resuscitation trolley on Chavasse ward and on the resuscitation on the trolley on Lipton ward.</p> <p>At the time of our inspection we found an empty box of adrenaline in the anaphylaxis kit on the resuscitation trolley on Lipton ward leaving the trolley with no available adrenaline.</p> <p>HSCA 2008 (regulated Activities) Regulations 2014, Regulation 12 (2) (f)</p>