Countess of Chester Hospital NHS Foundation Trust

Inspection report

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Ratings

Overall trust quality rating	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Requires Improvement**
Are services caring?	**Good**
Are services responsive?	**Requires Improvement**
Are services well-led?	**Requires Improvement**

Our findings

Our reports

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

Overall summary

What we found

Overall trust

The Countess of Chester Hospital NHS Foundation Trust provides acute services for 343,000 people across Chester, West Cheshire and Welsh patients living within the area served by Betsi Cadwaladr University Health Board. The trust employs over 5000 staff.

The trust has over 5000 members and was one of the first ten trusts to achieve foundation status, which was awarded in 2004. The trust has two locations where services are provided:

- The Countess of Chester Hospital, an approximately 600-bedded general hospital providing services from the Countess of Chester Health Park.
- Ellesmere Port Hospital, a 60 bedded rehabilitation and intermediate care service.

The trust was also providing services from Tarporley War Memorial Hospital although this was not a location included within the trust's registration at the time of our inspection.

We undertook this unannounced inspection because we had concerns about the quality of services. We inspected the trust's services for children and young people to specifically to provide an up-to-date assessment of the quality and safety of this service for patients, the public and stakeholders.

We inspected four acute core services across two locations provided by this trust on 17-19 October 2023. We inspected urgent and emergency care services, medical wards, maternity services and services for children and young people at The Countess of Chester Hospital. We also inspected medical wards at Ellesmere Port Hospital. We also inspected the well-led key question for the trust overall on 14-16 November 2023.

During our inspection we identified significant risks to quality and safety in several services, particularly in the trust's urgent and emergency care services. We considered using our urgent enforcement powers. We decided to provide

Our findings

detailed feedback to the trust about our findings, requiring the trust to take urgent action. The trust provided an action plan detailing the immediate action taken in response to our concerns and the longer-term actions required to ensure the improvements would become sustained and embedded. The action taken by the trust mitigated the immediate risks to patient safety sufficiently to mean CQC did not need to use urgent enforcement powers.

We undertook a follow-up visit to the trust's urgent and emergency care services during our inspection of the trust's governance and leadership. Our follow-up visit found some improvements although some concerns remained. Our service-level ratings therefore reflect our findings during our inspection of core services during October 2023.

Our rating of the trust stayed the same. We rated the trust as requires improvement because:

- We rated safe, effective, responsive, and well-led as requires improvement, and caring as good. The overall rating for well-led had improved from inadequate to requires improvement.
- The trust provides 12 core services in total from the two locations which we inspect and rate. We rated one of the trust's 12 services as inadequate, five as requires improvement and six as good. In rating the trust, we considered the current ratings of the services we did not inspect this time and aggregated the ratings for outpatients and diagnostic imaging together as they were inspected jointly in 2016.
- We use ratings characteristics to determine our ratings for each question and for the trust overall. We assessed that the trust met the rating characteristics of requires improvement overall.
- People could not always access services when they needed it or receive the right care promptly. The demand on services had frustrated access and flow through the trust and left services gridlocked. Urgent and emergency care services were providing care for too many patients without enough staff and without enough space. This had resulted in corridor care becoming normalised which compromised patient safety, privacy and dignity. The trust had too many patients waiting to be discharged with a third of beds occupied by people who did not need hospital care. There was more that the trust needed to do, and more that system partners needed to contribute to alleviate the pressures on services.
- In multiple services the trust did not always have enough staff with the right skills, training and regular appraisal to provide safe and effective care. Mandatory training rates were low in several areas and for specific courses including resuscitation and safeguarding training. Appraisal rates were lower than the trust's target.
- The trust did not manage infection prevention and control well. Clinical environments and equipment were not always clean and fit for purpose. Equipment and medicines including resuscitation trolleys were not always stored or checked appropriately to ensure they were fit for purpose.
- The trust did not consistently operate effective governance processes to ensure all patients received high-quality care which met their needs. The trust did not always have effective oversight of the quality and safety of care provided to patients. There were examples where failures in governance systems had resulted in unmitigated risks.
- The trust's systems for identifying, escalating and managing risks, issues and performance were not always effective and had resulted in significant unmitigated risks developing in frontline services. The trust's internal audits showed significant improvements were still required to many aspects of how care was being delivered.

However:

Our findings

- The trust had prioritised diagnostic activity and self-assessment since the last inspection to enable it to act to improve care and treatment. The trust welcomed external reviews in several key areas to stress test internal systems, identify weaknesses and formulate improvement plans. Leaders understood the priorities and issues the trust faced and needed to turn plans into action to embed and sustain improvements.
- Staff in most services and leaders at all levels told us that the trust was a better place to work than it was a year ago. The trust had relaunched Freedom to Speak Up processes with a refreshed policy and new champion roles to ensure all staff felt able to raise concerns. Leaders told us they were committed to acting the concerns raised by staff.
- The trust was due to launch a new strategy shortly after our inspection. The new strategy committed the trust to making significant improvements in the quality and safety, as well as rebuilding public trust and confidence in the trust's services.
- Staff consistently demonstrated resilience in the context of significant internal and external pressures on services. Staff continued to treat patients with compassion and kindness, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.

How we carried out the inspection

The inspections of the trust's core services were led by a CQC operations manager and supported by ten CQC inspectors, one CQC regulatory coordinator, a CQC inspection planner and 9 specialist professional advisors.

The inspection of the well-led key question (the trust's senior leadership and governance) was led by a CQC Deputy Director of Operations and supported by an operations manager, one CQC inspector, one CQC regulatory coordinator and an inspection planner. The team also received support from four specialist professional advisors and executive reviewers with a background and experience in NHS senior management.

You can find further information about how we carry out our inspections on our website: www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Outstanding practice

We found the following outstanding practice:

- The trust's maternity service had raised funds to publish a book in collaboration with a woman who had experienced baby loss. The book was published in October 2023 and raised awareness about stillbirth and gave support to bereaved families including support for siblings. The service had planned further fundraising to gift all UK NHS trusts with 10 copies of the book.
- The trust's services for children and young people had a strong visible person-centred culture with staff delivering exceptional and personalised care to babies, children, young people and their families. All staff demonstrated great resilience to continue their roles in providing excellent care under difficult circumstances. In October 2022 the service had introduced a pilot phlebotomy service on Saturdays for blood sample tests. This had this had been so successful it was made permanent. The service now completes approximately 500 appointments a month. Staff were very experienced with distraction techniques whilst taking blood samples which meant families avoided paying any parking charges. This also meant families who worked during the week could access the service for their child.
- The trust's neonatal unit had introduced new tools to communicate with women and birthing partners in real time and share videos and pictures using a secure communication system.

Our findings

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve:

We told the trust that it must take action to bring services into line with legal requirements. This action related to five services and to the trust overall.

Trust wide

- The trust must assess, monitor, and drive improvement in the quality and safety of the services provided, including the quality of the experience for people using the service in line with the regulations (Regulation 17)
- The trust must ensure risks in services are appropriately recorded, assessed, escalated to the trust's board where required, and regularly reviewed. (Regulation 17)
- The trust must ensure effective action is taken to address risks in services including areas of low compliance highlighted through internal governance systems. (Regulation 17)
- The trust must ensure risks on the risk register are regularly reviewed. (Regulation 17)
- The trust must ensure patients waiting to receive treatment after a referral are clinically reviewed and validated. (Regulation 17)
- The trust must implement effective systems to comply with the requirements of CQC registration. The system must ensure services are provided from locations which have appropriately added to the trust's registration. (Regulation 17)
- The trust must ensure strategies designed to support the delivery of the trust's new overall strategy are completed, implemented, and monitored to ensure their effectiveness. (Regulation 17)
- The trust must ensure staff feedback is captured and responded to appropriately to identify risks and drive improvement in services. (Regulation 17)
- The trust must implement an effective system to ensure the assessment, prevention and management of infection prevention and control in the physical environment, this is recorded, monitored, and audited with actions taken to improve compliance. (Regulation 17)
- The trust must ensure there is effective oversight of the quality and safety of care provided to patients with mental health needs. (Regulation 17)
- The trust must implement an effective system to identify, report and learn from incidents involving the use of restrictive interventions including restraint and rapid tranquilisation. (Regulation 17)
- The trust must ensure staff undertake thorough assessments for patients who have a learning disability, care needs are assessed and planned to meet their individual needs. (Regulation 17)
- The trust must ensure service user records are audited appropriately to evidence ongoing compliance with the requirements of the Mental Capacity Act 2005 and to identify missed opportunities to safeguard service users. (Regulation 13)

Our findings

- The trust must implement an effective system to ensure that medical, nursing and midwifery staff have the skills, knowledge, experience, and appraisal to care for and meet the needs of patients within their service area. (Regulation 18)

Medicine (The Countess of Chester Hospital)

- The trust must ensure that staff receive appropriate training, supervision and appraisals, this must include but not be limited to training in life support training, as is necessary to enable staff to carry out the duties they are employed to perform. (Regulation 18 (1)(2)(a))
- The trust must ensure that staff are assessing the risk of, and preventing, detecting and controlling the spread of infections, including those that are health care associated. (Regulation 12 (1)(2)(h))
- The trust must ensure that fire exits are clear from obstruction and well maintained. (Regulation 12(1)(2)(d))
- The trust must ensure there are effective systems in place for the safe management, storage, and monitoring of medicines. The system must ensure the safe administration of medicines. (Regulation 12 (1)(2)(g))
- The trust must seek to eliminate mixed sex accommodation breaches and must identify and report mixed sex accommodation breaches appropriately for all inpatient settings (Regulation 10 (2)(a))
- The trust must ensure that effective and timely care is provided; to improve patient access and flow through the hospital to safe discharge or transfer to other appropriate services. (Regulation 12 (1)(2)(i))
- The trust must ensure the risks presented by gaps in the out of hours stroke service are effectively assessed and mitigated. (Regulation 17 (1)(2)(a)
- The trust must ensure that staff receive conflict resolution training in a timely manner, as is necessary to enable them to carry out the duties they are employed to perform. (Regulation 17 (1)(2)(a)(b))
- The trust must ensure there is effective action to address low compliance and areas for improvement in quality and safety identified through internal audits. (Regulation 17 (1)(2)(a)(b))

Urgent and emergency care (The Countess of Chester Hospital)

- The trust must ensure that patients are cared for in areas where dignity and respect are not compromised. (Regulation 10(1)(2)(a)(b)(c))
- The trust must ensure that nurse staffing levels, are safe for the numbers of patients in the department. (Regulation 18 (1))
- The trust must ensure that medical staffing levels, with the right qualifications and competencies, are safe for the numbers of patients in the department. (Regulation 18 (1))
- The trust must ensure that the service meets infection, prevention and control standards and that staff adhere to those standards. (Regulation 12(1)(2)(h))
- The trust must ensure that there is sufficient equipment that is maintained to keep patients safe. (Regulation 12(1)(2)(e))
- The trust must ensure that doors to clinical rooms where hazardous substances are stored are kept secure and accessible only to staff. (Regulation 12(1)(2)(a)(b)
- The trust must be assured that medicines are being stored securely and administered safely as per manufacturing guidance. (Regulation 12(1)(2)(g))

Our findings

- The trust must ensure that oxygen is prescribed as required by national guidelines. (Regulation 12(1)(2)(g))
- The trust must ensure that patients identified with a mental health condition are cared for in a safe ligature free environment and have appropriate risk assessments completed. (Regulation 12(1)(2)(a)(b)(d))
- The trust must ensure that there is effective oversight of checks to maintain patient safety. (Regulation 17(1)(2)(a)).
- The trust must ensure there is effective action taken and evidenced in response to risks, issues and low compliance with audits (Regulation 17(1)(2)(a)(b))
- The trust must ensure that there are sufficient numbers of qualified staff that have completed mandatory training requirements including safeguarding. (Regulation (18)(1)(2)(a))
- The trust must ensure that all staff receive an annual appraisal. (Regulation 18(1)(2)(a))

Maternity (The Countess of Chester Hospital)

- The trust must ensure doors are not left unlocked and accessible to patients or members of the public. (Regulation 12(2)(b))
- The trust must ensure that the assessment of risk, preventing, detecting, and controlling the spread of, infections, including those that are health care associated is managed in line with trust and national guidance. (Regulation 12(2)(h))
- The trust must ensure the maternity theatre, birthing rooms and room 15 are serviced, maintained, and fit for purpose in line with best practice guidance. (Regulation 12(2)(b))
- The trust must ensure that a robust system is in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users. (Regulation 17(1)(2)(b)
- The trust must ensure patient records are complete, contemporaneous and securely stored. (Regulation 17(1)(2)(c)
- The trust must ensure waiting times and other key metrics are in line with national standards. (Regulation 17(2)(a))
- The trust must ensure that policies and procedures are reviewed and follow national guidance. (Regulation 17(1)(2)(a))

Services for Children and Young People (The Countess of Chester Hospital)

- The trust must ensure that mandatory training (including safeguarding) compliance meets the trust target. (Regulation 12(1)(2)(c)
- The trust must ensure premises and environment are safe and secure. This includes but is not limited to ensuring storeroom doors are not left open or unlocked and COSHH cleaning chemicals and oxygen cylinders are safely stored. (Regulation 12(1)(2)(d))
- The trust must ensure the premises and environment are clean and maintained to prevent the spread of infection. This includes but is not limited to repairs to flooring, walls and door frames, plumbing / drainage, and food storage within patient's fridges. (Regulation 15(1)(a)(2))
- The trust must ensure that appropriate nutritional risk assessments are completed for anyone with specific dietary requirements or anyone with social, religious, or cultural needs. (Regulation 12(1)(2)(a)(b))
- The trust must ensure that a robust system is in place to assess, monitor and mitigate the risks relating to the health, safety, and welfare of service users. (Regulation 17(1)(2)(a)(b))

Our findings

- The trust must assess, monitor and improve the quality of the services provided and ensure waiting times and other key metrics are in line with national standards. (Regulation 17(1)(2)(a)(b))
- The trust must assess and manage the risks relating to the electronic patient record system and transcription services. The trust must improve the quality of the services provided and ensure this did not impact on delays to patients care and treatment. (Regulation 17(1)(2)(a)(b))

Medicine (Ellesmere Port Hospital)

- The trust must ensure that staff receive appropriate training, supervision and appraisals, this must include but not be limited to training in life support training, as is necessary to enable staff to carry out the duties they are employed to perform. (Regulation 18 (1)(2)(a))
- The trust must ensure there are effective systems in place for the safe management, storage, and monitoring of medicines. The system must ensure the safe administration of medicines including medicines administered covertly. (Regulation 12 (1)(2)(g))
- The trust must ensure that fire exits are clear from obstruction and well maintained. (Regulation 12(1)(2)(d))
- The trust must ensure that effective and timely care is provided; to improve patient access and flow through the hospital to safe discharge or transfer to other appropriate services. (Regulation 12 (1)(2)(i))
- The trust must ensure there is effective data collection and analysis in relation to patient outcomes, including relevant clinical audits to drive improvement in patient care. (Regulation 17(1)(2)(a))
- The trust must ensure there is effective action to address low compliance and areas for improvement in quality and safety identified through internal audits. (Regulation 17 (1)(2)(a)(b))

Action the trust SHOULD take to improve:

Trust wide

- The trust should implement effective systems to identify and plan services to address health inequalities.
- The trust should improve the visibility of senior leadership in all services and particularly in urgent and emergency care services.
- The trust should implement effective patient engagement in the development of the trust's services.

Medicine (The Countess of Chester Hospital)

- The trust should ensure that the premises are safe to use for their intended purpose and are used in a safe way.
- The trust should ensure that there are sufficient numbers of nursing staff that can meet peoples care and treatment needs and keep them safe from avoidable harm.
- The trust should review the prescribing of medicines that control distressed behaviour to ensure the policy is followed and monitoring is completed.
- The trust should ensure when peoples medicines are given covertly, the covert administration care plan is completed, reviewed and updated regularly.

Urgent and emergency care (The Countess of Chester Hospital)

Our findings

- The trust should ensure that reasonable adjustments are in place to meet the needs of patients living with complex needs such as dementia and learning disabilities.
- The trust should ensure that health promotion and information is available in all areas in the department and in languages other than English.
- The trust should ensure that all doors leading to the children's area are secure.
- The trust should ensure that the nationally recognised screening tool to monitor patients at risk of malnutrition is included in the audit programme for nutrition.
- The trust should ensure it maintains local oversight of the quality of responses to complaints.
- The service should ensure that patients' privacy, dignity and confidentiality is maintained in the reception area.
- The trust should ensure that patient identifiable details are kept confidential when displayed or stored in public areas.

Maternity (The Countess of Chester Hospital)

- The trust should ensure that medicines are being stored securely.
- The trust should continue to embed the changes made to the post-operative care of women and birthing people following obstetric surgery.
- The trust should continue to embed the changes made to the triage systems and processes.

Services for Children and Young People (The Countess of Chester Hospital)

- The trust should ensure all medicines are stored securely at all times.
- The trust should ensure resuscitation equipment is checked in line with trust policy.
- The trust should ensure that information for children, young people and families is available in languages other than English, in child friendly versions, and in alternative formats.
- The trust should ensure staff improve the compliance of completing the sepsis screening tool on the electronic patient record.

Medicine (Ellesmere Port Hospital)

- The trust should ensure that the premises are safe to use for their intended purpose and are used in a safe way.
- The trust should ensure that there are sufficient numbers of nursing staff that can meet peoples care and treatment needs and keep them safe from avoidable harm.

Is this organisation well-led?

Our rating of well-led improved. We rated it as requires improvement.

Leadership

A significant period of change and churn in senior leadership meant the trust board lacked stability. There was a continued reliance on senior leaders covering key posts on an interim basis.

Our findings

However, the trust was seeking to recruit permanent leaders at the time of our inspection. Leaders, including those in interim positions, understood and managed the priorities and issues the trust faced. The board was actively seeking to increase the diversity in knowledge, skills and abilities to effectively lead the trust. They were visible and approachable in the trust for patients and staff.

The board was comprised of the executive and non-executive directors. There were six executive directors including the acting chief executive, the chief finance officer, the medical director, the acting director of nursing and quality and acting assistant chief executive officer, the chief operating officer and the chief people officer. There was an additional non-voting director post for a chief digital information officer which was vacant at the time of our inspection. The chief finance officer was also the deputy chief executive.

In the three years leading to the inspection, the trust had experienced a significant period of instability at board level. This had included three new chief executives and three new chairs in this period. Most of the trust's executive team had been appointed since March 2022, including the medical director and chief people officer. The acting chief executive and the acting director of nursing and quality were also both substantive executive directors of a nearby NHS trust. Both had acted in interim positions to support the trust's board since 2022.

The trust had reviewed leadership capacity and capability and had recognised there was more to do to ensure there was stable leadership with an appropriate range of skills, knowledge and experience to effectively lead the trust. At the time of our inspection, the trust was finishing recruitment processes for a new permanent chief executive and had active recruitment processes ongoing for a permanent chief nurse and director of finance. The recruitment processes had been intentionally staggered to ensure the new chief executive would have a role in building the new permanent executive team. The trust had engaged specialist agencies to recruit new non-executive directors with a focus on increasing both clinical and human resources knowledge and expertise on the board.

The trust board and senior leadership team displayed integrity on an ongoing basis. Leaders were clear that whilst the trust had made improvements since the last inspection, there was still a need for further significant improvements.

Succession planning was not in place throughout the trust although leaders had recognised this was an area for improvement. The chief executive told us that the trust faced significant challenges recruiting experienced directors with diverse skills and backgrounds. The trust planned to implement a succession planning process after the board-level recruitment processes had been completed. There was a draft plan to implement succession planning which included improvements to appraisal systems which would allow the trust to identify aspiring leaders.

The trust did not have a board level lead director for mental health. The director of nursing was the board level lead director for learning disability and autism.

There was a programme of visits to services and staff fed back that leaders were approachable. Governors and non-executive directors were involved in visits to services.

The trust leadership team had a comprehensive knowledge of current priorities and challenges across all services. Since our last inspection, the trust has prioritised diagnostic activity and self-assessment to identify risks. The trust had welcomed external reviews in several key areas to stress test internal systems, identify weaknesses and formulate improvement plans. This meant leaders were sighted on the priorities and challenges faced by the trust and plans to make improvements.

Our findings

There was a board development plan with further sessions planned, these included equality and diversity and Freedom to Speak Up in December 2023, and a session on strategy and systems in January 2024.

Leadership development opportunities were available, including opportunities for staff who were not members of the board. The trust had appointed a Head of Leadership, Talent and Skills and implemented new daily huddles to support leaders at all levels. The trust had plans to launch a new leadership framework in 2024. This had been finalised at the time of our inspection and set out the competencies and behaviours expected by the trust in aspiring leaders, first line leaders, senior and clinical leaders, and strategic leaders.

Fit and Proper Persons Regulation (Directors)

Fit and Proper Person checks were in place. We reviewed a sample of files for voting members of board. The sample included files of both executive and non-executive directors, and included files of interim executive directors for completeness. All files showed the trust had completed appropriate checks of directors' suitability for their roles, including checks with the disclosure and barring service, insolvency registers and disqualified directors' lists. The trust had also undertaken further checks of directors' characters by undertaking social media searches. Directors' files included records of qualifications where required for the specific directors' role.

All members of the board had received an annual appraisal within the previous year. The trust maintained a record of annual appraisal dates for both executive and non-executive directors.

Vision and Strategy

The trust had a vision for what it wanted to achieve and was about to launch a new strategy to turn it into action, developed with some stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress. However, there was limited evidence of patient and public involvement in the development of the trust's new strategy. Supporting strategies were still in development or had not been started.

The trust had a clear vision and set of values. The trust's vision was 'Integrated Care at its Best' and the three trust values were:

- Safe: avoiding harm and reducing risk to all
- Kind: Considerate and non-judgemental
- Effective: Consistently maximising resources to deliver excellent and reliable care.

Staff did not know the trust's vision, values and strategy or how achievement of these applied to the work of their team. The vision and values were not widely publicised within the trust and during our inspection staff made limited reference to them. The trust had not embedded its vision or values in corporate information received by staff. The planned launch of the new strategy would ensure staff had a better understanding of the new strategy and how it would apply to their work. There were engagement roadshows planned to coincide with the launch of the new strategy and to develop a new 'civility charter' in line with the trust's values.

The trust had a clinical vision workstream which aimed to 'prevent inadvertent harm to patients, to improve both patient and staff experience from front door and assessment to inpatient and discharge with focus on right patient right team, to reduce occupancy, improve ambulance handover process implement BR/WR and optimising discharge processes'. The September 2023 update on this workstream identified that most actions were on track for delivery by their target, with the majority due for completion by March 2024.

Our findings

The trust did not have a robust and realistic strategy for achieving trust priorities and developing good quality, sustainable care although it was due to launch a new strategy shortly after our inspection. The trust's previous strategy had limited impact on the direction of the trust. The previous strategy was recognised by leaders as no longer representing the needs of the trust.

The new strategy established six strategic objectives and a number of strategic goals which were planned to be refreshed each year as the trust made progress or completed each goal. The trust's new strategic objectives were:

- Inspiring leadership
- Create a positive patient and family experience
- Proactive contribution in improving population health
- Add value within West Cheshire
- Actively seek new partnerships
- Create a team COCH [Countess of Chester Hospital] approach

The trust aligned its strategy to local plans in the wider health and social care economy and had developed it with external stakeholders. The strategy had been aligned to the strategies of the local authority and aligned to the direction of the integrated care board. The board had established plans for how they would monitor the progress on delivering the strategy.

There was limited evidence of patient and public involvement in the development of the trust's new strategy. The trust had held workshops and meetings with staff and stakeholders. Similar meetings or opportunities for input from people using services and the local community had not taken place.

The trust identified that there were a number of key strategies including the clinical strategy, patient experience strategy, estates strategy, and digital strategy which were still in development. The trust had in draft form strategies for meeting the needs of patients with a mental health, learning disability, autism or dementia diagnosis as part of a wider 'Supporting Patients with Additional Needs Strategy' due to be launched in 2024 to cover the period 2024-27.

The trust had planned services to take into account the needs of the local population. The trust had launched new services including a Same Day Emergency Care (SDEC) service to enhance the provision of urgent and emergency care services. The trust was improving maternity and children's services. This included a new women and children's services building which was under construction at the time of our inspection. The trust had appointed an interim director to lead on engagement with external partners and other NHS trust. This included joint reviews of 'at-risk' services, including services facing significant pressure or demand.

Culture

Staff did not always feel respected, supported and valued. The trust needed to do more to ensure there was an open culture where patients, their families and staff could raise concerns without fear. Whilst the trust promoted equality and diversity in daily work, staff did not feel there were equal opportunities for career development.

However, staff were focused on the needs of patients receiving care. The trust had recently relaunched Freedom to Speak Up to improve culture.

Our findings

The trust had recognised that there was work to do to rebuild a positive culture in all teams. The trust described their focus as 'Putting the basics back in place: getting everyone engaged in describing the culture we want to achieve'. The trust had launched a culture and civility roadshow which focussed on refamiliarising staff with the trust's values and expectations. The trust's people strategy was agreed in 2020 and was due to run from 2021-26. The board received an annual report on the implementation of the people strategy which sought to develop a 'strong Team Countess Culture'.

The 2023 National Staff Survey was open for staff to complete at the time of our inspection which meant the most recent results available for review were from the 2022 survey. The results showed staff did not always feel respected, supported or valued. The most recent staff survey results for the trust were from the 2022 staff survey. The staff survey is analysed to produce a score for each question between 0 and 10. The results were consistently below the national average and were within 0.1-0.3 of the worst performing trusts in the country for seven of the nine themes of the survey. Two themes matched the scores of the worst performing trusts in the country. These were the 'we work flexibly' and 'we work as a team' themes from the survey. The trust's staff survey response rate was 38.2% which was low and had been consistently lower than the median response rate for all trusts.

Staff did not feel equally respected, supported and valued across all sectors. The trust's staff survey results showed better or more positive results in some divisions including corporate non-clinical, human resources, diagnostics and pharmacy, finance and performance and women's and children's divisions. Divisions including estates, nurse management, and planned care were below the trust's overall scores for all or most of the nine staff survey themes.

The trust's response to the staff survey results recognised the level of action required to make improvements. The trust described the staff survey results as 'the worst staff survey results in the region, amongst the worst in the country' in the presentation delivered to support the assessment of the trust's leadership and governance. The trust's new strategy, and vision and values sought to launch a culture which was patient centred. The trust described 'focussing on valuing staff' as one of the main areas of focus for the trust at the time we were inspecting. The trust had developed an action plan to improve staff experience in response to the staff survey with 43 of 112 actions in the plan completed by the time we inspected.

Staff gave us differing feedback on whether they felt respected, supported and valued. In urgent and emergency care we received negative feedback about the support provided from senior leaders and their visibility in the service. In medicine and maternity services, staff were more positive about the trust, and in services for children and young people staff were very positive about the support they had received.

The trust had restarted initiatives to recognise staff success by staff awards. This included a small annual awards ceremony which took place during the same week as our initial inspection of the trust's core services. The trust's urgent response services had received national recognition and were shortlisted for a national nursing award. The trust had new initiatives including a reward recognition strategy and a 'team of the week'.

The trust worked with trade unions through established relationships and regular meetings with staff-side representatives.

Managers addressed poor staff performance where needed. We reviewed two examples of recently concluded disciplinary processes. Both showed managers had acted in accordance with the trust's disciplinary policy and process. The trust's average time taken to complete disciplinary processes had reduced over the last three years. In 2021/22 the average time taken was 177 days, falling to 128 days in 2022/23 and falling again to 78 days between April and July 2023.

Our findings

The trust applied Duty of Candour appropriately. The trust's serious incident reports included explicit reference to Duty of Candour and details for how this had been carried out. The reports showed patients received an apology without delay after an incident had occurred. The trust monitored compliance with a requirement to complete the Duty of Candour within 10 days of an incident occurring. The trust's compliance had varied since March 2023 although low numbers of incidents resulted in significant changes to compliance data. The trust's data showed there were 23 incidents requiring the Duty of Candour, and staff had completed the Duty of Candour within the required timeline for 18 incidents.

Staff did not always have the opportunity to discuss their learning and career development needs at appraisal. At the time of our inspection 76% of all staff had received an appraisal which equated to 2836 of 3734 eligible staff. The trust did not provide data which evidenced whether volunteers, locum staff or agency staff received an appraisal.

Staff had access to support for their own physical and emotional health needs through occupational health. The trust had appointed a workforce well-being lead and was shortly launching a workforce well-being hub. The trust's disciplinary records showed staff were encouraged to use the workforce well-being lead for support through specific processes including disciplinary processes. The trust had a wellbeing strategy for 2023-26 which established set milestones for how the trust would improve the staff wellbeing offer each year.

The trust's sickness and absence figures were not outliers and were within expected ranges. As of August 2023, the trust's sickness rate was 5% and the top sickness reason was anxiety, stress, depression or other psychiatric illness. The trust's turnover rate was 10% and was consistently below the sector average which looks at comparable acute trusts.

Vacancy rates had fallen although still exceeded the trust's target. As of June 2023, the trust's overall vacancy rate was 9% which was a reduction from 12% in June 2022. The vacancy rate for nursing and midwifery staff had fallen from 10.5% in June 2022 to 7.5% in June 2023. The vacancy rate for medical staff had increased from 6% in June 2022 to 10% in June 2023 although this was primarily due to increases in the number of medical roles available.

The trust had a Guardian of Safe Working Hours who produced an annual report for the People and Organisational Development committee. The next report was due to be presented to the board in January 2024. The report for 2022 showed a significant increase in exception reports which are reports from junior doctors submitted when there is a planned or unplanned variation in work schedules. Most reports were submitted by junior doctors working in planned care. There were 25 exception reports about loss of teaching and training opportunities.

The trust's staff survey results showed staff did not always feel equality and diversity were promoted in their day-to-day work and when looking at opportunities for career progression. The trust showed multiple areas of high inequality in the Workforce Race Equality Standard (WRES) 2021/22 report, particularly in career progression, equal opportunity for promotion and harassment, bullying or abuse from staff. The 2022 staff survey indicated 4 measures where results from all other ethnic groups were notably worse than for White staff at the trust. The staff survey indicated 6 measures, under the Workforce Disability Equality Standard (WDES), showing poorer experiences from disabled staff non-disabled staff..

The Workforce Race Equality Standard showed that the majority of staff from ethnic minority groups were employed in lower bands with little or no representation after band 5, and zero after band 7. This had remained constant for the previous three years. For clinical staff, the data showed that there was increased representation from band 5 to 8a over the last 3 years. The trust noted that for medical and dental staff, representation of staff from ethnic minority groups

across the grades and at higher levels was significantly more than the local population and staff demographics and the figures showed a year-on-year increase of staff from ethnic minority groups at each grade. The trust had high numbers of staff who did not declare their disability status with between 7%-33% of staff across the pay scales choosing not to disclose their status.

The trust had a WRES and WDES action plan for 2023/24. The action plans identified specific indicators requiring improvement, alongside details for how the actions would be made sustainable and embedded.

Staff networks were in place although some networks were less embedded than others. The trust had seven networks which were the Women's Network, the BAME Network, the LGBTQ+ Network, the Disability and Wellbeing Network, the Carers' Network, the Faith and Belief Network and the Neurodiversity Network. The Faith and Belief Network was relaunched during our inspection of the trust's senior leadership team. Network chairs did not have protected time for their roles which limited their capacity to lead and develop staff networks. Only one of the staff networks had an executive sponsor.

Freedom to Speak Up

The trust had appointed a Freedom to Speak Up Guardian and provided them with sufficient resources and support to help staff to raise concerns. In 2023, the trust had invited an external review of Freedom to Speak processes.

Following the review, the trust refreshed the policy and relaunched Freedom to Speak Up across the trust. The relaunch included the recruitment and training of new Freedom to Speak Up champions and the implementation of a new Freedom to Speak Up network. At the time of our inspection, the trust had over thirty trained champions and a waiting list for staff to become champions. The network comprised of the Freedom to Speak Up Executive Director, Non-Executive Director Lead, the Freedom to Speak Up Guardian and the champions.

Staff knew how to use the whistle-blowing process and about the role of the Speak Up Guardian. Staff received training in Freedom to Speak Up and compliance with this training was 85% at the time of our inspection. The relaunch of Freedom to Speak Up in the trust had resulted in significant increases in staff feeling able to raise concerns. The Freedom to Speak Up Guardian told us that following the relaunch, the trust had since received more concerns and feedback from staff in three months than it had received in the previous year. The data to support this was not available at the time of our inspection as the most recent report to the board for Freedom to Speak which was presented in September 2023 included data up until the end of June 2023. This report showed consistent numbers of speaking up in most quarters between March 2022 and June 2023, with between 10-16 concerns raised, with the exception of a spike of 22 concerns raised in July-September 2022.

Governance

Governance processes were improving although there was more to do to ensure there was good governance throughout the trust. The trust had identified weaknesses in governance systems and plans to make improvements.

However, leaders at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. The board had refreshed the board assurance framework and implemented measures to ensure there was an organisation-wide ownership of risk.

The trust did not have effective structures, systems and processes in place to support the delivery of its strategy including sub-board committees, divisional committees, team meetings and senior managers. This was an area of

concern recognised by the trust prior to this inspection and there was evidence showing the trust had effective plans to make improvements. Since our inspections in 2022, the trust had undertaken a series of diagnostic phases into several areas of governance which included external reviews. The trust had reviewed, planned to improve, or had started to improve areas of governance including the diversity of board's skills and experience, committee effectiveness, quality of management information, Freedom to Speak Up processes, financial management, digital systems, risk management processes and the board assurance framework. The diagnostic activity undertaken in the previous year meant that leaders knew the trust's issues and had identified the weaknesses in governance systems which was an improvement from the last inspection.

The trust board had delegated oversight of key areas of quality, safety, performance and governance to five board committees. The committees were the charitable funds committee, the quality and safety committee, the audit committee, the finance and performance committee and the people and organisational development committee. Each committee was chaired by a non-executive director. The board had also established an operational management board which was a meeting of executive directors and senior clinical and non-clinical leaders across the trust.

Leaders had recently reviewed these structures and had plans to make improvements to governance structures. The trust had invited an external peer review of the trust's adherence to the CQC well-led inspection framework. This involved partners and colleagues from nearby NHS trusts, the local integrated care board and NHS England. The findings of the review were available in draft form at the time of the inspection and in most areas matched our inspection findings. The trust was due to undertake a review of committee effectiveness as part of the next steps of the external governance review.

The trust did not have an up-to-date governance manual and the document provided did not reflect the trust's current structures or requirements. This was under review at the time of our inspection.

The board had recognised there was further work required to ensure the papers for board meetings and other committees were of a reasonable standard and contained appropriate information. Papers were lengthy and were focussed on providing the board with a detailed narrative. The board had recently introduced an integrated performance report for incidents, complaints, claims and inquests which provided details of the numbers and trends in performance data in these areas. The board had a separate comprehensive integrated performance report covering areas of quality and safety including mandatory training compliance, appraisal rates, cancer and elective performance, urgent and emergency care performance. These were areas of low or concerning performance identified during the inspection.

The trust had improved the board assurance framework since our last inspection. The board assurance framework separated risks to the delivery of the trust's strategy into seven areas which were people, finance, digital, operational effectiveness, quality, safety and governance. The trust board had sight of the most significant risks and mitigating actions were clear. The trust's six top risks in the board assurance framework were:

- Underlying long term trust financial sustainability
- Impact of EPR upgrade
- Failure to achieve access, waiting times, care pathways, and constitutional standards
- Failure to comply with safer staffing levels (nursing and maternity workforce)
- Failure to respond to CQC report and warning letters

Our findings

- Failure to assure patients and the wider public that the trust's services are safe, effective and well led in the light of the Lucy Letby verdict

The board assurance framework showed that the impact and likelihood of risks identified by the trust had remained mostly static since 2021, despite the action taken by the trust. The risks in the people category on the board assurance were the only risks on the framework where the action taken by the trust had created a trajectory of a reduction in risk scoring for some of the identified risks.

The trust had started to address this through board development sessions in 2022 and 2023 which focussed on establishing risk appetite and upper risk tolerance levels to set the required pace for reducing risks in each risk area. Risk owners who were the board level leads responsible for managing each risk had assessed the risk appetite for their areas, and risks assessed as exceeding the upper tolerance limit were identified as needing more urgent action to reduce the risk to manageable level more quickly.

Leaders' concerns matched those on the board assurance framework. The board had a strong and consistent awareness of the risks faced by the trust and the mitigations in place.

Non-executive and executive directors were clear about their areas of responsibility. The board had recognised the need to enhance the diversity of board members' skills and experience including the clinical representation on the board.

Appropriate governance arrangements were in place in relation to Mental Health Act administration and compliance. The trust had a service level agreement with a specialist NHS mental health trust who provided administrative support for compliance with the Mental Health Act. The same specialist NHS mental health trust provided a mental health liaison service. A partnership arrangement was in place for the provision of psychiatric liaison services with appropriate governance arrangements.

The trust did not have a strategy specific to providing care for patients with a mental health need, learning disability or autism. The trust's governance framework did not address the need to meet people's mental health needs. There was limited evidence of oversight of the quality of care provided for patients with a mental health need, learning disability or autism. The trust did not regularly monitor incidents of restraint or rapid tranquilisation. Staff did not receive training in mental healthcare, learning disabilities or autism. Security staff who used restraint did not receive training in the safe use of restrictive interventions in line with the requirements of the Restraint Reduction network.

The trust was working with third party providers effectively to promote good patient care. The trust described close working relationships and shared escalation processes with neighbouring NHS acute, community and mental health trusts. Leaders recognised that there were significant areas for improvement which were within the trust's scope of control, and there were further areas for improvement which required the support of partners in the integrated care system and neighbouring systems. Leaders told us that they were working closely with partners to manage the pressures on the trust's services.

The trust had governance systems for the management of medications. There was a medicines safety group which reported to the trust's quality governance group and to the quality and safety committee. The trust's pharmacy team described their key priorities as improving waiting times for outpatient prescriptions, reducing harm from medicines, implementing sustainable change and partnership working within the integrated care system.

Our findings

CQC Registration

The trust did not have effective governance systems to maintain appropriate registration with CQC. Prior to our inspection we identified the trust's nominated individual was not up to date. This required several prompts before the trust took action to update CQC with the details of the new nominated individual.

When providers, including NHS trusts, register with CQC they must identify each 'location' in their statement of purpose which is where providers intend to carry on a regulated activity at or from. CQC restrict providers' registration to only carry on the activity at or from these locations by using conditions of registration and if providers add or remove a location, they must apply to vary their conditions of registration.

During our inspection, we identified the trust had failed to tell CQC of a location where they were operating services and providing regulated activities. We alerted this error to the trust and the trust submitted an immediate application.

Learning from deaths

Effective systems were in place to identify and learn from unanticipated deaths. The trust had a mortality review policy and process in place at the time of our inspection and had an improved version of the process in draft form which was shortly due to launch. The trust was also reviewing the interrelationships between mortality reviews (learning from deaths), hospital level mortality data, the work streams of the deteriorating patient group, mortality and morbidity outputs, to be able to best describe the assurance process whilst optimising the experience in the delivery of safe patient care. This review was in progress at the time of our inspection.

We reviewed examples of structured judgement reviews (SJRs). These showed deaths were reviewed appropriately and in line with the trust's mortality process. The trust board received a quarterly learning from deaths report from the medical director. The most recent report from September 2023 noted that trust's mortality indicators which were up to February 2023 for Hospital Standardised Mortality Ratio (HSMR) and up to January 2023 for Summary Hospital-level Mortality Indicator (SHMI) rates. The Summary Hospital-level Mortality Indicator was 100.80 which was within the expected range for the trust and consistently within the expected range for the previous 12 months. The Hospital Standardised Mortality Ratio was 103.2 which was also within the expected range and was better than the previous reporting period.

The trust additionally monitored deaths occurring in the women's and children's division. The most recent report noted during the period of 1st April 2023 to 30th June 2023, the Trust recorded no pediatric deaths but one neonatal death. The neonatal death was the result of extreme prematurity at 21+4 weeks. The care was deemed by the trust to have been managed well and the outcome could not have been predicted or prevented. There were no incidents resulting the death of a neonatal patient in January to March 2023.

Management of risk, issues and performance

Leaders and teams had systems to identify and manage risks, issues and performance although these were not always effective. The systems did not identify many of the risks found by the inspection team. The trust did not have up to date plans to cope with unexpected events. The impact of financial pressures on the quality of care was rarely assessed.

However, the board had refreshed the board assurance framework and implemented measures to ensure there was an organisation-wide ownership of risk.

Our findings

Senior management committees and the board reviewed performance reports. The trust had recently reviewed the processes and had implemented new regular daily meetings for leaders to manage risk and performance.

The trust had a risk management policy and procedure which had been implemented in 2022. The policy set out expectations for how staff and leaders would identify, assess, escalate and mitigate risks.

Staff had access to the risk register at a division level and were able to effectively escalate concerns as needed. The trust had implemented new daily huddles for leaders at all levels to share risks. Divisional leaders within the trust were required to present their top risks at each operational management board and executive directors reviewed the trust's top risks on a monthly basis in the executive directors' group.

The trust used an electronic risk management system to identify, record and manage risks, issues and mitigating actions. Recorded risks were mostly aligned with what staff said were on their 'worry list'. The system showed there were a significant number of risks which were overdue for review. The risk registers provided by the trust showed there were 439 risks recorded on the electronic system, of which a third (143 risks, 33%) were overdue for review. The corporate services' risk register had the most risks which were overdue for review, whereas the risks on the therapies and integrated community care and the women's and children's divisional risk registers had all been reviewed within the required timeline.

The trust had appropriate structures to meet statutory responsibilities in relation to safeguarding adults and children. There was an executive lead for safeguarding, up to date safeguarding policies for children and adults, and an annual safeguarding report which was presented to the board. The trust had an internal safeguarding team and systems to ensure the team were sighted on all safeguarding incidents. Safeguarding adults training was below but near the trust's target. Overall compliance across the trust with level one and level two safeguarding adults training was 88% and 89% respectively. Safeguarding children training as of quarter two of 2023/24 met or was near the trust's target for level one (89%) and level two (90%) but was significantly below the target for level three (43%). The trust provided training in the Mental Capacity Act and Deprivation of Liberty Safeguards within a wider 'Think Family' training session. This was also significantly below the trust's target with compliance reaching 43%. The number of safeguarding referrals made by staff in the trust had increased year on year since 2021/22 for both adults and children.

The trust did not have up to date plans in place for emergencies and other unexpected or expected events, for example adverse weather, a flu outbreak or a disruption to business continuity. The trust had recently appointed a lead for emergency preparedness, resilience and response. The trust told us the lead was reviewing and updating the trust's current business continuity plans. The trust's full capacity protocol for urgent and emergency care services was not used effectively and did not result in significant action to alleviate the pressures in these services.

The trust had significant financial challenges which were reflected in the trust's board assurance framework as the top risk and the only risk to be assessed as the highest possible score of 20. The forecast deficit for the end of the financial year ranged from a best-case scenario of £28.3m to a worst case of £43.5m. As part of the trust's mitigating actions to address the financial risks, the trust had implemented an overall 6.4% cost improvement programme target for 2023/24, totalling £20,802k.

The trust did not have a robust arrangement to consider the impact of cost savings on patient care. Quality impact assessments were rarely completed as part of the trust's cost improvement programme and leaders told us they were required only where the cost improvement programme's value exceeded £50k. This differed from the requirements of the trust's cost improvement programme procedure and policy which required quality impact assessments as part of project initiation documents. These were required for projects meeting the following criteria: a change in clinical

practice, the procurement of a different or new clinical product, a change to service delivery or service redesign, changes to income that may have a contractual impact and/or where the value of the scheme exceeded £100k. The trust had completed three quality impact assessments for the current cost improvement programme. This meant that the trust could not evidence that the cost improvements in place did not present risks which would compromise patient care.

Access and Flow

The demand on services had frustrated access and flow through the trust and left services gridlocked. The trust faced the dual issues of too great a demand on urgent and emergency care services leading to an overcrowded accident and emergency department, compounded by reduced capacity in social care services and backlogs in assessments leading to significant numbers of patients stuck on wards waiting for discharge.

Since May 2023, the trust's urgent and emergency care services saw more than 7,000 attendances per month. The trust was regularly dealing with patients with high acuity. The trust's performance data showed more people came to the trust's services to receive care for major illnesses or injuries than the national average, and fewer people came with minor illnesses or injuries than the national average. The number of patients successfully streamed to receive care in a primary care setting was broadly in line with the regional average but significantly below the national average. The pressure in urgent and emergency care services had resulted in the trust routinely providing care for too many patients with high risks and levels of need, without enough staff and without enough space. Ambulance delays were common, and the trust was regularly in the worst three performing trusts in the region for ambulance handovers within 15 minutes, 30 minutes and 60 minutes. Between April and June 2023, almost 3000 people waited more than four hours to be admitted to a ward after there was a decision to admit, and over 1,700 people waited more than 12 hours. Corridor care had become normalised which compromised patient safety, privacy and dignity.

The trust had significant numbers of patients waiting to be discharged from the trust's wards. Bed occupancy rates for Quarter 2 2022/23 showed an average of 91% of the trust's beds were occupied overnight, and 93% of the trust's general acute beds. At the time of our inspection, the equivalent of a third of the trust's beds were occupied by people who did not need hospital care. In October 2023, data for the average number of people per day with length of stay 14 days or over who no longer met the criteria to reside but were not discharged showed the top three reasons for a delayed discharge were:

- Pathway 1: awaiting availability of resource for assessment and start of care at home (average of 22 patients).
- Pathway 2: awaiting availability of rehabilitation bed in community hospital or other bedded setting (average of 22 patients).
- Pathway 3: awaiting availability of a bed in a residential or nursing home that is likely to be a permanent placement (average of 9 patients).

These averages were broadly similar to the reasons for delayed discharges from the previous month. The trust told us that capacity issues in social care services was the primary cause of delayed discharge. NHSE data showed that in the three months between August and October 2023 the trust discharged 2,866 patients of which 703 were discharged with some form of ongoing package of care including domiciliary or residential care. This meant that one in four patients admitted to the trust's care in this period required further packages of care after their admission to be arranged to support their discharge.

Our findings

Audit

Leaders were satisfied that clinical and internal audits were sufficient to provide assurance. However, there were significant numbers of audits with low compliance and examples where teams had not acted on results when needed.

The trust's infection prevention and control report for 2022/23 noted there was good compliance (over 95%) with hand hygiene audits. Our inspection found staff were not always bare below the elbows and did not always wash their hands or change gloves between patient contacts. The trust's fire risk assessments for some wards noted there was immediate action required to remove equipment blocking fire doors. Our inspection found equipment was still stored in front of fire doors.

In urgent and emergency care services, medical wards and maternity services, there was a consistent theme of audits identifying low compliance in significant areas of service quality and safety. These included audits of care records, risk assessments, risk management strategies (including CTG monitoring), incident reporting, ward environments, equipment checks, medication and medicines prescribing, nutrition and hydration and sepsis care. Whilst the trust's audit programme was effectively sighting leaders on the risks in services, there were repeated examples where audits had either not been acted upon, or the action taken had resulted in limited improvement, or it was too early to assess the effectiveness of actions.

Cancer and elective performance

The trust's cancer performance data showed delays in patients being referred to services, although better than average performance for time taken to treat patients following a decision.

The trust was in the lowest 25% of trusts nationally for the percentage of patients seen with 2 weeks following GP referral. In July 2023, 64% of patients were seen within 2 weeks, compared with 79.7% regional and 77.5% national average. 92.1% of patients were treated within 31 days of decision to treat, which is in the middle 50% of trusts nationally and compared with 91% regionally and 91.8% nationally. The trust was in the middle 50% of trusts nationally for the percentage of patients treated within 62 days of a decision to treat. In July 2023, 66.2% of patients were seen within 62 days, compared with the 62.8% regional and 62.5% national average.

The trust's elective performance showed no patient waited more than 78 weeks from referral to receiving treatment, although there were increasing numbers of patients waiting more than 52 and 65 weeks. In August 2023, 48% of patients were treated within 18 weeks of referral which was a slight improvement since the previous month. The total number of patients waiting over 52 weeks had increased slightly. The trust had a national requirement to eliminate waiting times of more than 65 weeks by the end of March 2024. The trust's performance had positively deviated from the planned trajectory which meant the trust was treating more people in less than 65 weeks than originally planned. The trust had plans to implement a new tool to identify patients who may be at the most risk of suffering complications whilst on the waiting list so that they may be prioritised. This was planned to start from April 2024. In the interim, the trust told us each speciality with a long waiting list reviewed 30 patients from their lists to assess if harm occurred as a consequence of a long wait. If themes are identified from these reviews, then patients meeting the identified theme still on the waiting list were then prioritised for rapid review. The trust provided an example of patients with glaucoma who had been identified as experiencing harm on waiting lists and who had been now prioritised for review. However, this process was not a substitute for clinical validation of waiting lists and trust data showed only 44% of referral to treatment waiters over 12 weeks had been validated.

Our findings

Information Management

The trust collected reliable data but did not always analyse and present data clearly to understand performance, make decisions and identify areas for improvement. Information systems were integrated although staff did not always ensure records were kept secure.

However, the trust had addressed issues in the training provided to staff to use the electronic patient record system. The trust had completed external reviews of digital systems to identify further areas for improvement.

Staff had access to the IT equipment and systems needed to do their work and the trust now ensured staff had the training required to ensure they could use the systems well. The trust had implemented a new electronic patient record system in 2022. Our inspections in 2022 found that staff did not have sufficient and appropriate training in how to use the system which presented significant risks. Since our last inspection the trust had invested in new training with an increased offer of face-to-face training for staff. We found staff familiarity and confidence in using the electronic patient record system had significantly improved although staff in some core services told us they would like further training in the system.

The trust had committed to an extended programme of investment in the electronic patient record system. There were plans to make further improvements to the system including a significant programme of upgrades which included process mapping to streamline how the system operated.

Systems were in place to collect data from frontline services although there was further work planned to ensure data was used effectively. The trust had developed early examples of dashboards to present data succinctly including a harms dashboard and a complaints dashboard. The trust was developing further dashboards with plans to deliver a nursing and midwifery staffing dashboard and an improved quality dashboard before the end of 2023/24.

The board and senior staff expressed confidence in the quality of the data. The trust was aware of its performance through the use of KPIs and other metrics. Information was in an accessible format, timely, accurate and identified areas for improvement. The trust had developed a strategic oversight framework report which included data covering key performance and quality indicators. The report presented to the board in September 2023 identified there was need for improvements in sepsis indicators, falls, emergency medicine performance, cancer performance, mandatory training and annual appraisal compliance, and the trust's financial overspend.

The trust had completed the Data Security Toolkit assessment. The trust's submission was audited by an external agency with a risk assurance rating of moderate and an overall confidence rating of high assurance. The confidence level had increased since the previous year's assessment. The actions from the assessment were monitored by the trust's finance and performance committee. The trust had commissioned an independent team to audit data security. The trust had in place a senior information risk owner, a Caldicott guardian, and a data protection officer.

Information governance systems were in place including confidentiality of patient records. The trust's electronic patient record system could only be accessed by staff with passwords or identification cards. However, during the inspection staff were regularly observed leaving computers unattended with the electronic patient record system accessible and we found examples where paper records were left unattended.

The trust learned from data security breaches. The trust took appropriate action including disciplinary action to respond to data security breaches. The trust had experienced two recent cyberattacks which had not had significantly impacted on the delivery of care.

Our findings

Leaders submitted most notifications to external bodies as required. Between January and September 2023, the trust declared 32 serious incidents of which 24 were identified and declared within 14 days. Only one of the 32 incidents took more than 90 days to be declared and reported to external bodies.

The trust had failed to notify CQC of changes to the trust's nominated individual and had failed to submit an appropriate application to deliver services from a new location.

Engagement

The trust engaged with local partners and with partners in the integrated care system to help improve services for patients. Leaders were committed to rebuilding trust with patients, staff and the public.

Communication systems including a public website and staff intranet were in place to ensure staff, patients and carers had access to up-to-date information about the work of the trust and the services they used. The trust maintained public profiles on social media. There was a trust newsletter which was published twice a year between 2020-22 with a commitment to publish three times a year in 2023. The trust's website did not have additional features to ensure information was accessible to all, such as options to change font size and contrast settings, or to translate information into languages other than English. The trust had recognised that the website was not compliant with accessibility requirements which was due to the website's age and the software used to construct it. In 2020 the trust committed to launching a new website however as of our inspection in 2023 the website had not been relaunched.

The trust had an accessible information standards policy which was in date and not due for review until 2025. The trust had a contract with an external provider for interpretation and signing services.

The trust did not have a structured and systematic approach to staff engagement although leaders recognised that staff engagement was a priority area for improvement. Staff engagement was a risk on the trust's board assurance framework and the failure to develop and implement an employee engagement strategy was noted as a gap in the trust's risk control. The trust had a staff engagement working group.

The trust did not have a structured and systematic approach to engaging with people who used services, those close to them and their representatives. The trust planned to launch a new patient and family experience strategy in quarter four of 2023/24. This strategy replaced the patient experience and involvement strategy which expired in 2019. The trust was due to launch a new overarching five-year strategy shortly after our inspection. The development of the new strategy had involved stakeholders and system partners. There was limited evidence of patient or public involvement in the development of the strategy.

The trust had relocated the patient advice and liaison service to the main reception of the Countess of Chester hospital to improve the visibility of this service.

The trust had access to feedback from patients, carers and staff and were using this to make improvements. The CQC adult inpatient survey results looked at the experiences of 453 people who stayed at least one night in the trust's inpatient services. The results showed the trust ranked in the bottom three regionally for patients being asked to give a view or provide feedback on the quality of the care they received during their stay. The trust expressed disappointment with the survey results and was formulating an action plan in response at the time of our inspection.

Our findings

There was limited evidence showing the trust sought to actively engage with people and staff in a range of equality groups. The trust had launched a new equality, diversity and inclusion strategy for 2023-26. The strategy committed the trust to six strategic objectives.

- To grow a compassionate and inclusive culture, which is evidenced by our employee and patient voices.
- To evidence that patients (and others) who are challenged to communicate easily, are able to access all of the services we offer.
- To widen participation in the delivery of Trust services for our local community by increasing employment opportunities across all protected characteristics.
- To evidence our people are better equipped and feel confident to spot and deal with EDI issues in their day-to-day work.
- To evidence social disadvantage and health inequalities are addressed by putting EDI at the heart of our institutional processes and decision making.
- To evidence our commitment for promotion of EDI best practice by being recognised as a exemplar in the North-West Region and beyond.

The trust's equality, diversity and inclusion strategy included a series of descriptors for what the successful implementation of the strategy would look like in practice. The descriptors of good were heavily focussed on improving the experience of staff.

The trust had made limited progress in addressing health inequalities. The trust's equality, diversity and inclusion strategy and the new overarching trust strategy included commitments to developing a trust approach to health inequalities and prevention. The trust's strategy included the objective to make a 'proactive contribution in improving population health'. The interim Director of Strategy was the trust's nominated lead for this work.

The trust's board of governors included members of the public, staff and stakeholders. The trust offered most governors training on appointment. Governors told us they felt actively involved in the operation of the trust. Most felt listened to by the trust's board and were satisfied by the board's performance. The governors were mostly positive about the quality of papers provided by the trust. All the governors we spoke with told us they felt proud to be a trust governor.

Patients, staff and carers were able to meet with members of the trust's leadership team and governors to give feedback. The trust held an annual meeting for the trust's members which included members of the public. The trust's website included contact information for governors representing specific constituencies. Governors visited services supported by non-executive directors, and also held pop-up events within hospital entrances for members of the public to provide feedback.

Managers, on behalf of front-line staff, engaged with external stakeholders such as commissioners and Healthwatch. The trust's accident and emergency services and same day emergency care service had been recently visited by Healthwatch in September 2023. The report from the visit highlighted the pressures on accident and emergency services. The Healthwatch annual report for Cheshire West which covered the catchment area served by the trust noted there were areas improvement in discharge planning in Ellesmere Port Hospital. The report noted the trust's response to this feedback which included an action plan for improvements.

Our findings

External stakeholders said they received open and transparent feedback on performance from the trust. The trust's performance data formed part of the publicly performance data packs provided to the integrated care board's regular public meetings. Partners in the integrated care system told us that the trust was part of the system-wide approach to Winter planning.

Learning, continuous improvement and innovation

Staff and managers were committed to improving the quality of services. Leaders had identified and had plans to address the areas still needing improvement. Leaders encouraged innovation and participation in research.

The trust had delivered most of the quality priorities for 2022/23. These included the implementation of the Patient Safety Incident Reporting Framework (PSIRF) and the elimination of waiting times exceeding 78 weeks for patients waiting for treatment. The trust had held a Harms Summit in March 2023 which agreed seven areas of focus for quality improvement. These were:

- Sepsis identification and management
- Acute kidney injury (AKI)
- The Trust Emergency Department (ED) improvement strategies and plans
- The deteriorating patient
- Falls management
- Pressure ulcer prevention
- Medication incidents

Staff were encouraged to make suggestions for improvement and the trust provided examples of quality improvement ideas which had been implemented.

The trust actively sought to participate in national improvement and innovation projects. This included participation in 43 national audits and 7 national confidential enquiries during 2022/23. The trust also participated in 83 local and regional audits in the same period.

The trust delivered on some but not all of the Commissioning for Quality and Innovation (CQUIN) targets. The CQUIN framework supports improvements in the quality of services with financial incentives for trusts who make the required improvements. In 2022/23, the trust at least met minimum compliance against targets in most or all quarters for the following CQUINs:

- Recording of National Early Warning Score 2(NEWS2) score, escalation time and response time for unplanned critical care admissions
- Appropriate antibiotic prescribing for Urinary Tract Infection (UTI) in adults aged 16+
- Supporting patients to drink, eat and mobilise after surgery

The trust did not meet the following targets:

- Staff flu vaccinations (64% achieved against a target of 70%)

Our findings

- Treatment of community acquired pneumonia (CAP) in line with BTS care bundle (Minimum target of 45% not achieved)

The trust had a planned approach to take part in national audits and accreditation schemes and shared learning. The trust had an annual clinical audit programme, a clinical audit policy and a clinical audit strategy for 2023-25 which set out objectives for the successful implementation of the trust's clinical audit policy.

Staff had training in improvement methodologies and used standard tools and methods. The trust had trained 588 staff in lean methodology at a variety of levels ranging from foundation training to quality improvement champion, practitioner and advanced training.

Senior leaders were committed to ensuring the trust became a leader in research. There were organisational systems to support improvement and innovation work. The trust had a research and innovation committee which was a sub-committee of the trust's quality governance group. The trust's new strategy included a commitment for medical director and nursing director to lead on developing a bespoke research, education, and innovation strategy. The trust had been awarded £330k by the National Institute of Health Research to pay for new research equipment and technology and boost research and innovation. The trust had recruited 1250 into clinical trials this financial year which was an increase of 33% compared to the trust's performance prior to the COVID-19 pandemic. Participants in the trust's research were positive about their experience as noted in the trust's Quality Account for 2022/23. In the National Participant Research Experience Survey (PRES) for 2022/23, the Trust had the second highest number of surveys returned across the North West Coast Clinical Research Network. 170 people who participated in one of 25 different trials completed the survey with 92% of people said that they would agree or strongly agree to consider taking part in research again.

Key to tables

Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	→←	↑	↑↑	↓	↓↓

Month Year = Date last rating published

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires Improvement →← Feb 2024	Requires Improvement →← Feb 2024	Good →← Feb 2024	Requires Improvement →← Feb 2024	Requires Improvement ↑ Feb 2024	Requires Improvement →← Feb 2024

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
The Countess of Chester Hospital	Requires Improvement → ← Feb 2024	Requires Improvement → ← Feb 2024	Good → ← Feb 2024	Requires Improvement → ← Feb 2024	Requires Improvement → ← Feb 2024	Requires Improvement → ← Feb 2024
Ellesmere Port Hospital	Requires Improvement ↓ Feb 2024	Requires Improvement ↓ Feb 2024	Good → ← Feb 2024	Requires Improvement ↓ Feb 2024	Requires Improvement ↓ Feb 2024	Requires Improvement ↓ Feb 2024
Overall trust	Requires Improvement → ← Feb 2024	Requires Improvement → ← Feb 2024	Good → ← Feb 2024	Requires Improvement → ← Feb 2024	Requires Improvement ↑ Feb 2024	Requires Improvement → ← Feb 2024

Ratings for the trust are from combining ratings for hospitals. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for The Countess of Chester Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Requires Improvement → ← Feb 2024	Requires Improvement → ← Feb 2024	Good → ← Feb 2024	Requires Improvement → ← Feb 2024	Requires Improvement → ← Feb 2024	Requires Improvement → ← Feb 2024
Services for children and young people	Requires Improvement → ← Feb 2024	Good → ← Feb 2024	Good → ← Feb 2024	Requires Improvement ↓ Feb 2024	Good → ← Feb 2024	Requires Improvement ↓ Feb 2024
Critical care	Good Jun 2016	Good Jun 2016	Good Jun 2016	Requires improvement Jun 2016	Good Jun 2016	Good Jun 2016
End of life care	Good Jun 2016	Requires improvement Jun 2016	Good Jun 2016	Requires improvement Jun 2016	Requires improvement Jun 2016	Requires improvement Jun 2016
Outpatients and diagnostic imaging	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016
Surgery	Requires improvement Jun 2022	Requires improvement Jun 2022	Good Jun 2022	Requires improvement Jun 2022	Requires improvement Jun 2022	Requires improvement Jun 2022
Urgent and emergency services	Inadequate ↓ Feb 2024	Inadequate ↓↓ Feb 2024	Good → ← Feb 2024	Inadequate ↓ Feb 2024	Requires Improvement → ← Feb 2024	Inadequate ↓ Feb 2024
Maternity	Requires Improvement ↑ Feb 2024	Requires Improvement → ← Feb 2024	Good → ← Feb 2024	Good ↑ Feb 2024	Requires Improvement ↑ Feb 2024	Requires Improvement ↑ Feb 2024
Overall	Requires Improvement → ← Feb 2024	Requires Improvement → ← Feb 2024	Good → ← Feb 2024	Requires Improvement → ← Feb 2024	Requires Improvement → ← Feb 2024	Requires Improvement → ← Feb 2024

Rating for Ellesmere Port Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Requires Improvement ↓ Feb 2024	Requires Improvement ↓ Feb 2024	Good → ← Feb 2024	Requires Improvement ↓ Feb 2024	Requires Improvement ↓ Feb 2024	Requires Improvement ↓ Feb 2024
Outpatients and diagnostic imaging	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
Overall	Requires Improvement ↓ Feb 2024	Requires Improvement ↓ Feb 2024	Good → ← Feb 2024	Requires Improvement ↓ Feb 2024	Requires Improvement ↓ Feb 2024	Requires Improvement ↓ Feb 2024

The Countess of Chester Hospital

Executive Suite, Countess Of Chester Health Park
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www.coch.org

Description of this hospital

The Countess of Chester Hospital is an approximately 600 bedded large district general hospital which provides a full range of acute services. This includes acute and specialist services including an urgent and emergency care service, general and specialist medicine, general and specialist vascular surgery and full consultant led maternity, obstetric and paediatric hospital services for women, children and babies.

Maternity

Requires Improvement

Is the service safe?

Requires Improvement

Our rating of safe improved. We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills and monitored completion levels. There was high compliance with most groups of staff who met, or were close to, the trust target.

We reviewed the mandatory training information provided by the trust and calculated the mandatory training compliance for different groups of staff within the maternity team. These results showed that the service mostly met the trust target of 90% for mandatory training.

- 91% of midwifery staff
- 89% of obstetrics and gynaecology medical staff
- 90% of additional clinical staff (includes midwifery support workers)

The following staff groups that had not met the trust target equated to 10 members of staff.

- 86% of administrative and clerical staff

The overall compliance for mandatory training for maternity service was 91% which met the trust target.

The mandatory training was comprehensive and met the needs of children, young people and staff. Staff received training in areas such as infection prevention, equality and diversity, and health, safety and welfare.

Staff completed study days for additional mandatory training relevant to their role including practical obstetric multi-professional training (PROMPT) and electrical fetal monitoring (EFM). The training was attended by obstetricians, anaesthetists, midwives, and midwifery support workers. The PROMPT training covered a wide range of obstetric emergencies such as sepsis awareness, shoulder dystocia, post-partum haemorrhage, eclampsia, cord prolapse and management of epidural. Data from August 2023 showed compliance was 99% for midwives, 93% for midwife support workers and 91% for medical staff which met the trust target. Compliance for anaesthetists was 71% and 35% for junior doctors. The trust clarified that the service had a trajectory to have 100% of these staff groups trained in PROMPT by December 2023.

Consultants we spoke with told us they completed PROMPT training and were allocated protected time to complete it.

EFM training was comprehensive and delivered by the fetal monitoring lead. Training involved real life localised case studies to consolidate learning and included the most recent National Institute of Health and Care Excellence (NICE) guidance. Compliance for this training was 100% for midwifery staff and 100% for medical staff which met the trust target.

Maternity

We reviewed the current compliance rates for basic life support training.

The compliance rates for midwives were:

- Adult basic life support 95%
- Newborn basic life support 92%
- Paediatric basic life support 100%

The compliance rates for medical staff were:

- Adult basic life support 97%
- Newborn basic life support 92%
- Paediatric basic life support 97%

The compliance rates for additional clinical support staff including midwife support workers were:

- Adult basic life support 90%
- Newborn basic life support 77%
- Paediatric basic life support 90%

Compliance data for advanced life support (ALS) was provided trust wide and not broken down to the maternity service. Data showed that 100% of medical and dental staff had completed ALS, 96% of nursing and midwifery staff and 80% of allied health professionals.

Compliance data for advanced paediatric life support (APLS) was also provided trust wide and showed 100% of medical and dental staff had completed it. Compliance for nursing and midwifery staff and allied health professionals was also 100%.

Trust data showed that some midwifery and medical staff within the women and children's division had completed immediate life support (ILS) and paediatric immediate life support (PILS) training. However, the trust did not provide overall compliance rates or details of the number of staff who were required to undertake this training. This meant the trust did not evidence that sufficient staff had the training required to undertake their role.

Staff completed deteriorating patient level 1 training which incorporated sepsis training. Data showed that 78% of midwifery staff had completed it in 2023 and 100% had completed it since 2022. 100% of the obstetrics and gynaecology medical team had completed it in 2023. For additional clinical staff, 69% had completed it in 2023 and 97% had completed it since 2022.

Clinical staff completed training on recognising and responding to children and young people with mental health needs, learning disabilities and autism. The trust had recently introduced the Oliver McGowan, learning disability and autism training as part of mandatory training. Trust data showed a compliance rate of 74% for maternity staff and 56% for obstetrics & gynaecology medical team across the women and children's division. Mental capacity act training was delivered as part of level 3 safeguarding training although compliance rates were not provided.

Staff told us that managers monitored completion levels and sent email reminders when training was approaching the due date.

Safeguarding

Staff understood how to protect women and birthing people from abuse and the service worked well with other agencies to do so. They knew how to recognise, and report abuse and they knew how to apply it. However, midwifery and medical staff did not always meet the trust target for safeguarding training. Doors on the antenatal and postnatal ward were not always locked and secure.

The overall compliance for midwifery staff was 85% for safeguarding adults' level 2 and 100% for safeguarding children level 2 and 89% for children level 3. They were 95% compliant for PREVENT awareness level 3. This is training designed to prevent radicalisation, extremism, and terrorism. This meant midwifery staff did not achieve the trust training target of 90% in safeguarding adults level 2 training.

The overall compliance for medical staff was 97% for safeguarding adults' level 2, and 94% for safeguarding children level 2 and 79% for children level 3. They were 97% compliant for PREVENT awareness level 3. Medical staff did not achieve the trust training target of 90% in safeguarding children level 3.

The overall compliance for additional clinical staff which included midwifery support workers was 97% for safeguarding adults' level 2, and 95% for safeguarding children level 2 and 82% for children level 3. They were 100% compliant for PREVENT awareness level 3. This meant clinical support staff did not reach the trust training target of 90% in safeguarding children level 3.

Female genital mutilation training (FGM) was delivered as part of safeguarding children level 3 training. The service had a comprehensive and in date FGM policy that staff could follow for guidance. The trust used the FGM-IS (female genital mutilation information system) to support the early intervention and ongoing safeguarding of women and birthing people under the age of 18 who have a family history of FGM. This was managed through the national health care record and recorded on the electronic patient record. Women and birthing people who had been subjected to FGM were being monitored and assessed through the safeguarding process.

From January 2023 the service offered a "think family" safeguarding level 3 face to face study day. This combined both adult and children safeguarding level 3 training and included domestic abuse training and the mental capacity act (MCA) training inclusive of deprivation of liberty safeguards (DoLS).

We reviewed the training data for level 3 'think family' training and it showed that the maternity team had 6 staff who had completed the training. The obstetrics and gynaecology medical team had 2 staff who had completed it. However, the trust did not provide overall compliance rates or details of the number of staff who were required to undertake this training. This meant the trust did not evidence that sufficient staff had the training required to undertake their role.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff we spoke with knew who the safeguarding leads were to access support when reporting concerns. Community midwives had a safeguarding supervisor and told us they could easily access support or training. Trust data showed that all eligible community midwives had received safeguarding supervision in the previous 12 weeks.

Women and birthing people with safeguarding risks had an alert on their electronic patient record. We observed these alerts in some of the records we looked at. The alerts then triggered an automatic safeguarding referral. For the period

of 2022/2023 the safeguarding and complex care team (SACCT) received 1432 from staff. They received 101 safeguarding referrals from maternity services with 5 women who lived outside of commissioned area. This had reduced from the previous year of 217. We reviewed safeguarding policies for both adults and children, they were comprehensive and in date.

The safeguarding and domestic abuse lead worked with external and specialist services such as the perinatal mental health team and drugs and alcohol team. They were also part of the North West safeguarding midwives' network and attended regional safeguarding professional's meetings.

Posters were placed discreetly to signpost women and birthing people to domestic violence support services.

Staff used the electronic patient system to complete assessments of maternal mental health and substance misuse at the booking appointment. Staff knew how to make a safeguarding referral and who to inform if they had concerns. They could refer to the perinatal mental health midwife at the hospital or specialist perinatal mental health team depending on concerns and urgency. Disclosure of current or previous substance misuse recorded on the system alerted staff to refer to the SACCT.

For women and birthing people who lived out of the trust's catchment area, the safeguarding team liaised with community midwives in their local area to discuss referral and safeguarding concerns.

The entrance to the antenatal and postnatal ward (Cestrian ward) and central labour suite was accessed via locked doors with an electronic access system for staff only. At a previous inspection in February 2022, it was recommended that the service should ensure that all clinical areas are secure to prevent anyone leaving the area unsupervised. However, at this inspection we found repeated concerns. We found some doors on the Cestrian ward that were unlocked and accessible to patients or members of the public. This meant there was risk a baby could be abducted from the unit. Whilst we raised this with managers during our inspection, and they took immediate action to ensure all doors were secure, the security issues found during the inspection meant that the trust did not have a robust process to identify and assess environmental risks.

Staff followed the baby abduction policy which was in date and staff told us they had received training in baby abduction. The service conducted annual baby abduction drills. The most recent baby abduction drill from September 2023 highlighted areas of positive actions, areas of learning and recommendations. This included all visitors to now be signed in when entering the ward and for staff to challenge unidentified persons attending the ward.

The improvements were shared with staff in a presentation displayed on the staff noticeboard and in safety huddles. All staff we spoke with described the learning and actions that had been taken. We looked at the action plan and it showed the actions had been completed in a timely manner and that managers were considering the introduction of a baby tagging system.

Cleanliness, infection control and hygiene

Staff used equipment and control measures to protect women, birthing people, themselves, and others from infection. They kept equipment and the premises visibly clean. However, the service did not always control infection risk well.

The service generally performed well for cleanliness. Matrons completed monthly walk arounds to observe and monitor the environment, medication safety, hand hygiene, emergency equipment and patient bed areas. Data from the previous 4 months of walk arounds showed the Cestrian ward scored on average 41 out of 45.

Maternity

Maternity areas we visited were visibly clean and had suitable furnishings which were visibly clean and well-maintained. Cleaning records were up to date and demonstrated all areas were cleaned regularly. Cleaning audits showed that the central labour suite scored between 98% and 99% for the previous 3 months.

However, there were significant gaps observed in two bathroom and toilet checklists for October on the central labour suite. We also found stained bed linen which was escalated to managers and immediately changed.

We looked at the environmental audits for the central labour suite from April 2023 which showed 98% compliance. The associated action plan showed that items were repaired, and areas cleaned in a timely manner by the estates and domestic teams.

IPC and environmental audits were conducted either monthly or quarterly and action plans were monitored monthly by the IPC champion and matrons walk about. Each action had an accountable person assigned responsibility.

Audit results for the central labour suite and the Cestrian ward showed a high compliance rate of 100% for hand hygiene carried out in the previous 3 months. The wards were also part of the trust wide departmental IPC audit programme for 2023 to 2024. In April 2023, the central labour suite scored 100% for 8 out of 9 areas such as personal protective equipment (PPE) and departmental waste. The Cestrian ward scored over the trust target of 90% for 6 out of 9 areas such as safe handling & disposal of sharps and isolation precaution. Overall, the wards scored close to the trust wide average score of 90%.

Compliance for IPC training level 2 was 97% of medical staff, 95% of midwifery staff and 92% of additional clinical staff. This met the trust target of 90% compliance rate.

Staff followed infection control principles including the use of PPE such as aprons and gloves. We observed staff regularly washing their hands and were bare below elbow when delivering care. Most staff were compliant with the uniform and dress policy. However, some staff had their hair in loose ponytails with the hair touching or below the collar.

Staff cleaned equipment after contact with women and birthing people. Staff cleaned couches between use in the antenatal clinic and it was clear equipment was clean and ready for use. Disposable curtains were visibly clean and dated within 6 months.

However, we found some areas of concern in the central labour suit and Cestrian ward relating to infection control risks. This included limescale buildup on sinks in patient bathrooms, visible mould on grout in patient showers, and broken wall and floor tiles which were not sealed. The infection prevention and control (IPC) audit for the Cestrian ward dated April 2023 showed 89% partial compliance. The associated action plan showed that staff had already raised these issues to the estates team at the time of the audit. There were approximately 11 actions relating to repairs for flooring, tiles, limescale or mould in showers with due dates set for May 2023. At the time of inspection only one of these actions had been completed by estates which had been the replacement of ceiling tiles.

We escalated some of these issues at the time of the inspection. Senior leaders provided assurance by completing an action plan to address concerns highlighted. These included both immediate and long-term actions. The action plan indicated that the estates team were now undertaking work to remove the mould in the bathrooms.

The trusts corporate risk register had recorded risk of infection transmission as a divisional risk due to poor state of repair of environments across the hospital. This had been categorised as a moderate risk level.

Maternity

Environment and equipment

The design and use of facilities and premises did not always keep women, birthing people and staff safe. However, the service had enough suitable equipment to help them to safely care for women and birthing people and babies. Staff managed clinical waste well.

The women and children's building had been constructed between 1967 and 1969 which meant the age of the building presented environmental risks. However, a new women and children's building was being constructed with plans to open in 2025.

The service had some suitable facilities to meet the needs of women, birthing people and their families. The blossom birthing unit had 2 delivery rooms, each with en-suite facilities and a birthing pool. The central labour suite had 7 delivery rooms, 1 had a birthing pool and 3 were equipped with baths. However, we observed that 3 delivery rooms shared one bathroom and access to the bathroom was via a small rear corridor which was cluttered with chairs and birthing balls.

The maternity service had 1 theatre within the central labour suite and an additional delivery room (room 15) which was used in an emergency as a back-up theatre. Room 15 had an anaesthetic machine, an operating table and handwashing facilities. However, there was not enough space for a full scrub sink which meant when room 15 was used as a second theatre, staff had to use the adjacent scrub room. To mitigate the risk of infection both doors were opened for the practitioners who have scrubbed. There was not enough space in the room for the required equipment. A notice on the door described where to locate equipment when setting up the room as a second theatre in an emergency. The equipment was located nearby, for example the theatre light and surgical instrument stand were kept in the corridor outside the room.

We escalated these issues at the time of the inspection. Senior leaders told us that although the room did not meet theatre requirements it was only used in escalation when the central labour suite theatre was already in use and when a transfer to main theatres wasn't deemed safe. The room had been used 7 times as an emergency second theatre since December 2022 and had been incident reported on each occasion.

Post inspection, senior leaders immediately implemented a new maternity theatre escalation procedure to ensure clear and formalised process of escalation when room 15 was used as a second theatre in an emergency.

Following the inspection, we asked for evidence of any risk assessments carried out for the use of room 15 for surgery in the last 12 months. We received a workplace risk assessment dated December 2022 and date of review December 2023.

The service had identified the lack of a second theatre on the central labour suite as a significant risk. This had been scored high on the divisional risk register since 2015.

To mitigate risk the elective caesarean section lists were undertaken twice a week in theatre B situated in the main hospital. This was to ensure availability of the maternity theatre which was situated in the same building as the neonatal team. Any baby that was to be delivered that may require neonatal team input was being delivered in the maternity theatre. However, this could not always be predicted.

Maternity

The service recognised the risk of using theatre B for elective caesarean sections. This was due to the significant distance from the neonatal unit to theatre B, which was situated across the connecting bridge in the main hospital. This impacted on how quickly the neonatal team could arrive in main theatre and the transfer time back to the neonatal unit. Elective caesarean sections were supported by a band 6 midwife who had completed newborn life support (NLS) training. Staff we spoke with told us “It can be scary as it takes the neonatal some time to arrive”.

Another risk of the significant distance from theatre B to the maternity ward was the risk of babies temperature dropping during transfer. We reviewed the service’s recent Situation, Background, Assessment and Recommendation (SBAR) report into higher rates of babies suffering from hypothermia after been born by caesarean section in theatre B. Despite many actions such as theatre temperature control, using hot cots and thick sterile blankets there were still incident reports of cold babies. In response, the service had purchased a warming mattress to decrease the chance of hypothermia and maintain optimal body temperature for women, birthing people and babies during skin-to-skin contact.

The new women and children’s building opening in 2025 will have two obstetric theatres which would remove these risks.

We requested confirmation of servicing for maternity theatre air flow equipment to evidence the quality assurance on air flow. The trust provided a ventilation inspection report for the maternity theatre dated May 2022. The report showed that the theatre was not compliant with Health Technical Memoranda (HTM) 03-01 guidance for theatre air change rate and anaesthetic extract air change rate. Recommendations were made in the report to rebalance and improve the air change rates.

The ventilation inspection report for room 15 and the 9 birthing rooms. The report was dated May 2023 showed that were not compliant for supply and extract air change rates in line with HTM 03-01 guidance. The report stated that all air change rates failed throughout the birthing suite and that further investigation was required.

Following our inspection, we requested actions taken by the trust to address the recommendations noted in the ventilation inspection reports. However, the trust did not provide further evidence of actions taken to improve the air change rates.

The service had processes in place to monitor the water supply for legionella. The thermostatic mixing valve service report for the central labour suite dated April 2023 showed compliance with the hot and cold water temperature requirements.

On the Cestrian Ward we found a small number of urine strips and test strips out of date and 4 containers of breast milk in the freezer that were out of date. These were immediately removed by staff.

However, clinical waste was stored and disposed of safely and sharps bins were used correctly.

Staff carried out daily safety checks of specialist equipment. The service shared resuscitation trolley audit results from July 2023 to September 2023 for the maternity wards. The central labour suite had 92% of trolley checks completed, Cestrian ward scored 93% and the antenatal clinic scored 99%. This meant the wards met the trust target of 90%. However, we did see some gaps in daily records for resusitaires in the central labour suite and theatre B located in the main hospital where elective caesarean sections were carried out.

Most specialist equipment had stickers to show they had been safety checked regularly as per recommendations. Some equipment didn't have stickers on which meant it was unclear if they had been serviced. We raised this at the time of inspection with the clinical engineering and estates team who evidenced they had been safety checked within the last 12 months. The service had a system in place whereby staff would manually report if a piece of equipment was faulty or due a service.

The service had enough suitable equipment to help them to safely care for women and birthing people and babies. For example, in the day assessment unit and triage unit there was a portable ultrasound scanner, cardiotocograph (CTG) machines and observation monitoring equipment. The service also had wireless fetal monitoring equipment. This meant that women and birthing people who needed continuous fetal monitoring could mobilise more freely during labour and adopt more comfortable positions.

The service had pool evacuation hoists available and staff told us an evacuation drill had recently been done in October 2023. The service had a policy for the use of the birthing pool with a printed date of April 2017 but no issue or review date recorded. This meant staff might not have the most up to date guidance to follow.

During an inspection in July 2022, it was found the service did not have enough suitable equipment to undertake rapid assessment of the efficiency of blood coagulation at the point-of- care (POC). However, on this inspection we found that the service had taken action to ensure the maternity theatre had a rotational thromboelastometry (ROTEM) machine. This meant staff could test the efficiency of blood coagulation in a timely manner without travelling to main theatres to access the equipment.

The infant feeding team told us they had no issues accessing breast pumps and sterilisation equipment to support women and birthing people feeding their babies. This included sufficient breast pumps to support those at home after being discharged.

Assessing and responding to risk

Staff did not always complete and update risk assessments for each woman and birthing person and staff did not always take action to remove or minimise risks. Therefore, staff were not always able to identify and quickly act upon women and birthing people at risk of deterioration.

Staff in maternity theatres used the World Health Organisation (WHO) surgical safety checklist. However, we reviewed 4 women and birthing people's notes and found gaps in some of the safety steps. For example, no signature for the time out step and no consent form. Audit data for the WHO checklist from August 2023 showed compliance was 87% against a trust target of 100%.

Audits were carried out to check risk assessments and other key areas. There were 15 care metric audits that were carried out monthly with a trust target of 100%. These included electric fetal monitoring, surgical checklist, reduced fetal movement, Modified Early Obstetric Warning Score (MEOWS) and postpartum haemorrhage (PPH) assessment. Data from August 2023 showed that compliance rates varied across the metrics. There were 10 metrics with compliance scores of 80% and above. However, 3 metrics had compliance scores that ranged from 49% to 73%. Where issues were identified, action was taken to increase safety and compliance.

Appropriate monitoring and escalation management of PPH had been implemented using the all Wales pathway. This is a recognised tool developed by the Obstetric Bleeding Strategy (OBS) Cymru (Wales). The service completed monthly audits for PPH assessments. However, August 2023 audit data showed that compliance for completing assessments was 73%. This meant that women and birthing people at risk of PPH might not be identified and escalated quickly.

Maternity

Staff reviewed care records from antenatal services for any individual risks. There was a fetal surveillance lead and staff used the fresh eyes approach to safely and effectively carry out fetal monitoring. Leaders audited how effectively staff monitored women and birthing people during labour having continuous cardiotocograph (CTG). The September 2023 audit showed 70% compliance with hourly CTG assessment throughout labour and 97% overall compliance with 4 hourly intrapartum risk assessment. Staff did 'fresh eyes' at each hourly assessment in 60% of cases, this had declined from 90% in August 2023.

Risk assessments at the time of booking were completed and reviewed by a consultant to assign consultant or midwifery led care. The level of risk at the booking appointments and risk factors were recorded in all 8 maternity records we looked at. However, risk was not always assessed at each maternity contact/appointment. There were 3 records where risk assessments were not completed at each maternity contact. This meant there was a risk women and birthing people might not be allocated to the right pathway with the correct team to lead and plan their care.

At the time of inspection, the triage service did not use a formal prioritisation tool for assessing risk. The triage midwife used clinical judgment to assess those in most clinical need. However, the service had piloted a nationally recognised tool for clinical prioritisation in triage in June 2023 which was then suspended. The service told us the new triage system, following the nationally recognised tool was being reintroduced on 13 November 2023 and the service had a comprehensive policy in place to guide staff.

The triage unit was staffed by 1 midwife. This was not in line with the guidance for the new triaging model that had been piloted in June 2023. Guidance recommends that triage should be staffed with 1 midwife and 1 midwife support worker in units with less than 3000 births a year. However, staffing would be in line with the guidance when the new triaging model was reimplemented in November 2023.

The triage midwife was responsible for assessing women and birthing people on arrival to the unit in addition to answering the triage telephone line. During our inspection we observed 1 phone call not answered in triage and another call lasted 20 minutes where the phone line would not have been available. This meant that staff could not be assured all telephone calls from women and birthing people were consistently answered.

Unanswered phone calls on the triage unit were diverted to the delivery suite. However, we observed 1 phone call not answered in the delivery suite and any diverted triage calls could be answered by any member of staff. This meant the service could not be assured that staff answering the telephone had the appropriate training and skills or that the call would be answered in a timely manner when acuity on the delivery suite was high. This increased the risk of women not accessing advice and support from an appropriate member of staff in a timely manner putting them at risk of harm.

There was no system in place to indicate length of wait, signpost or take a message from women and birthing people. The service did not monitor or collect data on how many calls were abandoned. We asked senior leaders about monitoring calls that were not answered, they told us they did not monitor call drop off rates. In addition, there was no system to recognise or follow up women and birthing people who did not attend (DNA) the triage unit on advice from the triage helpline.

We escalated these concerns at the time of inspection and senior leaders took several immediate actions. They implemented new maternity triage stickers for women and birthing people's notes to inform them of two alternative telephone numbers on the delivery suite if the triage phone line was busy. This information was also shared on their social media pages. An additional staff member was allocated to the delivery suite to answer the phones until the new triage model commenced on 13 November 2023.

Maternity

An audit of triage phone calls was completed between 23 October and 25 October 2023 after the implementation of additional staff. It monitored length of wait, abandoned calls and unanswered calls. The audit showed that 2 phone calls out of 143 were not answered.

The service created a standard operating procedure for staff to follow when women and birthing people did not attend maternity triage when advised to do. This included contacting women and birthing people to perform a full telephone triage if they chose not to attend the unit. A process was added to the shift leader hand over to check for any DNA's and to audit compliance daily.

There was a system used to consistently record triage phone calls and advice given to women and birthing people in their paper notes. Although there was no system to record this information on the electronic patient notes, senior leaders told us that this process could be added once the new triage model was implemented.

Staff completed risk assessments for women and birthing people at triage and were mandatory fields on the patient electronic record system. They included medical conditions, mental health issues, obstetric factors such as previous stillbirth, previous caesarean, and other factors such as alcohol use, substance use, gestational diabetes and complex social factors.

Staff knew about and dealt with any specific risk issues. The service had comprehensive and in date policies for intrapartum care and management, continuous electronic fetal monitoring, Modified Early Obstetric Warning Score (MEOWS), postpartum haemorrhage and Sepsis.

Staff used a nationally recognised tool to identify women and birthing people at risk of deterioration. In the 8 sets of maternity records we reviewed we found the appropriate use of MEOWS to identify women and birthing people at risk of deterioration. The service completed audits to check the forms were fully completed. The August 2023 audit showed 85% compliance.

Staff used an inpatient maternity sepsis tool as standard practice and completed sepsis training level 2 as part of mandatory training requirements. Compliance for obstetrics and gynaecology medical staff was 94% and 99% for the maternity team.

Staff completed risk assessment for ligatures for women and birthing people thought to be at risk of self harm of suicide. The central labour suite and Cestrian ward had ligature cutters that were easily accessible. However, the associated action plan showed that risk assessments of the environment had not yet been completed.

Maternity Staffing

The service had enough maternity staff with the right qualifications, skills, training and experience to keep women and birthing people safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service had no current risks with recruitment, retention and staff sickness. Staffing levels usually achieved the planned numbers. During our inspection the planned staffing met actual staffing levels on the central labour suite and Cestrian ward. At times when staffing numbers were short, an escalation pathway was followed to make leaders aware of staffing needs in each area and to organise appropriate cover. Some staff were moved from their usual working areas to cover staff shortages in other areas.

Maternity

Between January 2023 and June 2023 there had been no incidents where staff were unable to provide continuous one-to-one care during established labour. The midwifery coordinator in charge of the central labour suite had supernumerary status with all women in active labour receiving one-to-one midwifery care.

Acuity reviews were reported to the Cheshire and Merseyside local maternity and neonatal system (LMNS). We reviewed the data between October 2022 and October 2023 that showed on average the service met acuity needs 84% of the time against a trust target of 85%. Occasions when staffing was 2 or more midwives short was less than 1% and up to 2 midwives short 15% of the time.

The service last completed a safe staffing and acuity review in December 2021. It said the service had enough staff to meet the planned needs of women. NICE guidance recommends that assessment be carried out every 3 years. Senior leaders told us that there were plans to repeat this in future. There was no set time for this.

The service used a nationally recognised safe staffing tool to monitor staffing and acuity on the maternity wards. The acuity tool was used every 4 hours and staff monitored midwife to birth ratio levels. Staffing was also discussed at daily safety huddles.

We reviewed the midwifery and maternity safer staffing report dated 5 July 2023. The data showed that between 1 January 2023 to 30 June 2023 the service was compliant with monthly midwife to birth ratio levels. The report noted that appropriate actions taken had successfully maintained safe staffing levels. However, delays in care were reported and there had been an increased utilisation of the community midwifery team to support safe staffing.

There was a high fill rate between January 2023 to June 2023 for registered and unregistered midwives. For day and night shifts, the average fill rate for registered midwives was 97% and 93% respectively. The average fill rate for unregistered midwifery staff was 91% during the day and 100% during the night.

The sickness rate for midwifes had steadily decreased from 9% in January 2023 to 5% in June 2023. The sickness rate for midwife support workers had remained at 0% from January 2023 to May 2023. In June 2023 it has increased significantly to 5%.

At the time of inspection, the turnover rate for all midwifery registered staff and additional clinical staff was 9% and 4% respectively.

The service used bank and agency staff to cover maternity leave and long and short-term sickness. Managers requested NHS bank staff familiar with the service and made sure all bank and agency staff, if used, had a full induction and understood the service. Trust data showed that in January 2023 the service used 146 bank hours and this had increased to 304 in June 2023. The service had reducing rates of agency hours. In January 2023 the service had used 846 agency hours and this had gradually decreased to 456 in June 2023.

However, at the time of inspection, the vacancy rate had significantly reduced and this would be reflected in a reduction of bank and agency usage in the future. At the time of inspection, the vacancy rate for midwifery staff was low. The whole time equivalent (WTE) vacancy rate for midwives was 0.6 and 5.9 for community midwives. The service had recently recruited 3 new band 6 midwives and 15 new band 5 midwives (newly qualified students). International recruitment had also been successful with 3 newly recruited midwives joining the service.

The service had recently appointed new staff into the following roles: antenatal and postnatal ward manager, risk and governance midwife, audit midwife and pelvic health midwife. Other roles which were planned for advertisement included a smoking cessation midwife, practice educator facilitator and specialist diabetic midwife.

Staff reported red flag events in line with the safe staffing policy. There had been 121 red flag events reported between January 2023 and June 2023. A red flag event is a warning sign that something may need attention in midwifery staffing numbers or skill mix. The service reported red flag incidents well and they were recorded and managed to consider themes. The top 3 most reported events were delayed or cancelled time critical activity (88 occasions) Delivery Suite Coordinator unable to maintain supernumerary status (16 occasions) and delay between admission for induction and beginning the process (13 occasions).

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep women and birthing people and babies safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave locum staff a full induction.

The service had enough medical staff to keep women and birthing people and babies safe. The medical staff on duty achieved the planned number. The service had comparably low vacancy, turnover and sickness rates for medical staff. At the time of inspection, the turnover and sickness rate for the obstetric and gynaecology medical team was 0% and 3% respectively. There were no vacancies for medical staff.

Medical staffing was compliant with Royal College of Obstetrics and Gynaecology (RCOG) guidance. The service audited compliance with RCOG obstetric medical workforce criteria. Trust data showed that between February 2023 and August 2023, all job plans for medical staff did not have clinical activity the day after being on call. There were no incidents escalated where compensatory rest has not been taken. Between January 2023 and June 2023 audit results showed 100% consultant attendance for all clinical situations listed in RCOG workforce recommendations.

The service had a good skill mix and availability of medical staff on each shift and reviewed this regularly. The service had access to 24 hour anaesthetic and theatre cover. Theatre staff were rostered to cover surgical procedures in the maternity theatre and could be bleeped in an emergency with twenty-four hour, seven day a week cover.

The service always had a consultant on call during evenings, nights and weekends. Consultants covered both obstetrics and gynaecology and provided support when room 15 was used for emergency obstetric surgery.

Medical ward rounds were carried out twice a day so women and birthing people could be assessed, and their care reviewed. Medical staff involved woman and birthing people in decision making about the plan of care. Ward rounds were comprehensive and women and birthing people were given the time they required to ask questions or raise concerns.

During the inspection we observed a medical handover which was multidisciplinary (MDT). It was attended by an obstetric and gynaecology consultant, registrar, junior doctor, neonatal nurse, labour ward coordinator and anaesthetic consultant. The handover was focused, systematic and staff used a nationally recognised communication tool. The service also had a daily consultant to consultant handover.

Maternity

Records

Staff did not always keep detailed records of women and birthing people's care and treatment. Records were not always clear, up to date, stored securely nor easily available to all staff providing care. Staff did not always have access to up-to-date, accurate and comprehensive information on women and birthing people's care and treatment.

Women and birthing people's clinical records were comprehensive but not all staff could access them easily. The trust used a combination of paper and electronic records. Staff told us that recording in both paper and electronic notes was time consuming and that the electronic patient record system was difficult to navigate. We reviewed 12 sets of women and birthing people's records, which were all linked paper and electronic records. We found the records were comprehensive but not always complete. We asked a number of staff to assist in finding information on the electronic system and observed they could not always find information in a timely manner. There were 5 records that did not have a risk assessment recorded at every contact and 1 record did not have fetal movements recorded at every required appointment.

A requirement of all maternity services is to ask women and birthing people about domestic abuse. This was a mandatory field in the electronic patient records system which alerted staff when this had not been recorded. However, we found that this had not been recorded in 4 records. This was an area of concern found in a previous inspection in 2022. Audits were carried out monthly to check records were fully completed. The August 2023 audit showed 70% compliance. There was an associated action plan with actions taken to improve documentation.

Records were not always stored securely. Staff locked computers when not in use and stored paper records in locked cabinets. However, we observed patient information in an unlocked cabinet on a corridor situated on the Cestrian ward and in an unlocked milk room on the same ward. This was escalated at the time of inspection and staff took action to make the information secure.

When women transferred to a new team, there were no delays in staff accessing their paper records.

Medicines

The service used some systems and processes to safely prescribe, administer, record and store medicines.

Staff followed some systems and processes to prescribe and administer medicines safely. Staff completed medicines records accurately and kept them up-to-date. During the week pharmacists provided a review of some women and birthing people's medicines. For example, those with more complicated medicines and elective surgery. However, we found electronic records were highlighting missed doses of medicines. Further investigation showed that some had been administered but later than prescribed but still showing on system. The service had tried to mitigate this by asking the medics to prescribe medicines as when needed and not at specific times.

Staff reviewed each person's medicines regularly and provided advice to women and birthing people about their medicines. They also provided advice at ante-natal clinics on medicines.

Staff stored and managed some medicines and prescribing documents safely. However, we found IV fluids on open shelving in a clinic room, which was accessible by non-nursing staff and increased risk of tampering with the medicine.

Staff followed national practice to check women and birthing people had the correct medicines when they were admitted or they moved between services. Pharmacists provided a more detailed review of medicines for women and birthing people which had for example a more complex medicines prescribed prior to elective surgery.

Staff learned from safety alerts and incidents to improve practice. Pharmacists provided information at staff huddles on medicine incidents and new guidance.

Community midwives held insulated and tagged medicine bags. Medicines and batch numbers were logged in a file on the labour ward. The date of the medicines was recorded and monitored so it could be discarded after one month or if temperature was over 25 degrees celsius.

The service completed audits for the changeover of homebirth medications to check staff signed them out and replaced home birth medications at least monthly. The audit from October 2023 showed 79% compliance and actions had been taken to improve performance.

Incidents

The service managed safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave women and birthing people honest information and suitable support.

Staff knew what incidents to report and how to report them. Staff told us they felt safe and confident reporting incidents and they used the trusts incident reporting policy and visual flow chart for guidance when needed. The policy was comprehensive, in date and had been reviewed to reflect the most up to date national guidance.

The service monitored incidents, themes and shared learning from incidents. Senior leaders attended a daily incident meeting every morning to discuss harm levels and categorise moderate harm incidents that required a rapid review. There was a weekly review of these incidents and a trust wide serious incident panel every week. Matrons presented learning themes in a monthly safety huddle report which was shared with staff. There was a weekly obstetric safety incident review meeting that was attended by the inpatient matron head of midwifery, obstetric lead and risk midwife.

In June 2023 the service conducted a cluster review after there were 11 cases of 3rd degree tears between January 2023 and June 2023. Contributing factors and themes were identified. There was an associated action plan with some actions already implemented by October 2023. This included the employment of a pelvic health midwife and providing education leaflets. Pelvic health was being added to the future PROMPT training programme.

Staff received feedback from investigations. Many staff we spoke with told us that they received feedback from managers and learning points were shared well following an incident. Community midwives attended governance meetings so that learning from incidents could be shared. They told us they had also had lessons learnt through safety huddles and email alerts.

The service had no ‘never’ events. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

Staff reported serious incidents clearly and in line with trust policy. Between October 2022 and September 2023, the service reported 7 serious incidents to the NHS Strategic Executive Information System (StEIS).

Managers investigated incidents thoroughly. They involved women, birthing people and their families in these investigations as our review of 3 serious incident investigations showed. In these 3 investigations, managers offered an apology and explanation under duty of candour regulations, and shared draft reports with the families for comment.

Maternity

In the last 3 months, 1 incident had been referred to the Healthcare Safety Investigation Branch (HSIB) for investigation under the guidance for referring certain events. The investigation into this incident was ongoing. However, a rapid review had been carried out by the trust and a review of the induction of labour policy had already been implemented in response.

Staff met to discuss the feedback and look at improvements to women and birthing people's care. Following 3 controlled drug incidents in close succession, the practice development midwife (PDM) created a training trolley. The training was based on learning points from the incidents. At the time of inspection, compliance was 44%. The pass rate was set at 100% to ensure safety, and evidence of learning had taken place. At the time of inspection, the service had recruited training champions to increase compliance and the PDM was sharing the training with community midwives.

Staff understood the duty of candour. The duty of candour is a regulatory duty that relates to openness and transparency with patients if their treatment causes or has the potential to cause harm or distress. Staff were able to articulate to us their understanding of duty of candour and what they would do to comply with this. We were shown documentation that highlighted that duty of candour had been followed when something had gone wrong. The service audited incidents of postpartum haemorrhage (PPH) and duty of candour. Data showed that between April 2023 and September 2023 all women and birthing people received both verbal and written duty of candour letters.

At a previous inspection in February 2022, concerns were raised regarding the reporting and categorisation of harm for PPH incidents. The trust took action and made improvements. The follow up inspection in July 2023 found that new guidance and training for staff was in place to ensure PPH was appropriately identified, categorised and reported. At this inspection, the service continued to follow the new guidance and all PPHs over 1500mls blood loss were investigated using a rapid review tool to identify learning and take immediate measures if required.

When improvements were made, actions and learning were not yet fully embedded. For example, audits of compliance of PPH risk assessment showed continued non-compliance against a trust target of 100%. In December 2022, compliance was 69% and in August 2023 compliance was 73%.

Is the service effective?

Requires Improvement ➔➔

Our rating of effective stayed the same. We rated it as requires improvement.

Evidence-based care and treatment

Policies were not always updated with national guidance and evidence-based practice in a timely manner. However, staff consistently protected the rights of women and birthing people subject to the Mental Health Act 1983.

Staff were not able to consistently follow up-to-date guidelines and policies to plan and deliver high quality care according to evidence-based practice and national guidance. At a previous inspection in February 2022, we found that 26 out of a total of 131 guidelines were past their expiry date for review. We told the trust that it must take action to ensure that policies and procedures are reviewed and follow national guidance. However, during our inspection, we

looked at 12 policies and found that there were 3 policies out of date and 2 policies with no issue or review date. Senior leaders acknowledged there were approximately 12 policies being reviewed within the region and extensions for the review dates had been agreed. Of the policies we reviewed that were in date, all of them were comprehensive and in line with evidence-based practice and national guidance.

The service was partially compliant with elements of the saving babies lives care bundle (version 3). This was based on national guidance such as NICE and RCOG to target a reduction in perinatal mortality. The service was fully compliant with 2 out of the 6 elements. The element with the lowest compliance score 40% was smoking in pregnancy. The service had interviewed for a new smoking cessation lead midwife and 2 other smoking cessation roles had been appointed. Senior managers anticipated they would be fully compliant when the smoking cessation lead was in post. The other 3 elements had compliance scores ranging from 75% to 83%. The service had an overall score of 76% compliance across all 6 elements which met the requirement of 70%.

Staff protected the rights of women subject to the Mental Health Act and followed the Code of Practice. They could make referrals to the perinatal mental health midwife at the hospital or specialist perinatal mental health team depending on concerns.

Staff used a structured escalation process for escalating clinical concerns in line with Royal College of Obstetrics and Gynaecology (RCOG) recommendations.

At handover meetings, staff routinely referred to the psychological and emotional needs of women and their relatives. Women and birthing people we spoke with told us that they had been asked about their general health and wellbeing at appointments and most women told us they had been given a named midwife throughout their pregnancy. Women who had given birth confirmed they had skin to skin contact (baby naked, directly on the chest or tummy) with their baby shortly after the birth. This demonstrated compliance with best practice and national guidance.

Nutrition and hydration

Staff gave women and birthing people enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. However, staff did not always fully and accurately complete women and birthing people's fluid balance charts where needed.

Staff made sure women and birthing people had enough to eat and drink, including those with specialist nutritional needs such as diabetes. All women and birthing people we spoke with who had given birth said they were offered food and drink including their partners. There were informative posters on walls that told women and birthing people how to access snacks if they missed mealtimes.

The service had a specialist infant feeding team to offer support for women and birthing people, for both breastfeeding and formula feeding. Information was available on promoting healthy pregnancy, donor breastmilk, and breastfeeding and formula feeding guidance. There were breast pumps and hand expressing kits available to support with expressing breast milk.

Staff told us that women and birthing people had two breast feeding assessments during their admission and another feeding assessment before discharge. There was a 'topic of the month' board focusing on breastfeeding assessments on the Cestrian ward.

However, staff did not always assess and monitor the hydration status of women and birthing people. The service completed audits for fluid balance charts and provided data from October to December 2022 showing 64% compliance. We asked senior leaders for more recent data and the August 2023 data showed compliance had significantly dropped to 49%. The service had taken action to improve compliance by putting a monthly focus board on the topic fluid balance in the staff office.

Pain relief

Staff assessed and monitored women and birthing people regularly to see if they were in pain, and gave pain relief in a timely way. They gave additional pain relief to ease pain when requested.

Staff assessed women's pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff had completed a quality improvement project to compare the effectiveness of two analgesics for post-operative elective caesarean section.

Women received pain relief soon after requesting it. Women and birthing people we spoke with told us that their pain was managed well.

Staff prescribed, administered and recorded pain relief accurately. There were Entonox ports available in all rooms including the birth centre for pain relief. The service had access to 24 hour anaesthetic cover.

The maternity dashboard showed that all women and birthing people who requested an epidural in labour received it.

The service recorded and monitored information on pain scores and satisfaction. They presented the results in monthly obstetric anaesthesia newsletters. The most recent newsletter from September 2023 showed satisfaction scores for spinal and epidural were 96% and 78% respectively. Post operation analgesia satisfaction score was 94% and average pain score was 5.8/10.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for women and birthing people. The service had been accredited under relevant clinical accreditation schemes.

We reviewed clinical quality improvement metrics (CQIMS) for the service. CQIMS are a set of metrics obtained from the maternity services dataset to identify areas that may require clinical quality improvement. The maternity dataset showed trust performance compared to the national average and Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE) average. In August 2023 the trust was not an outlier for any of the 11 key metrics reviewed. Women who had a PPH of 1,500mls or more and women who were current smokers at booking appointment were within the middle 50% of all organisations.

In April 2023 the rate of women who had a PPH of 1,500ml or more had increased to 47 per 1000 which was above the national average and MBRRACE rate. This fell to 33 per 1000 in July 2023, equal to the MBRRACE rate and above the national average of 31. In August 2023, this increased to 40 per 1000 which was above the national average of 31 and MBRRACE rate of 33.

The rate of women who were current smokers at delivery was 9.95% which was higher than the national average of 7.7% and MBRRACE rate of 8.3%. Babies with a first feed of breast milk was 63% which was lower than the national average rate of 72% and MBRRACE rate of 66%.

Maternity

The service provided data that showed there had been no direct maternal deaths since 2019. Data from 2022 and 2023 showed that the stillbirth rate for the trust was 0.8 and 1.8 respectively per 1,000 births. This was lower than the national average of 3.9 per 1,000.

Data for 2022 showed that the rate of hypoxic-ischaemic encephalopathy (HIE) also known as perinatal asphyxia was 0.4 per 1000 which has lower than the national average of 2.4 per 1000. In 2023 the trust rate for HIE rate was 0.

August 2023 data for admissions to neonatal units for babies born at or after 37 weeks was 3.29% which was below the national average of 6%.

The service reported rates of small for gestational age (SGA) as part of the growth assesssment protocol (GAP) programme. Data from July 2023 to September 2023 shows that their SGA detection rate was 54% which was above the GAP user average of 43%.

The service collected data on smoking during pregnancy, including carbon monoxide (CO) monitoring in pregnant smokers. For the reporting period of April 2023 to September 2023 the audit showed that compliance for CO measurement was 99.8% which was close to national recommended guidance of 100%.

The service conducted an audit of the management of post-natal sepsis. The report dated June 2023 showed the outcomes for 5 women and birthing people with suspected sepsis between August 2022 and December 2022. Results showed that all 5 women and birthing people were reviewed within the first 3 hours by an appropriate clinician as per policy. However, not all women and birthing people (4 out of 5) had a sepsis pathway completed and reasons for delays in actioning the sepsis six were not always documented in the women and birthing people's care notes. An action plan was implemented and action taken to increase safety and compliance. Performance continued to be monitored via quarterly audits, the next audit was planned for October 2023.

The central labour suite and Cestrian ward had achieved gold standard accreditation in March 2023. The wards had been internally audited by a multidisciplinary team including the practice development midwife, IPC lead, quality team and matron. The accreditation process scored the wards against 15 standards that were linked to the CQC domains of safe, effective, caring, responsive and well led. The outcome reports highlighted both positive practice and areas of improvement. Action plans were implemented and shared with the quality team within 2 weeks of receiving the report.

The infant feeding service was accredited by UNICEF UK Baby Friendly Initiative (BFI) with a plan for reaccreditation in March 2024. The service completed audits for readmissions of babies who had a weight loss over 12%. Data showed that readmissions had reduced from 2.6% in May 2023 to less than 1% in September 2023. Readmissions after 28 days for feeding problems had also reduced from 10% to 2.1% for the same time period.

The anaesthetic department achieved Anaesthetic Clinical Services Accreditation (ACSA) in 2020 which is a voluntary scheme run by the Royal College of Anaesthetists. Anaesthetic departments must provide evidence of continuous quality improvement and service development in order to maintain their accreditation status. The next review visit by the ASCA panel was planned for April 2024.

Competent staff

The service did not always make sure staff were competent for their roles. However, managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were not always experienced, qualified or had the right skills and knowledge to meet the needs of women and birthing people. In a previous inspection in February 2022, we had concerns that midwives were providing immediate postnatal recovery care to women following obstetric surgery. During this inspection, we observed a patient be transferred from theatre to an adjacent recovery room and observations were taken every 15 minutes by a band 6 midwife. There was no set recovery time and the patient was taken to the central labour suite when another midwife arrived to support the transfer with a porter.

Staff we spoke with told us that they had not completed any specific training for recovery after an anaesthetic. Following the inspection, the service told us that staff completed specific training modules on recovery that included epidural care, airway management and PPH.

We escalated this at the time of the inspection. The trust provided assurance within 24 hours by implementing a policy for immediate post-operative care of patients following obstetric surgery. The policy included guidance to ensure women and birthing people were recovered safely prior to handover to a midwife. The policy applied to both elective caesarean sections in the main theatre and obstetric surgery on the central labour suite. With immediate effect all elective obstetric theatres would be supported by a trained recovery nurse.

The service also implemented Situation, Background, Assessment and Recommendation (SBAR), a nationally recognised communication tool to handover care. The SBAR would be signed by the anaesthetist to confirm the patient was safe to step down to midwifery led one to one care. The service immediately started to audit the new handover process to monitor compliance. Data provided showed that between 20 October 2023 and 24 October 2023, all emergency and elective theatre cases had an SBAR completed post recovery.

Managers gave all new staff a full induction tailored to their role before they started work. New staff we spoke with told us they were supernumerary during their 2 week induction which was supervised and signed off by the practice development midwife.

The service had a preceptorship programme for newly qualified midwifery staff. The 12 month transition period included structured support and portfolio evidence to enhance skills and competencies for newly qualified staff. Staff could access support from the practice development team throughout the programme.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. The service had a three year maternity improvement plan which included objectives to invest in skills and provide continual training and skill development. They had recruited a pastoral support midwife, conducted an annual training needs analysis and monitored training compliance at the monthly perinatal assurance improvement board (PAIB).

The clinical educators supported the learning and development needs of staff. We reviewed the training needs analysis for the service which demonstrated what specialist training staff would complete each year. This included 5 annual study days including fetal monitoring and surveillance, PROMPT and saving babies lives bundle (version 3). Midwife support workers had received additional infant feeding training and staff told us that all new starters completed a 2 day BFI course and infant feeding induction.

Managers supported staff to develop through yearly, constructive appraisals of their work. At the time of inspection, data provided by the trust showed that 86% of medical staff and 88% of the maternity team (including midwives and midwife support workers) had completed an appraisal within the previous 12 months. This met the trust target of 85%.

Maternity

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit women and birthing people. They supported each other to provide good care.

Staff held regular and effective multidisciplinary team (MDT) meetings to discuss women and birthing people and improve their care. We observed both the medical and midwifery handovers which had good multidisciplinary presence. The handovers demonstrated a clear, structured, and detailed communication style.

The ward round on the central labour suite was led by a consultant and attended by a registrar and junior doctor. The review was holistic with good communication and collaboration with women and birthing people.

Consultants told us they had positive and inclusive working relationships with obstetric staff. Junior doctors told us that consultants were approachable and they had good relationships with midwives, doctors and anaesthetists.

Community midwives told us they had a good working relationship with inpatient midwives and obstetricians. They said that they had regular team meetings and opportunities to work together.

The infant feeding team worked closely with a local community service to provide clinical advice to milk donors. Staff told us they also worked well with local services who delivered breastfeeding support groups.

Staff attended MDT daily safety huddles every morning to discuss women and birthing people and anticipate any future risks. Staff included the labour ward coordinator, consultant obstetric gynaecologist of the week, duty anaesthetist, neonatal senior staff nurse and clinical midwifery manager. Staff told us that they were effective and emerging risks could be discussed and escalated as a team. Staff gave examples of safeguarding and mental health concerns raised at a safety huddle which were then escalated to the safeguarding and complex care team and perinatal mental health midwife.

All staff we spoke with told us that they worked well as a team. For example, the triage midwife told us they could escalate concerns to the central labour suite medical team. When the triage unit was busy, a midwife from the central labour suite would be used for support.

Staff worked across health care disciplines and with other agencies when required to care for women and birthing people. Staff attended monthly perinatal pelvic health service (PPHS) clinical steering group meetings with professionals from other NHS trusts. We reviewed minutes from the July 2023 meeting which showed learning and experiences were shared to help decision making and actions taken forward.

Consultants told us they received good support from the perinatal mental health service at the weekly medical disorders clinics. There was also a gestational diabetes mellitus (GDM) clinic which consultants said was well supported by 2 diabetes midwives.

Staff worked well together to undertake multi-disciplinary cluster reviews for any emerging themes from incidents. We reviewed a cluster review dated September 2023 which investigated weight loss in newborn infants requiring hospital readmission. Contributing factors and actions were identified following discussions with the MDT.

Seven-day services

Key services were available seven days a week to support timely care.

Consultants led daily ward rounds on all wards, including weekends. There was always a consultant obstetrician and consultant anaesthetist on call for any obstetric emergencies.

Staff were supported by other hospital services such as mental health services, diagnostic screening and pharmaceutical help and advice 24 hours a day, seven days a week.

The service had 2 community midwives on call who could provide support to women 24 hours a day.

Women were advised to call the triage unit to discuss any concerns.

The infant feeding team was often available at weekends. Staff told us they were planning to make this a 7 day service and had generally managed to cover weekends.

Health promotion

Staff gave women and birthing people practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards/units. There were plenty of leaflets and posters with electronic codes that could be scanned using a mobile phone to gain health information. For example, infant feeding, skin to skin contact, smoking cessation, post pregnancy physiotherapy and sudden infant death syndrome (SIDS).

Staff assessed women and birthing people's health when admitted and provided support for any individual needs to live a healthier lifestyle. We reviewed 12 sets of maternity records and noted it had been documented that a woman's health had been assessed in areas such as smoking and alcohol intake and advised on leading healthier lifestyles in areas such as these.

Breastfeeding women and birthing people could access ward based support groups and were signposted to community breastfeeding groups on discharge.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff supported women and birthing people to make informed decisions about their care and treatment. They followed national guidance to gain women's consent. They knew how to support women who lacked capacity to make their own decisions or were experiencing mental ill health. However, the trust did not evidence that staff had completed the necessary training.

Staff understood how and when to assess whether a woman had the capacity to make decisions about their care. They gained consent from women for their care and treatment in line with legislation and guidance. The service had a Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) policy. It was comprehensive, in date and referenced best practice and national guidance.

Staff made sure women consented to treatment based on all the information available and clearly recorded consent in the woman's records. We observed staff gain consent before obstetric surgery and consent was recorded in all of the maternity records we reviewed where applicable.

There had not been any women or birthing people who had met the criteria for MCA assessment or DoLS in the previous 6 months. However, staff that we spoke with during our inspection were able to articulate to us what they would do in such an event.

Maternity

The service offered a “think family” safeguarding level 3 face to face training that included MCA and DoLS. However, the trust did not provide overall compliance rates or details of the number of staff who were required to undertake this training. This meant the trust did not evidence that sufficient staff had the appropriate training.

Is the service caring?

Good

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Staff treated women and birthing people with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for women and birthing people. Staff took time to interact with women and those close to them in a respectful and considerate way. They were welcoming and introduced themselves to women and their visitors.

We spoke with 5 women and birthing people and they all gave positive feedback and said that the midwifery staff treated them well and with kindness. For example, they told us “the staff were “brilliant”, “the staff are amazing”, “I’ve had a very positive experience”, “staff were really supportive”, “midwives were lovely and genuine, and felt that they really care”.

Feedback from social media and friends and family tests (FFT) were positive and confirmed staff to be very caring. There were many thank you cards displayed on the wards that praised staff for their support and caring nature.

We observed staff delivering personalised care to women and their family. All women and birthing people we spoke with told us that staff answered call bells quickly and frequently checked on the well-being of them and their baby.

Staff demonstrated attention to detail when ensuring privacy and dignity of women and those accompanying them. For example, they ensured curtains were closed and kept them covered up when being transported from theatre to the central labour suite.

Staff understood and respected the individual needs of each woman and showed understanding and a non-judgmental attitude when caring for or discussing women with mental health needs.

The service had a maternity improvement plan which included the objective of personalised care. This included listening to and working with women and birthing people with compassion.

Results from the annual maternity survey 2022 showed 96% of women and birthing people felt they were treated with respect and dignity during labour and birth. The survey had received 134 responses which was a 45% response rate. This was slightly lower than the average response rate of 48% for similar organisations.

The service had a policy in place for the management of surrogate pregnancies. We reviewed positive feedback that praised staff for providing compassionate care and took account of their individual needs throughout their surrogacy journey.

Emotional support

Staff provided emotional support to women, birthing people, families and carers to minimise their distress. They understood women's personal, cultural and religious needs.

Staff gave women and those close to them help, emotional support and advice when they needed it. We spoke with 5 women and birthing people who told us that their emotional wellbeing was checked and re-assessed during antenatal appointments and after they had given birth.

Staff understood the emotional and social impact that a person's care, treatment, or condition had on their wellbeing and on those close to them. For example, staff discussed the emotional care of women during multidisciplinary team handovers and safety huddles.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. Sonography staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. The service had a fetal medicine team and bereavement midwives who were specialist trained to offer emotional support. Staff shared positive feedback from a family who had received support from the fetal medicine unit. They said they were treated with the upmost care and compassion and felt fully supported.

Women and birthing people could access a birth reflections service. There were posters on the Cestrian ward that promoted this service as well as follow up support from local counselling services.

Women and birthing people who had experienced a bereavement could receive emotional support in the bereavement suite and access a memory making service. Staff completed bereavement training as part of their induction and could have one to one training sessions with bereavement midwives to enhance their knowledge and confidence. Bereavement midwives also provided practical guidance and information on local and national bereavement charities.

There was also a specialist postnatal counselling clinic, and the bereavement midwife could make referrals to a bereavement counsellor.

The chaplaincy team were available 24 hours a day, 7 days a week. The team was made up of chaplaincy staff and volunteers of all different faiths. Women and birthing people could access religious support and request to light a candle in memory of a baby or babies.

Staff understood the emotional and social impact that a person's care, treatment, or condition had on their wellbeing and on those close to them. The service had a care pathway for women who were expecting twins or multiple births.

Understanding and involvement of women and those close to them

Staff supported and involved women, birthing people, families and carers to understand their condition and make decisions about their care and treatment.

The trust performed similarly to or better than other trusts for most questions in the CQC maternity survey 2022. The maternity survey is split into four sections that ask questions about antenatal care, labour and birth, postnatal care and feeding and care after birth.

Maternity

Results from the 2022 maternity survey showed that the service performed similarly to or better than other trusts in:

- 10 out of 14 questions for antenatal care.
- 10 out of 15 questions for labour and birth
- 8 out of 8 questions for postnatal care and feeding.
- 12 out of 16 questions for care after birth

Staff supported women to make informed decisions about their care. Results showed 95% of women and birthing people felt they were involved enough in decisions about their care during labour and after birth.

The top scores included:

- Given information/advice on risks of induced labour.
- Involved enough in decision to be induced.
- Given appropriate advice and support at the start of labour.
- Given information about changes to mental health after having baby.

Scores that were significantly worse than previous years:

- Support for mental health during pregnancy.
- Not left alone when worried (during labour and birth).
- Saw the midwife as much as they wanted (postnatal).

Scores that had improved compared to previous years included:

- Partner was able to stay with them as long as they wanted (in hospital after birth).
- GP talked enough about physical health and mental health during postnatal check-up.
- Felt concerns were taken seriously (during labour and birth).

The maternity service had an action plan in place to make improvements based on the results of the survey.

Staff made sure women and those close to them understood their care and treatment. Women and birthing people told us that staff answered their questions and made sure that they understood what would happen before and after their surgery.

Women, birthing people and their families could give feedback on the service and their treatment and staff supported them to do this. There were numerous posters and leaflets across the wards that encouraged women and birthing people to share their views. There was a survey being promoted on the central labour suite for women and birthing people who had experienced reduced baby movements. This allowed women and birthing people to give feedback regarding any advice and support they had received throughout their labour.

Staff provided examples which demonstrated an awareness of how they used different communication aids to speak with women, families, and carers.

Maternity

Women and birthing people gave positive feedback about the service. We spoke with 5 women and birthing people who told us the care they received was ‘amazing’ ‘brilliant’ and ‘really good’.

Is the service responsive?

Good  

Our rating of responsive improved. We rated it as good.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services so they met the needs of the local population. The service had approximately 2300 births per year. Midwifery led care was available to women and birthing people with an uncomplicated pregnancy and consultant led maternity care for higher risk pregnancies. The Cestrian ward had 27 beds for both antenatal and postnatal care alongside 4 transitional care beds. There was a community midwifery service and a fetal medicine service for women, birthing people and babies with medical conditions or problems during delivery.

The service had not yet implemented the midwifery continuity of carer (MCoC) model of care. This model is a way of delivering maternity care so that women and birthing people receive dedicated support from the same midwife through their pregnancy. Staffing challenges had impacted on progress. We reviewed board papers from September 2023 that showed MCoC remained paused due to the workforce awaiting newly qualified staff. The Ockenden report (2022) recommended that newly qualified midwives should not work directly in the community and should remain in hospital settings for a year.

The service and facilities supported women and birthing people to have extended visiting times from 8am till 7.30pm and this included other children. Other relatives could also visit for 5 hours during the day.

We reviewed the maternity and neonatal voices partnership (MNVP) workplan for April 2023 to March 2024. It showed the workplan had been designed based on common themes noted within the maternity survey and MNVP general survey responses for 2022/2023. The plan for the year focused on antenatal care in the community, underrepresented groups, inpatient postnatal care and bereavement care.

The service had recently developed personalised care plans and had enhanced their specialist care provision by recruiting a pelvic health midwife and smoking cessation lead midwife.

There were alerts on women and birthing people’s records to identify the support they required. For example, safeguarding, substance use, domestic violence and mental health. The service had systems to help care for women in need of additional support or specialist intervention. Specialist midwives provided additional bereavement, infant feeding, perinatal mental health, fetal medicine, and pelvic health.

Some babies require a surgical intervention in order to release the tongue, which is known as a frenulotomy. There were 2 midwives trained to complete this procedure and staff could refer babies to a specialist frenulotomy clinic.

However, facilities and premises were not always appropriate for the services being delivered. The service had a bereavement room for women, birthing people and their families experiencing a bereavement. However, it was located at one end of the labour ward with no separate entrance and was not soundproofed. This meant that families would have to walk through the labour ward and overhear other women and birthing people including the sounds of other babies. The bereavement midwife told us that the new women and children's building opening in 2025 would have a soundproofed bereavement room with access to gardens and a separate entrance.

Meeting people's individual needs

The service was inclusive and took account of women's individual needs and preferences. Staff made reasonable adjustments to help women access services. They coordinated care with other services and providers.

Staff supported women living with mental health problems and learning disabilities. Staff gave examples when they had made reasonable adjustments when women or birthing people had been autistic. Staff we spoke with were familiar with 'This is me' documents and information passports for women and birthing people living with learning disabilities. There was a perinatal mental health service available 24 hours a day, 7 days a week for women and birthing people with mental health problems.

However, results from the maternity survey 2022 showed that one of the lowest scores was for support for mental health during pregnancy (72%). The service had implemented an action plan to make improvements which included the specialist mental health midwife facilitating group sessions for self-help strategies and to improve joint working. Staff were reviewing the telephone assessment forms and the community midwives telephone message book to capture ongoing satisfaction with mental health support.

Staff ensured any additional needs, which were required when the woman was admitted, was part of their plan of care. The service had specialist midwifery services and clear guidelines for the care of women with mental health problems, substance misuse, bereavement services and infant feeding. There was a range of specialist midwives including: a risk midwife, a fetal monitoring midwife, pelvic health midwife, infant feeding midwife and bereavement midwife. There was a new smoking cessation midwife role recruited to and smoke free practitioners to support women to have smoke free pregnancies.

However, we did not see evidence of specialist midwives working with women from vulnerable groups for example, asylum seekers and women and birthing people from ethnic minority backgrounds. We reviewed board papers from September 2023 that showed that the maternity service had achieved 69% compliance with completing ethnicity status for each woman and birthing person. This did not meet the trust target of 90%. The service was in the process of changing the data gathering process to improve submission of data.

Staff understood and applied the policy on meeting the information and communication needs of women with a disability or sensory loss.

The service had information leaflets available in languages spoken by the women and local communities. Leaflets in English could be provided in a range of alternative languages, font and braille if this was required. The maternity section on the trusts website asked what language women and birthing people preferred if it was not English.

Managers made sure staff, women, loved ones and carers could get help from interpreters or signers when needed. Staff we spoke with gave examples of when they had used the telephone interpretation service and there were posters on the wards promoting this.

Staff shared positive feedback from a family praising staff and senior management for the adjustments that were made to suit their needs. The family said they had felt valued, respected and listened to throughout their journey.

Transitional care was available on the Cestrian ward for babies with increased care needs. The service was delivered by the neonatal team and included a neonatal nurse and transitional care nursery nurse. This meant that women, birthing people and their babies could be cared for together and removed the need for admission to the neonatal unit.

Women and birthing people could have a chaperone during intimate investigations or procedures. There were numerous posters on the walls across the wards that shared information on how to request a chaperone if they wanted to.

Staff had completed equality and diversity training. Compliance for medical staff was 100%, midwives 96% and additional clinical staff including midwifery support workers 100%.

The results from the maternity survey 2022 showed one of the lowest scores was for 'being offered a choice of where to have their baby' (78%). We did not see data on the maternity dashboard that showed how the service compared their planned home births rates with the national or regional average.

Access and flow

The service did not always capture the data needed to evidence that women and birthing people could access the service when they needed it or receive the right care promptly.

Managers did not always monitor waiting times reliably or make sure women and birthing people could access services when needed or receive treatment within agreed timeframes and national targets. The service completed a retrospective audit for maternity triage waiting times in September 2023. According to the audit sent by the trust, limitations were recorded as; doctor review times were not being formally recorded at this time and were taken from documentation by the medical team, categorisation of urgency was performed retrospectively and not by the midwife who initially triaged them. The service provided data from 23 August 2023 and September 2023 that showed 40% of admissions had no triage time recorded. This meant the service could not be assured that women and birthing people were always seen in a timely way by a doctor in triage. Following the inspection, senior leaders told us they were making changes to the electronic record system to enable them to capture this information.

For the reporting period December 2022 and September 2023, there were 4 intermittent and temporary closures of the central delivery suite to avoid serious incidents and suboptimal care. This was due to acuity and staffing levels with an average closure time of 7.5 hours. There were 12 women and birthing people diverted elsewhere and on 1 occasion the home birth service was suspended. Staff had a standard operating procedure (SOP) to follow when the unit was on divert. This included contacting the women and birthing people to ensure there was no harm caused. Each divert was incident reported and duty of candour had been followed in all instances.

We looked at the maternity dashboard which showed the service recorded the number of women and birthing people who booked an antenatal appointment before 10 weeks and 13 weeks. The service reported this data to the North West Coast Clinical Network NHSE and recorded reasons for late bookings. However, there was no information to show that the number of bookings were measured against a trust compliance target or if these key metrics were in line with national standards.

The service moved women and birthing people only when there was a clear medical reason or in their best interest and avoided movement between wards at night.

Maternity

Staff planned women's discharge carefully, particularly for those with complex mental health and social care needs. Staff told us; any woman who had complex needs would have detailed discharge plans created with relevant specialist midwife input. The service audited incomplete discharges and provided data that showed there had been a reduction from 11.6% to 3.5% between August 2023 and September 2023.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included women and birthing people in the investigation of their complaint.

The service clearly displayed information about how to raise a concern in patient areas. There were numerous posters and leaflets on the wards that shared information on how to complain.

We spoke with 5 women and birthing people and most of them knew how to make a complaint if they wanted to.

Staff knew how to acknowledge complaints and women and birthing people received feedback from managers after the investigation into their complaint. There was comprehensive complaints policy for staff to follow. This explained response timescales and referenced the Parliamentary and Health Service Ombudsman (PHSO) if a complaint wasn't resolved locally.

Between July 2023 and September 2023 there had been one complaint for the maternity service which related to postnatal care. We noted that staff had followed the trust complaints policy and timescales. The complaint was acknowledged the same day it was received and an investigation was started the following day. The woman had been spoken to by staff and they had agreed to meet with managers to help resolve the issues.

Managers shared feedback from complaints with staff and learning was used to improve the service. Between January 2023 and March 2023, the service closed 3 complaints and 3 concerns. Managers had advised women and birthing people when complaints were not upheld and invited women, birthing people and families to meet with staff for further discussion. When complaints were upheld, 72 hour rapid reviews had taken place and learning was both shared and implemented. Apologies were offered when the complaint was due to poor experience and saw evidence of meetings between women, birthing people and managers.

Managers investigated complaints and shared a summary of complaints and themes with staff and in governance meetings. The top three themes for the women and children's division were communication, appointment issues, and delayed treatment.

Staff could give examples of how they used women's feedback to improve daily practice. Staff told us that visiting times had been extended based on feedback from families.

Is the service well-led?

Requires Improvement ↑

Our rating of well-led improved. We rated it as requires improvement.

Maternity

Leadership

Leaders had the skills and abilities to run the service. They understood the priorities and issues the service faced. They were visible and approachable in the service for women, birthing people and staff. They supported staff to develop their skills and take on more senior roles.

The maternity service was part of a newly formed women and children's division at the trust. There had been significant changes made in June 2023 to create a new senior leadership team and structure. The women and children's division included maternity, obstetrics, gynaecology, breast services and all paediatric, neonatal and milk bank services. The maternity obstetrics, gynaecology and breast services were included within one of the divisions care groups. Senior leaders told us that although recruiting to a whole new division had been challenging it meant they had a tighter governance structure and improved joint working.

The director of midwifery (DoM) held the title of director of midwifery and divisional director of paediatric nursing. The women and children's division leadership team were led by the divisional director, associate medical director and divisional director of nursing and midwifery.

Maternity, obstetrics, gynaecology and breast services was led by a directorate manager, head of midwifery (HoM) and clinical lead. At the time of inspection there was one vacancy for the governance lead which was being covered as an interim measure by the HoM. The role of HoM was being covered by the director of midwifery and divisional director of paediatric nursing. There was a vacant service manager post which was covered by an assistant service manager till the role was filled.

The women and children's division had a risk midwife lead and audit midwife who reported to the interim governance lead.

Inpatient and community midwives told us that ward managers were approachable, accessible, and supportive. However, we received mixed feedback from staff regarding the support they received from matrons and senior leaders. They said they did not always feel listened to when they made suggestions or changes.

The service recorded when members of the senior team had visited. We saw posters on the wards that evidenced regular senior team walk arounds. Most staff we spoke with reported senior leaders were visible and that safety champions and executives were more visible than they used to be. Executive safety campions visited wards bi-monthly and staff could meet with senior leaders on a monthly basis for 'tea with the team'.

Many staff told us that senior leaders were respected and described them as approachable and accessible.

The hospital was developing their own leaders to provide career progression and succession planning. There was 'aspiring clinical leaders' work being done to help support those who wanted to progress into leadership roles.

Vision and Strategy

The service did not have a fully developed or implemented vision and strategy at the time of our inspection. However, the service had a strategy development plan which involved staff and relevant stakeholders.

The trust had developed a vision and strategy for 2021 to 2026 called 'Five Year Strategy' with the vision of improving the lives of the community and provide excellence in healthcare, through partnership and innovation. The trust's new strategy had been developed with staff and partners and was due to be launched in early 2024. This strategy focussed on four key areas including clinical, people, digital and value. The trust values were to be safe, kind and effective.

Maternity

The service was currently developing a women and children's strategy which was in its infancy and had not been translated into action in maternity services at the point of our inspection. However, the strategy development plan included feedback from staff and stakeholders at workshops to discuss strategic goals and objectives. These included purposeful leadership, positive patient and family experience, adding value and developing a positive team culture. The vision of the strategy was to be the hospital choice for women and children's healthcare in the North West providing the highest level of care with compassion.

The service had developed a maternity workforce strategy which was presented at the perinatal assurance and improvement board (PAIB) in July 2023. The strategy focused on maintaining a sustainable workforce and incorporated the trusts vision and values. The strategy included a workforce improvement plan which was already implemented and monitored through the women and children's governance committee.

A new maternity transformation workforce programme had also been implemented and was reported to the (PAIB).

Culture

Staff felt respected, supported and valued. They were focused on the needs of women and birthing people receiving care. The service promoted equality and diversity in daily work. The service had an open culture where women, birthing people, their families and staff could raise concerns without fear.

Women and birthing people knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern throughout the wards and units we visited.

Staff told us the culture on the wards was positive and they reported good teamwork and morale. They told us that the culture was better than it used to be and was improving. Staff worked together to benefit care and treatment for women, birthing people and babies. Staff were recruited from the local areas and internationally and care was given to any pastoral needs. This included support for emotional, social and spiritual needs.

The service had 100% retention for student midwives and most students we spoke with told us they felt fully supported and everyone was willing to help out. Staff who had moved from other NHS trusts told us they were happy with their decision and were made to feel welcome.

Staff told us there was no barriers between clinical staff and managers and that they were encouraged to raise concerns. They described reporting incidents as a 'no blame culture'.

Staff were aware of the freedom to speak up guardians (FTSUG) across the trust and told us the FTSU service was actively promoted. For example, October 2023 was dedicated as FTSU month. FTSU training compliance was 93% for maternity staff and 94% for medical staff.

The trust had started engagement sessions with staff based on trust and civility which started in October 2023.

The trust had numerous staff support networks including wellbeing, disability, faith and belief, lesbian, gay, bisexual and transgender (LGBT) and Black, Asian and minority ethnic (BAME). The trust had recently recruited an equality and diversity lead to promote all aspects of equality and diversity both clinically and non-clinically. The trust was working on an 'equality matters' page on the intranet for staff to access dedicated pages for each of the staff networks.

Maternity

The service had a maternity improvement plan, one of the objectives was to reduce health inequalities in maternity and neonatal care. The action plan would be discussed in the next work force review in January 2024. Actions included implementing the midwifery continuity of carer (MCoC) model for women and birthing people from minority ethnic communities.

We reviewed the NHS staff survey results 2022 which highlighted a completion rate of 51% for the women and children's division. This was higher than the trust response rate of 38%. The women and children's division responses were either better or similar to other areas of the organisation for all of the 9 elements. The highest scoring responses were 'we are compassionate and inclusive' and 'we each have a voice that counts'. The lowest scoring responses were 'we are always learning', 'we work flexibly' and 'morale'.

There were several actions outlined in the divisional plan that included a number of themes: increasing the visibility of leaders, improving staff well-being and expanding opportunities for staff to feedback their views. The division were piloting a mobile communication app in November 2023 which meant staff could raise concerns, share what's working well and share solutions with managers in real time.

The service was also implementing a well-being hub in November 2023 which would promote key events and focus days throughout the year related to national health and wellbeing initiatives. The focus of events was physical, mental, financial wellbeing, safety and welfare. Staff could access a wellbeing guardian (non-executive director) and a workforce wellbeing practitioner and manager.

There were leaflets and posters on the walls signposting staff to access services for counselling, physiotherapy, general advice, occupational health and the well-being centre.

Governance

The service had made changes to implement effective governance processes, throughout the service and with partner organisations. Staff at service level were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The service had recognised the need to formalise the governance framework and processes to support the safe and effective delivery of care. The maternity service was now part of the women and children's division with obstetrics, maternity, gynaecology and breast services in one care group. Paediatrics and neonatal services formed the other care group. At the time of inspection there was one vacancy for the governance lead which was being covered as an interim measure by the HoM.

Leaders attended quality assurance meetings with changes to the agenda and structures. The divisional director of nursing and midwifery attended weekly governance meetings including reviews for serious incidents and daily trust wide safety huddles.

The divisional director, associate medical director and director of midwifery shared attendance at daily situation report (SitRep) meetings. They attended monthly meetings for perinatal assurance and improvement board (PAIB), equality governance and equality and safety group meetings. There was also a monthly women and children's divisional governance meeting.

Maternity

The maternity risk register, incidents and audits were a standing item at monthly clinical governance meetings for review and action planning. These were used to identify and manage known risks. Senior leaders told us they felt well represented and listened to at board level. They shared a quarterly maternity service update report to the board of directors to highlight and identify emerging safety concerns, performance and progress on actions.

The service had an executive and non-executive director (NED) maternity safety champion who also supported them at board level. The NED safety champion chaired the monthly quality and safety committee and produced a quarterly report which was shared with the board of directors. There were bi-monthly maternity safety champions meetings and 'walkabouts' to speak with women and birthing people and with staff. Safety champions meeting minutes from January 2023 to September 2023 showed that 1 walkabout had taken place in April 2023 and not bi-monthly as planned. However, there had been a recent period of instability and changes within the executive and non-executive safety champion roles. We asked about population demographics and the work that the maternity service was doing to address health inequalities. The safety champions did not talk in detail about the work the maternity service was doing or underpinning issues required to improve. This matched broader concerns identified during the inspection about the limited progress made by the trust in health inequalities.

Staff we spoke with understood what their individual roles and responsibilities were, what they were accountable for and to whom they were accountable. Staff told us that they were provided with information relating to learning and performance via themes of the week, safety huddles and staff meetings.

At a previous inspection in February 2022, we told the service they must ensure that policies and procedures are reviewed and follow national guidance. At this inspection we raised similar concerns. Senior leaders acknowledged that there were approximately 12 policies in total that were out of date waiting for regional input. Policies that were out of date included management of reduced fetal movements (review date May 2022) and management of neonatal jaundice (review date June 2020). The infant feeding policy and neonatal hypoglycaemia had no issue date and no review date. We reviewed incidents reported over the last 12 months and found there had been 2 incidents when babies with a risk factor for hypoglycaemia should have been fed at 1 hours instead of 2 hours and blood sugars should also have been taken.

Management of risk, issues and performance

Senior leaders did not always use systems to manage performance effectively. They did not have clear oversight of the key risks highlighted on inspection. Action plans put in place did not immediately address these risks.

The women and children's division had a maternity dashboard to monitor clinical performance and governance and a risk register that was reviewed monthly. Actions were discussed in the senior team meetings, divisional committee and governance meetings and escalation was made at quality governance group. At the time of inspection the risk register for the division held 38 risks, 13 of these risks were related to obstetrics. The lack of second theatre on the central labour suite was assessed as high risk. Other risks ranged from moderate to low such as the inability to maintain babies' temperatures following elective caesarean section lists in the main theatre.

Environmental risk factors within the theatre setting

Post inspection we reviewed the ventilation inspection reports which were undertaken in May 2022 (maternity theatre) and May 2023 (room 15 which was used as a second theatre and 9 birthing rooms). The reports showed that the maternity theatre, room 15 and 9 birthing rooms were not compliant with Health Technical Memoranda (HTM) 03-01 guidance. For example, air change rates and anaesthetic extract air change rates had failed. Recommendations were made in the reports to rebalance and improve the air change rates and that further investigation was required.

We requested further information taken by the trust to address the recommendations noted in the ventilation inspection reports. We did not receive this information or any action plans. The remedial works required were not listed on the division's risk register. This meant senior leaders could not be assured that the theatres were fit for purpose.

Postnatal recovery

In a previous inspection in February 2022, we had concerns that midwives were providing immediate postnatal recovery care to women following obstetric surgery. During this inspection, we highlighted concerns surrounding midwives undertaking recovery roles following caesarean sections. Midwives we spoke with confirmed they had not received training to support the recovery of women and birthing people following a general anaesthetic. This was not in line with best practice guidance surrounding the staffing of obstetric theatres (College of Operating Department Practitioners 2009 (CODP)).

The trust provided assurance within 24 hours by implementing a policy for immediate post-operative care of women and birthing people following obstetric surgery. Senior leaders told us that with immediate effect all elective obstetric theatres now had a trained recovery nurse, an SBAR tool was now used for handover of care and was audited.

We reviewed incidents that had been reported over the previous 12 months. There was one incident reported in November 2022 that involved a delay in obstetric surgery. The reasons given was lack of recovery trained staff to care for a woman or birthing person post operation and delay in making decisions. The incident highlighted that there was no policy for post operative care for elective caesarean section patients undergoing general anaesthetic within the main theatre department. This showed that staff had raised the lack of policy and guidance regarding post operative recovery almost a year before our inspection and it had not been acted on.

Audits

Senior leaders were sighted on the areas for improvement in the service through effective auditing. Our inspection found that audits had an action plan although the actions were still to be started or needed more time to have an impact. This meant there was still significant issues and risks in the service requiring further action from leaders.

At a previous inspection in February 2022, concerns were raised regarding the reporting and categorisation of harm for PPH incidents. The trust took action and made improvements. New guidance and training for staff was now in place to ensure PPH was appropriately identified, categorised and reported. However, when improvements were made, actions and learning were not yet fully embedded. For example, audits of compliance of PPH risk assessment showed continued non-compliance against a trust target of 100%. In December 2022, compliance was 69% and in August 2023 compliance was 73%. This meant that women and birthing people at risk of PPH might not be identified and escalated quickly.

Other audits flagging with low compliance included audits of fluid balance charts to assess and monitor the hydration status of women and birthing people. Data from October 2022 to December 2022 showed 64% compliance and this had significantly dropped to 49% in August 2023. The service had since taken actions to improve compliance.

Audit data for hourly CTG assessment throughout labour showed 70% compliance in September 2023. Compliance for completing 'fresh eyes' at each hourly assessment was 60% and this had significantly declined from 90% the month prior.

Triage systems

The triage phone line was staffed by one triage midwife and unanswered phone calls on the triage unit were diverted to the delivery suite. During our inspection we observed 1 phone call not answered in triage and another phone call not answered on the delivery suite. There was no system in place to take a message from women and birthing people to signpost or to indicate length of wait. The service did not monitor or collect data on how many calls were abandoned. This meant that the service could not be assured all telephone calls from women and birthing people were consistently answered.

Diverted triage calls could be answered by any member of staff. This increased the risk of women not accessing advice and support from an appropriate member of staff in a timely manner putting them at risk of harm. In addition, there was no system to recognise or follow up women and birthing people who did not attend (DNA) the triage unit on advice from the triage helpline.

We escalated these concerns at the time of inspection and senior leaders took several immediate actions. This included two alternative telephone numbers on the delivery suite with an additional member of staff to answer the phones. A system was implemented to monitor length of wait, abandoned calls and unanswered calls and this was now audited. The service also implemented a policy for staff to follow for DNA's and this was now audited daily.

Triage waiting times

Managers did not always monitor waiting times reliably or make sure women and birthing people could access services when needed or receive treatment within agreed timeframes and national targets. The service completed a retrospective audit for maternity triage waiting times in September 2023. According to the audit sent by the trust, doctor review times were not being formally recorded at this time. The service provided data from 23 August 2023 and September 2023 that showed 40% of admissions had no triage time recorded. This meant the service could not be assured that women and birthing people were always seen in a timely way by a doctor in triage. Following the inspection, senior leaders told us they were making changes to the electronic record system to enable them to capture this information.

Leaders monitored stillbirths, fetal loss, neonatal and post-neonatal deaths. The service had a paediatric mortality lead and used the Perinatal Mortality Review Tool (PMRT) to review baby deaths that occurred after 22 weeks gestation until the neonatal period. For the period of January 2023 to March 2023 the neonatal mortality rate was 0 and from April 2023 to June 2023 it was 1 (extreme prematurity) which equated to a rate of 2.19 for every 1000 reported deaths. There were no neonatal deaths above 24 weeks gestation.

Information and action plans within the reports submitted by the service identified issues to learn from and minimise or prevent reoccurrence. The service monitored compliance against PMRT requirements as part of the maternity incentive scheme and the service had achieved compliance with this.The service had monthly PMRT meetings. We reviewed minutes from August 2023 to October 2023 which showed the cause of each baby's death had been indentified by reviewing each case and the quality of care provided. Care issues were identified and graded to establish whether different care may have made a difference to the outcome.

The trust provided a perinatal mortality surveillance report dated October 2022 for perinatal mortality after 24 weeks gestation between January 2020 and December 2020. The report recorded 6 stillbirths, 2 late fetal losses and 0 neonatal deaths. The review panel concluded that of the 6 cases of perinatal mortality after 24 weeks gestation all were unpreventable with evidence of good care. All cases had been reviewed as per national guidelines and learning had been disseminated. The report showed 100% completion of data except 1 case which had no smoking status recorded. Notification to MBRRACE of death within 7 days was 57% which was highlighted as an area of improvement.

Maternity

We reviewed the trust's compliance with the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme. This scheme is designed as a financial incentive to support the delivery of safer maternity care. Data provided by the trust showed that the service had not achieved compliance in 3 of the 10 safety actions between May 2022 and December 2022. The next reporting period for compliance was from May 2023 and December 2023. At the time of inspection, there were 2 safety actions which had not been achieved to improve the delivery of best practice. There were action plans for achieving these by December 2023 and progress was closely monitored at monthly PAIB meetings. Assurance meetings were planned for December 2023 and January 2024.

We observed the LMNS assurance board report dated April 2023 in relation to the services Ockenden assurance visit. The report showed that the service was compliant with 8 of the 11 recommendations to improve care and safety in maternity services. The action plan for the recommendations showed that the service had already achieved some of these actions at the time of inspection. Following the inspection, the trust told us that the LMNS had revisited compliance and found the service was complaint with 10 out of the 11 recommendations.

Information Management

The service was improving the collection of reliable data and analysed it. Significant progress was being made so that staff could find the data they needed, to understand performance, make decisions and improvements. Improvements were being made to the availability of data to submit to external organisations as required.

At a previous inspection in February 2022, we found that the service could not always provide the data required to benchmark their performance against other providers and national outcomes appropriately. This was due to the implementation of the new electronic patient record (EPR) system not facilitating this. The service now had a digital strategy in place and a digital midwife who had made positive progress in using information from data sets to improve the maternity dashboards.

The service had a maternity dashboard to monitor clinical performance and governance. However, the dashboard did not always show the comparison data for the trust, regional or similar sized services for all metrics. The service also had a local dashboard; however some key metrics were not recorded to analyse themes over time such as staffing, 1:1 labour care, place of birth or born before arrival (BBA). We did not see that any dashboards used a visual traffic colour code system to use for benchmarking performance.

Following the inspection, the service told us the dashboard included national and regional comparisons where available and all required metrics. The dashboard included spark lines to show improvements or deteriorations. The service also provided performance within the systems oversight framework. This supplied the board with performance metrics in relation to perinatal services.

Acuity reviews were reported to the Cheshire and Merseyside local maternity and neonatal system (LMNS). However, there were gaps in their reporting. We reviewed the data between October 2022 and October 2023 and saw the trust had 83% compliance for completed data entries.

A recommendation from the most recent Ockenden assurance visit was for the trust to consider implementing a central system for the storage of audits and actions plans where they could be accessible by all levels of staff. This was because the trusts audit structure was partly paper based and required manual extraction of data with no central point to access audit outcomes and associated action plans. At the time of inspection, the service had appointed an audit midwife and was working with the trusts clinical audit lead to achieve this recommendation.

The service provided information governance training with a trust target of 90%. The service provided data that showed compliance for this training was 87% for medical staff, 89% for midwives and 97% for additional clinical staff.

Staff we spoke with told us that IT was still an area for improvement and we found that staff could not always find key information in a timely manner in patient electronic records. Staff told us that issues with the EPR system had caused delays in updating Serum Bilirubin results for jaundice in newborns. They told us they phoned the laboratory directly for results and that the IT department were currently trying to resolve the issue.

Improvements were being made to the availability of data to submit to external organisations as required. We reviewed minutes from the quality and safety committee dated July 2023. The director of nursing and quality stated that there were national reporting data sets for maternity that could not be extracted from the EPR reporting systems. These systems were being reviewed and the chief digital information officer reported that a lot of research had taken place regarding a solution. At the time of inspection, senior leaders told us that there had been significant improvements in the collection of data and the service was now the second highest reporter of metrics to the North West Coast dashboard .

The information systems were integrated and secure**.** Electronic records were protected by security access and only those staff with authorisation were able to see medical records.

Engagement

Leaders and staff actively and openly engaged with women, birthing people, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for women and birthing people.

The voices of women and birthing people were considered within key decisions. Leaders worked with the local Maternity and Neonatal Voices Partnership (MNVP) to contribute to decisions about care in maternity services. The MNVP Chair received 5 days of funding per month. The integrated care board (ICB) funded 3 days and the trust funded a further 2 days. The MNVP chair met with leaders frequently and were involved in key decisions affecting maternity services. The MNVP chair was encouraged to attend regular meetings to feedback the voices of woman, birthing people and pregnant people. Feedback was shared with leaders and the board through the MNVP annual plan. However, areas for improvement included more timely feedback to MNVP suggestions and for the trust to be more involved in quality improvement projects.

The service involved staff in the development of actions from the maternity survey 2022. Results from the annual survey had been shared with staff through a trust wide team brief and engagement workshops with staff had been held through October 2023.

Leaders understood the needs of the local population. The service had a three year maternity improvement plan which identified 4 themes. These included listening to and working with women and families with compassion and to improve equity. Progress against the plan had already been made with the recruitment of a pelvic health midwife and the MNVP workplan had been developed based on the maternity survey results.

The MNVP workplan for April 2023 to March 2024 included actions responding to health inequalities in Gypsy, Roma, and traveller communities to gain their views and feedback on their needs and experience of maternity care. This had not yet taken place and progress would be monitored by the safety champions and reported to the local maternity and neonatal system (LMNS).

Senior leaders had noted a rise in incidents related to vulnerable women and non-English speaking women. In response, a working group was being implemented and lead by the community matron. The aim was to explore the possibility of creating a MCoC team for women and birthing people from minority ethnic communities. A MCoC workforce review was planned for January 2024.

Listening events took place within the local community. For example, the MNVP community engagement lead had engaged with children's centres in deprived areas. They distributed feedback surveys to women and birthing people and recognised digital poverty by providing paper copies if needed. The service also held a stall focused on LGBT groups and involved LGBT women and birthing people in reviewing current information documents to check it was inclusive.

The service celebrated international day of the midwife annually and hosted a midwifery day awards. The 4 awards were to recognise the achievements and efforts of staff including inspirational leaders, midwifery team of the year and outstanding preceptee midwife.

The trust held monthly employee engagement working group (EEWG) meetings which were attended by all divisional leads. Meeting minutes from September 2023 showed that a civility roadshow was planned for November 2023. The roadshow would give opportunities for staff to feedback on the culture of the trust and help develop a new civility charter. The trust was implementing a new wellbeing strategy and promoting this at the roadshow along with the EDI strategy and talent and leadership framework.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The service was committed to improving by learning when things went well or not so well and promoted training and innovation. Staff participated in training simulations to aid learning and quality improvement (QI). For example, in the previous 3 months staff had participated in simulations for PPH following an elective caesarean section, shoulder dystocia in the birthing pool and neonatal thermoregulation. The training included discussions, feedback, learning points and associated actions.

The service promoted and coordinated the development of QI initiatives. The service had completed a QI programme for implementing the Obstetric Bleeding Strategy (OBS) Cymru (Wales) tool. Senior leaders told us that staff had been invited to present the learning form the QI work to the regional Cheshire & Mersey PPH study day in February 2024.

The service had completed a QI project before implementing a new system for assessing clinical risk in triage. The QI project in June 2023 recommended that the new triage system should be suspended due to staffing levels at the time. A new date was proposed for November 2023 when all vacancies had been filled with newly recruited staff.

The service had 8 professional midwifery advocates (PMA) which was described as 'a way of supporting staff through restorative clinical supervision and personal action for quality improvement.' The service planned to promote the PMA service further in November 2023 through a launch party on the Cestrian ward.

PMRT reports were submitted quarterly to the trust board and lessons learnt were shared with staff via the bereavement midwife and practice development midwife. Information was also shared at perinatal mortality and morbidity meetings, safety huddles and the North West Coast Network Special Interest Groups to enable wider learning across the network.

Maternity

A new maternity workforce programme had recently been implemented which was led by the director of midwifery and matrons. They were leading on retention, recruitment and focusing on perinatal mental health and ethnic minority groups.

The service was part of the national fetal monitoring network. The fetal monitoring lead told us they met virtually every month with over 100 staff from other hospitals nationally. Staff used this network to share learning, resources and case studies. The fetal monitoring lead also attended monthly regional meetings to discuss more local issues, peer reviews and share teaching resources.

The service had recently undertaken a thematic review of weight loss in babies requiring hospital readmission. The review highlighted themes, learning points and associated actions.

Services for children and young people

Requires Improvement ↓

Is the service safe?

Requires Improvement →←

Our rating of safe stayed the same. We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills to all staff; however not all staff had completed training.

Staff completed mandatory paediatric or neonatal training relevant to their role and attended practical study days.

All nursing staff we spoke with had completed their mandatory training. The practice nurse developer monitored mandatory training compliance and made sure staff were up-to-date with their training. They booked staff directly onto training courses.

Mandatory training information for September 2023 showed an overall compliance rate for the service as 87%. This meant the service was just below the training target of 90%.

Results showed there was high compliance with most groups of staff who met, or were close to, the trust target. For example, administrative and clerical staff 98%, paediatric medical staff 91% and nursing staff 90%. However, there was lower compliance for some staff groups such as community paediatric medical and professional scientific and technical staff which was affected by low numbers of staff not completing some specific modules which impacted on the overall compliance rate.

Staff received training for advanced paediatric life support (APLS) and newborn life support (NLS). The compliance for the division (which included Maternity and Gynaecology) was 84% for APLS and 77% for NLS. The service were 100% compliant with having one APLS trained member of staff per shift.

The mandatory training was comprehensive and met the needs of children, young people, and staff. Staff received training in areas such as infection prevention, information governance and health, safety, and welfare.

The service had introduced a “topic of the week learning” which staff found to be beneficial, especially as the training was delivered in a bite sized chunks.

Clinical staff completed training on recognising and responding to children and young people with mental health needs, learning disabilities and autism.

The trust had recently introduced the Oliver McGowan, learning disability and autism training as part of mandatory training and the compliance rate was positive at 69% for eligible staff. Mental Capacity Act training was delivered as part of level 3 safeguarding training

Services for children and young people

Safeguarding

Staff understood how to protect children, young people and their families from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. However, the service did not meet the trust target for safeguarding training.

Nursing and medical received training specific for their role on how to recognise and report abuse.

Mandatory training compliance for safeguarding training for eligible staff was;

Safeguarding children training

- 92% for level 1
- 87% for level 2
- 80% for level 3

Safeguarding adult training

- 88% for level 1
- 89% for level 2

These results showed the service were close to, but did not always meet, the trust target of 90%. However senior managers were due to complete a training needs analysis for level 3 safeguarding training to ensure it had been appropriately assigned to only the staff who needed it.

The latest safeguarding newsletter advertised “think family” training dates. This was a face to face training day which combined level 3 adult and children safeguarding training. This included training on domestic abuse, mental capacity act and Gillick competencies and awareness of Fraser guidelines. Most staff were 100% compliant with this training.

There was a new children safeguarding level 3 “plus” training module available for all staff. This included training on child exploitation, sexual harmful behaviours, and self-harm.

Most staff were fully compliant with chaperone training.

Staff could give examples of how to protect children, young people and their families from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

Safeguarding information was displayed throughout the service. This included information on “PREVENT” to safeguard people and communities from the threat of terrorism.

The service promoted an adult safeguarding week in November 2023 within the latest safeguarding bulletin. This also contained links to training, tools, and online referral forms to the local council and the police.

The trust’s domestic abuse policy was clear and comprehensive.

Services for children and young people

The service collected information on the number of children and young people who attended the emergency department. From October 2022 to July 2023, the numbers of mental health attendances had continued to increase and there were 200 attendances by under 16 year olds and 98 attendances for 16 to 17 year olds. The number of drug and alcohol related attendances were 39 for under 16 and 48 for 16 and 17 year olds.

Staff knew how to make referrals and access safeguarding policies and guidance. The service had contacted the children's social care team on 1067 occasions to discuss and share concerns which included looked after children or children on a protection plan.

The service made 183 safeguarding referrals to neighbouring social care services. They had access to the out of hours safeguarding support teams especially if there were concerns with babies who had been born on a weekend.

Staff knew who to inform if they had concerns. They could make online referrals to the safeguarding and complex care team (SACCT) who also received a daily list of 16 and 17 year old patients who had been admitted to an adult clinical area to make sure their needs were met.

The service had a named nurse specialist for safeguarding children. There was recent investment to create a post for an associate director of nursing and an operational service lead for safeguarding.

The trust had a named doctor for safeguarding children. They completed monthly peer reviews with paediatric medical staff and offered supervision on safeguarding cases.

The safeguarding and complex care team shared learning from safeguarding incidents and information via the trust weekly bulletin, staff noticeboards and quarterly newsletter.

The safeguarding and complex care annual report 2022 /2023 included a reflective case study in relation to safeguarding children.

All safeguarding related policies which were clear and comprehensive.

Staff had clear guidance to follow in the event of child abduction and they followed safe procedures for children visiting the ward.

Cleanliness, infection control and hygiene

The service mostly controlled infection risk well however, we found damage to floors, walls and door frames which was an infection control risk. Staff used equipment and control measures to protect children, young people, their families, themselves, and others from infection. They kept equipment and the premises visibly clean.

There was a good standard of cleanliness on all the wards and clinical areas we visited. There were posters displayed outside the children's ward and neonatal unit which showed 5 star ratings had been awarded for cleanliness in October 2023. The paediatric outpatients department and children's ward scored 100% in October 2023 for environmental audits.

There were suitable furnishings which were clean and well-maintained. However, there was significant damage to flooring, walls, and door frames on the children's ward, children's assessment unit, female adolescent ward area, and children's outpatient department. There was also rust found on numerous trolleys. This meant there was an increased risk of infection in these areas.

We identified concerns relating to basic food hygiene standards on the children's ward as there were out of date patient sandwiches and staff's food and drink inside a patient's fridge. This was escalated with the ward manager who took immediate action to remove the food, clean the fridge and informed all staff not to store food and drink in the patient fridge.

The service was not always compliant with meeting the trust target of 90% for level 2 infection, prevention and control (IPC) mandatory training with compliance rate of 84%.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. IPC checks were completed by staff and documented on the handover sheets. In all the areas visited there were hand washing facilities including hand sanitising gel readily available. However, in several store rooms we found boxes which were stored directly on the floor which prevented floor cleaning.

Staff followed infection control principles including the use of personal protective equipment (PPE) such as aprons and gloves. The service demonstrated high compliance against the most recent IPC audit for hand hygiene, correct use of PPE and for isolation precautions. Staff regularly washed their hands and had bare arms below elbow when delivering care. All staff were all compliant with the uniform policy.

The neonatal website page provided specific IPC guidance to parents when visiting their baby.

The service had appropriate side rooms for patients who were immune compromised or who required isolated.

The service had not reported cases of healthcare associated infections in the last year.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. However, a recent IPC audit from August 2023 showed poor compliance scores for equipment cleanliness on the children's ward.

The National Reporting and Learning System (NRLS) for incidents reported between September 2022 to September 2023 showed an example when a used incubator cot had not been cleaned or changed for 13 days.

Environment and equipment

The design, use of facilities and equipment kept people safe. However, there was poor maintenance of the premises. Staff were trained to use equipment and managed clinical waste well.

The service had suitable facilities to meet the needs of children and young people's families. However, the women and children's building had been constructed between 1967 and 1969 which meant the building had aged environmental concerns. Staff frequently contacted estates to report poor drainage, overflowing drains, and blocked toilets. On the day of our inspection, we saw estates staff attempting to fix a blocked drain and there was a strong unpleasant drain odour.

Services for children and young people

The September 2023 divisional report stated there had been two recent incidents whereby blocked drains had overflowed into ground floor ceiling void causing ceiling tiles to become sodden and displaced, and collapse in one particular incident. Staff informed us there were still dirty ceiling tiles on the children's ward. We observed a missing ceiling tile in one storage room which was also a fire hazard.

At the last inspection in 2016 the service was reported to have environmental risks and unlocked storage rooms. At this inspection we found repeated concerns. On the children's ward we found several unlocked storage rooms with unsafe storage of sharps including needles, syringes, sharps bins, intravenous infusion fluids and cannulas. There was unsafe storage of oxygen cylinders. All of these rooms had locks, but they were not being used. One door had been propped open with a bin. There was unsafe storage of sharps and controlled substances hazardous to health (COSHH) cleaning chemicals in the treatment room and this door did not have a lock.

We immediately escalated this risk to managers who locked all the doors and safely stored the oxygen cylinders. They completed an incident report for the door without a lock and escalated this to senior managers. The following day the door was fitted with swipe card access.

Following the inspection, the trust responded to the concerns raised on inspection. Staff were told to ensure all COSHH cleaning chemicals were safely stored in lockers and rooms were locked to avoid unauthorised access. Managers had started completing walkabouts to check all lockers and were completing a multiple daily checklist.

There was a significant risk that children had easy access to electric plug sockets which did not have child safety plugs. This was raised to staff on the day of the inspection.

Staff did not always carry out effective daily safety checks of specialist equipment such as on the resuscitation trolley equipment or check the safe storage of oxygen cylinders. In September 2023 there were two missing daily checks for the resuscitation trolley and 1 for the neonatal difficult airway trolley. However, evidence from the National Reporting and Learning System (NRLS) for incidents reported between September 2022 to September 2023 showed only one incident related to when emergency equipment had not been present on a difficult airway trolley.

A brand new neonatal unit was opened in 2021. It had been funded by a charity appeal which raised 2.4 million pounds. The unit covered a large spacious area. It had two separate entrances which were both covered by closed circuit television (CCTV) and access was via an intercom system.

There were adequate storage facilities which was an improvement following the previous inspection. At the entrance to the unit there were large lockers for parents/ carers to store personal belongings and hooks to hang their outside coats. Hand wash sinks were available for visitors at the entrance before entering the neonatal unit.

The unit had capacity for 12 cots. There was an extra stabilisation intensive therapy unit (ITU) cot which was used when babies were being stabilised with a view to transfer. This included 2 to 3 high dependency cots (HDU) cots and the remaining cots were utilised for special care and transitional care.

There was a large cot area, 4 twin nursery rooms and 2 single nursery rooms. The unit had been designed to be close to the labour ward corridor which meant a short distance to travel if babies needed to be transferred.

Services for children and young people

The unit had been designed with a focus on family integrated care. There were rooms to support infant feeding. Parents and carers had access to their own fridge to store breast milk. There was also another dedicated locked milk fridge. There was a 'Comfort Zone' where parents and carers could access hot drinks and meet with other parents and staff. There were two further ensuite rooms for families away from the clinical area with a lounge and kitchen.

On the neonatal unit there was there was outdoor access to a large secure garden leading out to a retreat which was a private area for families to use for peace and quietness.

There was a large play area on the children's ward area for children and siblings. There were games and activities suitable for all ages. There was a poster on the door which reminded everyone the room was a "child safe zone" which meant no medical assessments were allowed such as observations, medications, or examinations. The playroom had an adjoining outside area for children to play outside; however, staff told us this was temporarily closed due to ongoing safety works. There was a sensory room which had different light simulations and was used by all children, not just those with sensory loss.

All the wards and units were colourfully decorated and were child friendly. For example, there were suitable toilets, and every door hinge had a slam protection in place.

The service had enough suitable equipment to help them to safely care for children and young people. There was a fully stocked equipment trolley next to each cot. We checked a range of consumables items, and all were within their expiry date.

Staff informed us that storage was an issue on the children's ward however, we observed all equipment to be appropriately stored.

Staff disposed of clinical waste safely. There were arrangements in place for the handling, storage, and disposal of clinical waste. including sharps. All sharp boxes that we looked at were signed, dated, and stored appropriately.

A recent audit for the neonatal and children's outpatient unit which showed high compliance for managing waste and the safe handling and disposal of sharps.

Assessing and responding to patient risk

Neonatal unit

Staff completed and updated most risk assessments and removed or minimised risks and acted quickly acted upon risks of deterioration.

Staff completed risk assessments for each baby on admission. They used a newborn early warning scores (NEWS) nationally recognised tool to identify risks of deterioration and escalated them appropriately.

Staff provided care and support to neonatal babies, who had a gestational age of 32 weeks.

The service delivered a bespoke model of care which sat between the models of level one special care unit (SCU) and level 2 local neonatal unit (LNU).

Services for children and young people

There were restrictions on the service operating as a full level 2 unit because they only accepted babies who had a gestational age of 32 weeks or more.

The trust told us they could provide high-dependency care to babies for their full admission. The service assessed babies who required intensive care to check whether they could meet the baby's needs or whether it would be safer to transfer the baby to a tertiary unit. This meant the service continued to provide care at a higher level than a level one unit but did not fully deliver care at the level of a level two unit.

Staff knew about and dealt with any specific risk issues and would escalate any concerns to the medical team. They shared necessary information at shift changes and when handing over their care to others to keep children, young people, and their families safe.

There were multiple handover meetings, safety huddles and ward rounds where staff could escalate any concerns to relevant staff. They were scheduled to be at set times each day. They were well attended by all relevant staff. Staff held discussions about treatment management plans as well as staffing concerns, planned and unplanned admissions from Maternity referrals and discharges to transitional ward. All meetings were organised and structured in line with national guidance and good practice.

All staff were fully compliant with paediatric sepsis training. Risk assessments reviewed on inspection had been completed appropriately and this included the sepsis pathway.

There was on call medical cover with an allocated neonatal consultant who provided cover during the week and a neonatal / paediatric consultant who covered the weekend.

The neonatal unit was designed so that the emergency bell on the unit would sound and alert staff anywhere in the unit and staff responding quickly and effectively an alarm.

Staff could arrange urgent transfers to a level 2 local neonatal unit or level 3 neonatal intensive care unit for neonatal babies born under the age of 32 weeks or who required longer intensive care. There was a standard operating procedure to facilitate timely and safe transfers of babies from this trust to other trusts. The trust confirmed post inspection that any intensive care provided was always discussed with the tertiary neonatal unit as part of collaborative working. These transfers were completed by the Cheshire and Merseyside neonatal network transport service.

The neonatal service had a discharge checklist to ensure safe discharge. All babies under the age of 6 weeks of age were reviewed by a paediatrician, or by a year 3 specialist trainee (ST3) or above, prior to discharge in line with the discharge policy.

The transitional care handover also included information about the woman, and birthing person, as well as the baby.

The recent maternity inspection in 2023 highlighted a safety concern for when newborn babies were transferred from the Maternity theatres to the neonatal unit. Senior leaders explained this had been risk assessed and safety measures were in place to mitigate any clinical risks. For example, they used a warming “bear” to keep women warm during the transfer which meant the skin to skin contact could be maintained with the newborn baby.

Children’s ward

Services for children and young people

Staff completed and updated most risk assessments and removed or minimised risks and acted quickly acted upon risks of deterioration. However, staff did not complete nutritional risk assessments or identify risks associated with dietary requirements of children and young people.

Staff completed risk assessments for each child and young person on admission. They used a paediatric early warning scores (PEWS) which was nationally recognised tool to identify risks of deterioration and escalated them appropriately. We were informed the service was waiting for a new national PEWS form to become available.

Staff provided care and support to children and young people up to 16 years of age and who may require high dependency care.

Staff knew about and dealt with any specific risk issues and would escalate any concerns to the medical team. They shared necessary information at shift changes and when handing over their care to others to keep children, young people, and their families safe.

There were multiple handover meetings, safety huddles and ward rounds where staff could escalate any concerns to relevant staff. They were scheduled to be at set times each day. They were well attended by all relevant staff. Staff held discussions about treatment management plans as well as staffing concerns, referrals into the unit and discharges. All meetings were organised and structured in line with national guidance and good practice.

All staff were fully compliant with paediatric sepsis training. Risk assessments, with the exception of risk assessments in relation to nutrition and hydration, reviewed on inspection had been completed appropriately and this included the sepsis pathway.

There was access to a paediatric consultant who provided on call cover during the week and a paediatric/ neonatal / consultant who covered the weekend.

Managers told us that there was always a member of nursing staff on duty day and night with advanced paediatric life support (APLS) on the children's ward. All band 6 staff and above had received this training.

At the previous CQC inspection in 2016 the trust was advised to consider the introduction of a routine nutritional assessment tool for all patients on the children's ward. At this inspection there were similar concerns identified.

The service did not ensure appropriate nutritional risk assessments were completed by staff at the time of food ordering. This meant there was a risk that children and young people could choose, and eat, unsuitable foods or drink which did not meet their dietary requirements.

There was a standard operating procedure to facilitate timely and safe transfers of children and young people from the emergency department to the children's ward. It was a clear and comprehensive process and contained relevant numbers such as the advanced paediatric nurse practitioners (APNP) medical teams. Emergency department staff would complete regular observations and PEWS assessments and would escalate any concerns or deterioration during the wait for transfer. The APNP staff also carried a bleep and were responsible to respond to any paediatrics resuscitations.

Children's assessment unit

The children's assessment unit was managed by an advanced paediatric nurse practitioner (APNP). They assessed sick children, liaised with the medical team, and made decisions as to whether or not children required hospitalisation.

Services for children and young people

All services

Most entrances within the service were secure and had a ring bell and camera. This meant no one could enter or exit inappropriately. However, we were informed that a CCTV camera facing one of the units had not been operational for two weeks and had been reported to the estates department. We raised this safety concern to the ward manager and the following day we were informed the security camera had been repaired.

The service shared audit results which showed high compliance that babies, children, and young people received their first dose of intravenous antibiotics within 60 minutes. However, other audits showed poor compliance against the record keeping for sepsis. We reviewed the action plans following these audits which included further education with staff to raise awareness, and future audits to measure improvements.

The child abduction policy which provided appropriate and clear guidance to staff.

The service had 24-hour access to mental health liaison and specialist mental health support if staff were concerned about a child or young person's mental health. They could access mental health risk assessments using the electronic patient record system. Staff provided examples when they had completed risk assessments for babies who had been born to women, or birthing partners, who were dependent on drugs or alcohol.

Not all staff were fully compliant with paediatric sepsis training children's outpatient department (50%) but this data equated to low numbers of staff.

Community and specialist nursing staff who visited babies, children and young people in their homes completed appropriate risk assessments prior to the visit and adhered to the lone working policy.

Nurse staffing

The service had enough nursing staff with the right qualifications, skills, training, and experience to keep babies, children, young people, and their families safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave bank and agency staff a full induction.

Neonatal unit

At the time of our inspection the neonatal unit had low numbers of patients which meant there were enough nursing and support staff to keep children and young people safe. All staff reported they felt the staffing levels were safe.

The neonatal staff rotas for June to September 2023 showed the unit had always been staffed with higher numbers than recommended by the British Association of Perinatal Medicine (BAPM) for a level 1 unit.

The service delivered a bespoke model of care which sat between the models of a level 1 special care unit (SCU) and a level 2 local neonatal unit (LNU). The staffing requirements for the service were assessed using the level one standards as a baseline. The service met and exceeded the standards for level one, however the unique model of care provided by the service meant it was not possible to fully assess whether the service had enough staff with the right skills to provide this level of care.

There was only one night shift in September 2023 which did not have the minimum levels of staff. The fill rate at the time of inspection was 97% with registered staff and 88% for unregistered staff. The vacancy deficit was 4.05 WTE which was a 5% vacancy rate. Managers informed us that a band 5 and band 6 job had been advertised.

Managers informed us that gaps in the rotas were always mitigated. There was always an additional band 6 nurse available for the neonatal unit, especially when there were planned caesarean sections.

Managers accurately calculated and reviewed the number and grade of nurses and HCA, needed for each shift, in accordance with national guidance. Managers provided evidence of how they could flex the rota depending on numbers of admitted babies according to their needs / acuity.

The neonatal unit utilised the neonatal nursing workforce tool to remain compliant with the BPAM standards and department of health (DoH) toolkit for neonatal services (2009);

- One nurse to one patient on intensive care
- One nurse to two patients on high dependency care.
- One nurse to four neonates in special or transitional care.

From September 2022 to September 2023 a neonatal member of staff cared for one neonatal baby at a time.

The ratio of qualified to unqualified staff on the neonatal unit was 71:29 which was very close to the 70:30 compliance ratio recommended by BAPM.

In September 2023, the service's performance dashboard showed a 6% sickness rate for neonatal staff which did not meet the trust target of 4%.

Children's ward

At the time of our inspection the children's ward had low numbers of patients which meant there were enough nursing and support staff to keep children and young people safe. All staff reported they felt the staffing levels were safe.

The nursing establishment consisted of 1 whole-time equivalent (WTE) band 7 nurse, 8.62 WTE of band 6 nurses, 15.36 WTE band 5 nurses and 6.25 WTE band 3 HCA's and 2.38 WTE housekeeper.

There were gaps in the staffing rota on the children's ward which meant the actual number of nurses and healthcare assistants (HCA) did not match the planned numbers. However, the fill rate at the time of inspection was 100% with registered staff and 96% for unregistered staff. The vacancy deficit was 3.07 WTE staff which was a vacancy rate of 5%. Managers informed us there were 7 new staff who had completed their supernumerary training time, but this still left them with 2.6 WTE vacancies.

The children's ward was piloting a new staffing acuity tool and recorded the number of admitted children and their acuity. The preliminary results which were based on throughput, turnover and flow showed they were under established for registered nurses.

Managers informed us that gaps in the rotas were always mitigated. There was always an additional member of staff available for the children's ward.

Managers accurately calculated and reviewed the number and grade of nurses and HCA, needed for each shift, in accordance with national guidance. Managers provided evidence of how they could flex the rota depending on numbers of admitted children, and young people according to their needs / acuity.

During the day there was a 1 to 5 ratio of nurses to children. In order to meet the recommendations this should have been 1 nurse to 3 for children under two years of age and 1 nurse to 4 children above 2 years of age. During the night there was a 1 to 6/7 ratio of nurses to children. In order to meet the recommendations this should have been 1 nurse to 5 children. However, managers told us they would change staffing ratio according to patient acuity and would provide a ratio of 1 nurse to 1 or 2 children and for any patient who received high dependency care.

There was an additional band 3 nursing assistant available day and night to care for low acuity patients.

In September 2023, the service's performance dashboard showed a 4% sickness rate for paediatric staff which met the trust target of 4%.

Children's outpatient department

The nursing establishment consisted of 1 WTE band 6 nurse, 0.93 WTE band 5 nurse and 2.55 WTE band 3 HCA's. There was a 10% sickness rate which did not meet the trust target of 4%. They did not have any vacancies.

All

Managers made sure all bank and agency staff had a full induction and understood the service. However, the use of bank and agency staff was limited. Managers told us they would strive to use their own staff first and if they did use agency staff, they would request familiar staff.

There were additional staffing teams who provided care and treatment to babies, children, and young people for a number of defined hours;

- Neonatal community outreach team (NCOT) which also included a lactation consultant
- Paediatric community specialist nursing team
- Paediatric diabetes team
- Paediatric epilepsy team
- Senior wellbeing practitioner / Psychologist
- Play therapist team
- Hospital at home team
- Specialist outpatient team for children and young people with eating disorders (CHEDS).

The service was funded to have a dietician, physiotherapist, and occupational therapist for one dedicated day per week.

The service was an outlier for supernumerary staff working clinical shifts. We were informed that Band 6 shift leaders were not always supernumerary on every shift which meant they worked clinically rather in their managerial roles. Some mangers confirmed they did not always had time to complete managerial roles.

The transitional care unit was staffed by a neonatal nurse and nursery nurse and was modelled against the transitional care guidelines.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training, and experience to keep children, young people, and their families safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

Neonatal unit

The unit was referred to by the North West neonatal operational delivery network (NWNODN) as a level 2 local neonatal unit (LNU). The trust's board papers continued to state there was an ongoing review of neonatal critical care which would determine the future status of the neonatal unit. It was not clear whether this was an ongoing local review or referred to the national neonatal critical care review which completed in 2019. We asked the trust to provide evidence of how the service had implemented the recommendations of the national review. The trust provided limited evidence to support that the national recommendations had been implemented by the time of our inspection.

The service delivered a bespoke model of care which sat between the models of a level 1 special care unit (SCU) and a level 2 local neonatal unit (LNU). The staffing requirements for the service were assessed using the level one standards as a baseline. The service met and exceeded the standards for level one, however the unique model of care provided by the service meant it was not possible to fully assess whether the service had enough staff with the right skills to provide this level of care.

There were restrictions on the service operating as a full level 2 unit because they only accepted babies who had a gestational age of 32 weeks or more.

Medical staffing also included 2 advanced neonatal nurse practitioners (ANNPs) who helped medical doctors covered the tier 1 neonatal rota covering weekday and weekend long day shifts.

The service had enough medical staff to keep children and young people safe. It was fully compliant with all the recommendations and standards for a level 1 special care unit, as outlined in the optimal arrangements for neonatal intensive care units and in line with British Association of Perinatal Medicine (BAPM).

The number of tier 1 and 2 level paediatric doctors had previously been limited by the number of trainees however, in 2022 the national recruitment had improved.

We reviewed medical staffing data and saw that the numbers of medical staff matched the planned numbers. The service had a good skill mix of medical staff on each shift and reviewed this regularly.

We reviewed the tier 1 staffing rota for the neonatal unit. This met all the requirements of BAPM standards for a level 1 special care unit. The unit was staffed by 9 doctors which included year 1 and 2 paediatric speciality training (ST) doctors, year 1 and 2 general practice (GP) ST doctors and a year 2 foundation doctor. The service was over established as they had recruited an additional trust grade doctor to cover any sickness, annual leave and/or study leave.

Services for children and young people

There was a resident doctor dedicated to the neonatal service during daytime hours on weekdays. The service had introduced a twilight shift during the week from 9pm to midnight. This shift was covered by one of two advanced neonatal nurse practitioners (ANNPs) who were dedicated to support the tier 1 rota during the week (8.30am to midnight) and at weekends (8.30 to 9pm). There was also a continuously immediately available resident Tier 1 practitioner 24 hours seven days a week.

For the service to be compliant for a level 2 local neonatal unit they would need a residential Tier 1 practitioner to provide emergency care to the neonatal service 24 hours seven days a week. This meant the service needed to cover the gap from midnight to 8.00am during the week and at weekends. Senior leaders were considering different ways to achieve this, and one way would be for the task of newborn examinations to be reallocated to midwives in order to reduce workload. They were also enhancing neonatal nurse practitioner roles to include skills such has cannulation and septic screening.

We reviewed the Tier 2 staffing rota for the neonatal unit and children's ward. This met all the requirements of BAPM standards for a level 1 special care unit. The rota was staffed by 7 ST year 3 paediatric doctors and 1 speciality doctor. There was a dedicated tier 2 medical cover Monday to Friday 08:30 to 16:30 for the neonatal unit. They would provide support to tier 1 practitioners in admitting babies requiring respiratory support or of very low admission weight less than 1500 grams.

There was a separate on call rota for 12 hours every day covered by at least one resident junior paediatric doctor (ST 2 or below) who was dedicated to provide cover for all paediatric services but was immediately available to the neonatal unit.

The service was working towards the BAPM standards for a level 2 local neonatal unit which required a resident doctor (ST2) dedicated solely to the neonatal service and be located in paediatric unit between 09.00-22.00 seven days a week.

We reviewed the Tier 3 staffing rota which was compliant with BAPM standards for a level 1 special care unit. The rota was staffed by 12 consultant paediatricians. There was dedicated neonatal consultant cover during the week 8.30am to 4.30pm. There was consultant presence in the hospital during the week 8.30am and 7pm and at weekends 8.30am to 1pm and 5pm to 7pm.

To achieve the BAPM medical standards a level 2 LNU they would need to consider having a dedicated Tier 3 rota to the neonatal unit entirely separate from the paediatric department.

The consultants covered a 1 in 10 on call rota which meant there was always a consultant on call during the day, evenings, and weekends.

There was a medical ward round and handover at 4pm each weekday which was led by the consultant. There was a ward round on Saturdays and Sundays for both wards which was alternately led by the consultant or middle grade doctor. There was always a consultant on site during the transport of babies.

The service was compliant with BAPM standards for a level 2 LNU with having "consultant of the week" system with a separate consultant for neonatal and paediatric services. The trust did not provide information for whether the unit was compliant for consultants completing less than 4 consultant of the weeks annually or if they completed no more than one in every six weeks.

The activity of the unit met the compliance for a level 1 SCU.

The paediatric consultant and the neonatal consultant covered on call for both wards between them.

The service had low vacancy rates for medical staff.

Sickness rates for medical staff were low.

The service had low rates of bank and locum staff. Managers could access locums when they needed additional medical staff. Managers made sure locums had a full induction to the service before they started work.

Children's ward

The service had enough medical staff to keep children and young people safe.

We reviewed medical staffing data and saw that the numbers of medical staff matched the planned numbers. The service had a good skill mix of medical staff on each shift and reviewed this regularly.

The service had low vacancy rates for medical staff.

Sickness rates for medical staff were low.

The service had low rates of bank and locum staff. Managers could access locums when they needed additional medical staff. Managers made sure locums had a full induction to the service before they started work.

The service had 4 advanced paediatric nurse practitioners (APNPs) who worked closely with the medical team. They worked seven days a week 8.30am to 9pm and, within their scope of practice, were responsible for diagnosing, treating and discharging children and young people.

The service also recruited a year 1 foundation doctor who provided out-of-hours and cover as part of their rota for this ward and were supernumerary to cover paediatrics.

Records

Staff mostly kept detailed records of children and young people's care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care. However, staff were not always compliant with record completion

Patient notes were comprehensive, and all staff could access them easily. The service used a combination of paper and electronic patient records.

We reviewed 6 sets of records on the children's ward, which were completed to an excellent standard. All entries were signed, dated, were legible and records were in chronological order. All records showed a clearly documented history and treatment. This included appropriate PEWS / MEWS assessments and completed pathways such as sepsis.

There was positive evidence that family members had been involved in the planning of their child's care and these conversations had been documented in detail.

Staff told us the electronic patients records were clear to review and access.

Services for children and young people

When children and young people were transferred to a new team, there were no delays in staff accessing their records. Records which showed detailed information for transfers to and from the neonatal unit.

At the last inspection in 2016, medical records were not securely stored on the children's ward. At this inspection records were stored securely.

Recent records audits showed high compliance with full completion of electronic and patient's records. For example, fluid balance charts and appropriate escalation to medical teams following above threshold paediatric early warning scores (PEWS).

However, other audits showed low compliance with record completion. For example, not all PEWS parameters had been completed and there was poor recording for patients with suspected sepsis.

Medicines

The service had processes to administer and record medicines. However, they did not have reliable systems to prescribe medicines and did not always safely store medicines.

Most medicines, including controlled drugs were stored securely in appropriate facilities within locked medicines cabinets, trolleys, and fridges. This was in line with legislation. However, there were intravenous fluids stored in a glass fronted unlocked cupboard in an unlocked treatment room. This meant this medicine was accessible to all staff, patients, families, and their visitors.

Some medicines were being stored in warm rooms which did not comply with the safe and secure handling of medicines guidance from the Royal Pharmaceutical Society (RPS). The service did not measure ambient room temperatures of these rooms which meant medicines may be less effective.

We raised this with senior managers who said they would discuss this with the lead pharmacist. The estates department were due to install digital temperature equipment in December 2023 which meant an alarm would sound if the temperature exceeded a pre-determined temperature.

Controlled drugs were kept in separate locked cupboards and appropriate checks recorded and the nurse in charge would be responsible for holding all medicine door keys.

Staff followed processes to prescribe and administer medicines safely. We checked items against the controlled drug register, and these were recorded as the correct quantity and within date. However, the electronic prescription record system was not always accurate or reliable. The system showed red flags for missed doses of medicines, but staff explained these medications had been prescribed but at a later time than the pre-set time. Staff said they were extra vigilant and always checking the time of previous administration before continuing to prescribe any medication.

Staff used electronic prescription charts for all medicines apart from oxygen titrations and diabetic

prescribing. Staff were able to access the British National Formulary (BNF) and intravenous (IV) guidelines readily available on electronic system.

On the neonatal unit the 4 prescription charts we reviewed had been completed appropriately. This included gentamicin prescribed for two neonates and an appropriate checklist was in place for it to be completed and reviewed. On the children's ward the 5 prescription charts we reviewed had been completed appropriately.

There were clean utility rooms throughout the service. All doors were locked and had swipe card access for specific authorised staff. All medicines were within date and not past their expiry date for usage.

The service received weekly support from two clinical pharmacists who would replenish the stock of medicines to prevent supply issues and remove medicine recycling bins.

The medicine fridge temperatures had been recorded daily and were within acceptable limits.

Throughout the service we found leaflets relating to medicines for parents / carers of children and young people.

Staff reviewed each child and young person's medicines regularly and provided advice to children, young people, and their parents and carers about their medicines. We observed staff calculating different levels of medication. This was always checked by two additional members of staff prior to administration.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. There was an on call pharmacist available to assist with urgent medication required for any transfers out of or into the service.

The service had processes in place to ensure the safe issue of medicines at the point of a patient's discharge. Staff informed us that they always checked the discharge medication prescribed by medical doctors against the BNF guidance.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave children, young people and their families honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff raised concerns and reported incidents and near misses in line with trust/provider policy. They knew what incidents to report and how to report them using the electronic reporting system. They were encouraged, and felt supported, to complete self-reported incidents.

Managers investigated incidents thoroughly for serious incidents. The service monitored incidents, themes, and shared learning from incidents. Senior leaders attended a daily incident meeting every morning to discuss harm levels and categorise moderate harm incidents that required a rapid review. There was a weekly review of these incidents and a trust wide serious incident panel every week which was attended by a member of the clinical team. There was a monthly meeting where senior leaders reviewed all incidents, themes and trends and any associated learning. All deaths were discussed at quarterly paediatric or perinatal morbidity and mortality meetings, and they were always with the coroner.

There had only been one incident which was referred to the Healthcare Safety Investigation Branch (HSIB) for investigation under the guidance for referring certain events.

The National Reporting and Learning System (NRLS) for incidents reported between September 2022 to September 2023 showed multiple examples of incidents which had been correctly graded in accordance with NRLS definitions. The service had started to review incidents using the new Patient Safety Incident Response Framework (PSIRF) which has replaced NRLS.

Services for children and young people

The service had no never events on any wards.

Staff understood the duty of candour. They were open and transparent, and gave children, young people, and their families a full explanation if and when things went wrong.

Some staff told us they did not always receive feedback from investigation of incidents.

Managers shared themes and trends of incidents, and lessons learned with staff in various formats such as using emails, messaging services, governance boards, safeguarding bulletin, and the monthly risk newsletter.

Managers shared examples when changes had been made as a result of lessons learned from safety incidents.

- The outpatient manager reported immediate improvements after meeting with the phlebotomy service to improve the process of blood sample collections following a trend of incidents where blood samples were lost.
- The children's ward had introduced a new process of staff wearing red tabards when dispensing medications in response to feedback from incidents. We observed this in practice during inspection.
- The practice nurse educator shared positive examples of how they improved their teaching methods by learning from feedback from internationally recruited staff.

The monthly risk newsletter provided examples of medicine lessons learned for example reminders to staff that the electronic record system defaults dose units automatically to grams rather than milligrams.

Women and their families were involved in these investigations.

Is the service effective?

Good 

Our rating of effective stayed the same. We rated it as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidenced-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of children and young people subject to the Mental Health Act 1983.

Staff had access to and followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance.

All policies and care pathway guidance were all clear and comprehensive. They were within review date and in line with best practice and national guidelines.

- National Institute for Health and Care Excellence (NICE) guidance
- Royal College of Nursing (RCN)
- Paediatric Intensive Care Society (PICS)

- British Association of Perinatal Medicine (BAPM)
- General Medical Council (GMC).

The advanced neonatal practitioners (ANNP) provided a lot of input I the development of trust guidelines and protocols.

The trust's own self-assessment against the Facing the future standards 2015 corroborated the evidence found on inspection. The service had rated themselves as compliant for 9/10 national standards and non-compliant for one standard which was for the UK Working Time Regulations and European Working Time Directive. The service only had 7 x speciality training year 3 doctors and one speciality doctor which did not meet the standard of 10 general paediatric whole time equivalent posts. However, the service had mitigated this with the addition of 4 advanced paediatric nurse practitioner (APNP) and 2 advanced neonatal nurse practitioners (ANNP). This was supported by staff rotas which showed these staff were deployed for appropriate shifts.

The service was compliant against the standards for;

- transitional care pathway
- BAPM
- maternity clinical negligence scheme for Trusts (CNST)
- Avoiding Term Admissions in Neonates 2023 (ATAIN)

There was a poster displayed on the neonatal unit which showed in August 2023 staff achieved 100% compliance with high impact interventions to ensure that the appropriate techniques and standards were used during clinical procedures.

Staff protected the rights of children and young people subject to the Mental Health Act and followed the Code of Practice. Staff understood the relevant consent and decision making requirements of legislation and guidance, including the Mental Capacity Act 2005 and the Children Acts 1989 and 2004.

At handover meetings, staff routinely referred to the psychological and emotional needs of babies, children, young people, and their families.

Nutrition and hydration

Staff made sure children, young people and their families had enough to eat and drink. However, the menu did not include options for any specialist dietary requirements.

The results of the 2020 NHS children and young people's patient experience survey showed that the service scored better than the national average for patients liking the hospital food.

We spoke with one parent who described there was a good choice of food available from the adult menu. Parents / carers had access to a kitchen to make their own drinks. However, the children's menu did not include options for anyone with specialist dietary requirements or food intolerances.

Staff fully and accurately completed children and young people's fluid and nutrition charts where needed. We reviewed patient's records which confirmed these had been appropriately completed.

Services for children and young people

Specialist support from staff such as dietitians and speech and language therapists were available for children and young people who needed it.

The service had access to an infant feeding team and lactation consultant who were focussed on helping with and promoting infant feeding.

The children's menu did not show options for anyone with specialist dietary requirements, food intolerances such as dairy or gluten or for vegans or vegetarians. There were no options for anyone who had social, religious, or cultural needs. In addition, there were no nutritional healthy options available. However, there was a separate Halal menu.

Staff said they always checked for food allergies at the time of food ordering, but they were not clear on what options were available. They were aware that children and young people did not understand the foods available from the adult's menu.

Pain relief

Staff assessed and monitored children and young people regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using a pain assessment tool.

Staff used a 4 scale pain assessment tool to assess babies and children's level of pain. This was an adapted tool from 3 different pain assessments.

- face, legs, activity, cry, and console-ability (FLACC) scale for children between the ages of 2 months and 7 years or individuals that are unable to communicate their pain
- Wong-Baker scale showed faces as a scale to measure pain
- numerical pain ladder showed mild, moderate, or severe as a scale to measure pain (or asking for a pain score out of 10.

Patient records which confirmed staff used this assessment appropriately.

Babies, children, and young people did not look in discomfort with pain.

Staff prescribed, administered, and recorded pain relief accurately. We saw nurses wearing red tabards when dispensing medication.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for children and young people. The neonatal service had been accredited under North West neonatal operational delivery network (NWNODN) family integrated (Fi) care unit.

The service participated in relevant national clinical audits such as;

- avoiding term admissions in neonates (ATAIN)
- national neonatal audit programme (NNAP)
- national paediatric diabetes audit (NPDA)

Services for children and young people

Outcomes for children and young people were positive, consistent, and met expectations, such as national standards. Managers and staff used the results to improve children and young people's outcomes.

Avoiding term admissions in neonates (ATAIN) outcomes

The service demonstrated they achieved low numbers of avoidable or inappropriate admissions to the neonatal unit. There were clear transitional care pathway guidelines and criteria for admissions to the neonatal and transitional care units for postnatal care.

Babies who were born at or after 37 weeks, who required additional care, could be cared for on a transitional care unit instead of on the neonatal unit. For example, babies who needed support with nasogastric tube feeding or babies who were well enough to be discharged from the neonatal unit. This meant women, birthing partners could stay on the transitional care unit at the same time, share the care and treatment and reduce the need, and harm, of separation.

All staff were proactive in creating an environment to encourage the normal bonding process between women, birthing partners, and babies and understood the importance of this in terms of maternal mental health and infant feeding.

Babies who required more complex care and observations would be cared for on the neonatal unit. For example, babies who needed support for managing seizures or respiratory support, or babies who were jaundice, hypoglycaemic or had suspected sepsis.

The service shared improvement plans to reduce the number of these babies being admitted to the neonatal unit. For example, they planned audits on the maternal diabetes and elective caesarean births to avoid any complications which could impact these admissions.

The service reviewed neonatal unit full term admissions in line with CNST. There were monthly meetings with neonatal and maternity staff and presentations quarterly to the board.

National neonatal audit programme (NNAP) outcomes

The National Neonatal Audit Project (NNAP) audit 2022 outcomes were mostly positive for this service and the performance was better when compared against similar local level 2 local neonatal units. For example, babies weighing less than 1501g underwent their first retinopathy of prematurity (ROP) screening, and eligible babies who had received non-invasive breathing support during the first week of life.

Paediatric sepsis outcomes

The service achieved positive outcomes for treating children with suspected febrile neutropenic sepsis with intravenous antibiotics within 60 minutes and received a review by a senior clinician. This was in line with National Institute for Health and Care Excellence (NICE) guidelines.

Young children admitted to adult wards

The service achieved positive outcomes for a recent audit completed in October 2022 for the standards of care for young people admitted to an adult clinical area. For example, staff appropriately recorded information, made reasonable adjustments and ensured safe discharges.

Services for children and young people

National paediatric diabetes audit (NPDA) outcomes

The service had significantly improved the outcomes for young people aged 16-19 with type 1 diabetes since 2013/2014. This was from increased support from staffing, MDT working, networking, and QI methodologies.

The neonatal service was the first to be accredited by the North West neonatal operational delivery network (NWNODN) family integrated (Fi) care level 1 accreditation scheme in 2022. This meant the unit was recognised as a family integrated care model to support and provide education for women, and birthing people, to be integral participants in their baby's care. The neonatal service was planning to gain level 2 accreditation for family integrated (Fi) care.

The neonatal service had previously achieved level 3 accreditation for being a baby friendly unit by UNICEF in 2010, 2014 and 2017. The accreditation typically lasts for two years and had since lapsed. The service had met stage 1 of the standards required for this accreditation and were highly commended for the quality of the information submitted and that neonatal standards had been embedded into policies and processes. They were working towards achieving level 2 and 3.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. We reviewed the schedule for all national and local audits for the next 12 months.

The service had a paediatric mortality lead, and there were no exceptional trends in stillbirth or neonatal death rates. The neonatal mortality rates for January to March 2023 was zero and from April to June 2023 it was 1 which equated to a rate of 2.19 for every 1000 reported deaths. However, this was to be reported as a neonatal death within maternity core service.

The service was fully compliant with the essential minimum national perinatal mortality review tool (PMRT) standards. This was a tool designed to support objective, robust and standardised reviews of deaths of babies up to 28 days post birth and ensure local and national learning to improve care and prevent future deaths. The trust did not provide evidence of national comparisons with neonatal mortality rates.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

The service had a practice nurse developer who was proactive and supported the learning and development needs of staff. They booked staff into the bespoke paediatric and neonatal mandatory training sessions. They arranged additional study days or modules for staff to receive hands on practical training.

Staff felt they were offered multiple learning opportunities and spoke highly of the support they received in terms of training and progression.

The practice nurse developer kept up to date with recent changes to guidance and updates for clinical skills. They regularly met with, and received support from, other divisional practice nurse developers.

Staff were experienced, qualified, and had the right skills and knowledge to meet the needs of children, young people, and their families.

Services for children and young people

Managers told us that there was always a member of nursing staff on duty day and night with advanced paediatric life support (APLS) competencies on the children's ward and neonatal unit. All band 6 staff and above had received this training.

Managers gave all new staff a full trust and local induction tailored to their role before they started work. The local induction included a bereavement training session and a session on child exploitation. There were plans to incorporate maternity related modules into the paediatric mandatory training.

The trust offered comprehensive preceptorship programmes providing support and guidance to newly registered practitioners. All new staff were allocated a mentor who supported them as a buddy and provided them with shadowing opportunities.

Neonatal staff completed a local induction which covered competencies such as recording clinical observations, taking blood samples, nasal/oral gastric feeding and using equipment competencies. They also completed a North West neonatal network six month induction course within the first year of commencing on the neonatal unit. The percentage of neonatal staff who had completed the rolling programme of qualified in speciality (QIS) training was 81%. This was a standard level of knowledge and skills for nurses within neonatal care. This meant they were trained to deliver the care for neonates who required intensive and high dependency care. This was better than the minimum requirement of 70% recommended by the Department of Health (DoH).

Staff had opportunities to complete training such as speciality or educational degrees.

Junior medical staff and medical students reported a responsive mentoring system, and said the teaching was good and they felt well supported.

Managers supported staff to develop through regular, constructive clinical supervision of their work. Most of the staff we spoke with had received their appraisal within the last 12 months and this was confirmed on the performance dashboard. Staff reported appraisals were effective and supportive.

Managers worked with the practice nurse developer to identify staff training needs and specialist training for their role. Staff had the opportunity to discuss training needs with their line manager. They were given appropriate time and opportunities to support and develop their skills and knowledge.

There were plans for a bespoke training room suitable for clinical skills training needs for the new women's and children's building.

Staff felt they had the skills they needed to do their job and spoke highly of the specialist training they had received. Neonatal staff reported the advanced neonatal practitioners (ANNP) to be a really valuable resource.

Managers provided examples of when they had shadowed other managers and had attended developmental training.

The ANNP's and community team had been encouraged by their managers to undertake advanced skills courses such as medical prescribing.

Other staff had been encouraged to complete a wide range of courses such as;

- advanced neonatal nurse practitioner (ANNP)

- professional nurse advocate training
- post graduate certificate
- High dependency unit (HDU) training

Neonatal nurses had received funding to attend the national neonatal conference.

The service provided simulation training scenarios to staff which mirrored real life situations. Managers were able to use results of these for future improvements.

Managers identified poor staff performance promptly and supported staff to improve. Staff underwent a full probation to demonstrate their competencies.

Multidisciplinary working

Doctors, nurses, and other healthcare professionals were committed to working collaboratively. They found innovative and efficient ways to deliver joined-up care to benefit babies, children, young people, and their families. They supported each other to provide good care.

Staff worked across healthcare disciplines and with other agencies when required to care for babies, children, young people, and their families. For example, there was a coordinated and planned approach to births, admissions, transfers, and discharges. The service offered combined outpatient clinics and supported transitions to other services.

There were excellent examples of communication between teams and staff worked well together. Staff spoke positively of excellent multidisciplinary (MDT) team working, effective communication and peer support within the service. They offered a holistic approach and delivered person centred care within a family integrated care model. All treatment was based on personal needs and circumstances.

There were positive examples of MDT working;

- hospital at home team to prevent unnecessary admissions
- community teams for effective discharges
- maternity services for planned caesarean sections for known neonatal risks
- Connect North West (CNW) transport service to transfers
- neighbouring level 2 and 3 units within the network and used video conference calls for seamless transfers
- local safeguarding and social care teams

The service held regular and effective multidisciplinary meetings to discuss children and young people and improve their care. There were daily multidisciplinary meetings across the wards/units which were well attended by all relevant staff.

All staff we spoke with said they felt part of a multidisciplinary team where everyone was encouraged, and felt confident, to make a contribution or appropriately challenge clinical decisions.

Services for children and young people

Staff referred children and young people for mental health assessments when they showed signs of mental ill health, depression. The service provided psychology support care to patients as part of the children's eating disorders service (CHEDS) and child and adolescent mental health services (CAMHS).

Seven-day services

Key services were available seven days a week to support timely patient care.

The children's ward and neonatal unit operated seven days a week 365 days a year. Consultants led daily ward rounds on all wards, including weekends.

There was always consultant on call who was available to provide support, advice, and guidance.

Most services including mental health services, and diagnostic testing was available 24 hours a day, seven days a week.

The play specialist team worked Monday to Saturday as they helped cover the Saturday phlebotomy clinics. They were currently trialling full weekend cover.

Health promotion

Staff gave children, young people and their families practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards/units.

On each area we visited there were a variety of patient information leaflets and booklets available on a range of physical health conditions, discharge information and supportive local and national charities. There were digital displays with QR codes in all areas.

On the children's ward there were child friendly posters and we found one child-friendly leaflet.

The trust website displayed a wide range of relevant information promoting healthy lifestyles and support. This included "advice for parents after a child's first seizure" and "children who have sustained a head injury." There were online links to different organisations and charities to seek further advice.

The website had a dedicated section for breastfeeding with information, videos and step by step guides on different breast and bottle feeding techniques. We also saw leaflets for local breastfeeding charities.

Staff assessed each child and young person's health when admitted and were proactive in identifying those who need extra support including family members. The service promoted ways to encourage bonding between mother and baby with initiatives such as infant massage.

The trust's web team had collaborated with the diabetes team to produce a webpage specifically aimed young children with diabetes to provide information for making healthier lifestyle choices.

The service had implemented the "infant crying is normal" (ICON) and "infant safe sleep program" within the division. These were educated programs aimed at reducing the incidents of babies presenting with non-accidental head injuries and infant head trauma.

Services for children and young people

Consent and Mental Capacity Act

Staff supported children, young people, and their families to make informed decisions about their care and treatment. They knew how to support children, young people and their families who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff understood how and when to assess whether a child or young person had the capacity to make decisions about their care. They made sure children, young people and their families consented to treatment based on all the information available in line with legislation and guidance. Families we spoke with of babies, children and young people consented to treatment based on all the information available and felt fully informed.

When children, young people or their families could not give consent, staff made decisions in their best interest, taking into account their wishes, culture, and traditions.

Staff understood Gillick Competence and Fraser Guidelines and gave examples of how these would be applied in practice. Staff explained the consent process and actively encouraged young people to be involved in decisions about their care. Gillick competency helps staff assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

Staff clearly recorded consent in the children and young people's records.

Staff received and kept up to date with training in the Mental Capacity Act (MCA) and understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act and Mental Capacity Act 2005.

The safeguarding and complex care team provided bespoke staff training on MCA, and it was also included in the new “think family level 3 training”.

The safeguarding and complex care team also supported the staff induction with delivering training on dementia. The liaison psychiatry team also delivered an awareness session to new staff.

In June 2023 the trust introduced a new learning disability and autism eLearning training module onto the mandatory training.

The service understood the statutory responsibility under Section 11 of the Children Act (1989) and 2004 to safeguard and promote the welfare of all children. They knew who to contact for advice and could refer to the safeguarding and complex care team via the electronic system.

Is the service caring?

Good →←

Our rating of caring stayed the same. We rated it as good.

Services for children and young people

Compassionate care

The service had a strong, visible, person-centred culture. Staff were highly motivated and passionate to treat babies, children, young people and their families with exceptional compassion and kindness. Staff respected their privacy and dignity and took account of their individual needs.

Staff were discreet and responsive when caring for babies, children, young people, and their families. We observed staff taking the time to interact with them in a respectful and considerate way. They were welcoming, introduced themselves and demonstrated compassionate care.

Staff told us they felt honoured to deliver care.

There was excellent personalised care delivered by staff to promote privacy. For example, staff closed the curtains around cot and bed areas to enable conversations with parents / carers so that they remained confidential and private.

Staff completed and met the trust target for equality and diversity mandatory training which covered equality, diversity, and human rights. They followed policy to keep patient care confidential.

There were positive results from the 2020 NHS children and young people's patient experience survey as the service scored better than the national average for parents/ carers able to stay on the wards with their children aged 0 to 11 years.

Children, young people, and their families said staff treated them well and with kindness. Family members of patients were very complimentary with the care they had received from staff. One parent said that "staff were kind, caring and listened to them and checked on their own wellbeing".

There was positive service feedback on social media platforms, for example, the "whole experience had been brilliant".

Staff understood and respected individual needs, for example they displayed a non-judgmental attitude when undertaking infant feeding assessments and took time to understand the challenges for women, and birthing partners, and were able to offer advice accordingly.

Emotional support

Staff provided exceptional dedicated and personalised emotional support and advice to children, young people, and their families when they needed it to help to minimise their distress. They understood personal, cultural, and religious needs.

On all areas visited there were positive examples of emotional care. Staff were conscious of the needs of babies, children and young people and their families especially if the patients had been an inpatient for a significant length of time. We saw multiple thank you cards from families of babies, children and young people who had used the service.

Staff were proud to tell us about the new initiative on the neonatal unit called "V-Create" which allowed parents/ carers with a baby in a neonatal unit to view videos and photographs of their child through a virtual platform. Staff would also share clinical updates, and messages which could be translated in all languages.

Services for children and young people

The service provided appropriate emotional support to families following a bereavement. On the neonatal unit there was a designated bereavement suite available in the event of a baby passing away to allow family members to spend time alone with their baby. This consisted of a bedroom and separate family lounge area. There was also a separate exit from the premises for families who had suffered a bereavement.

Staff who worked within the bereavement service provided a full range of services to support families. For example, they could;

- facilitate transfers of patients to a local hospice
- arrange bereavement counselling
- provide palliative support for patients who were at end of life
- visit families in their own homes
- arrange for the chaplain to visit to provide spiritual, pastoral, and emotional support.

The chaplaincy team were available at all times and regularly visited the neonatal unit and the children's ward. They could access the hospital computer system to identify patients who were at end of life and would also receive phone referrals.

The spiritual care centre was always open and welcomed people from all faiths, and no faiths. There were various ways which prayers or messages could be dedicated to loved ones. There was a book of remembrance which listed names of babies who had died and a display board where personal messages could be hand written to patients. There were spiritual prayer leaflets available to take away which offered words of comfort and blessings. We also saw a leaflet advertising a local cathedral service for bereaved families of babies who had died.

Staff supported children, young people and their families who became distressed in an open environment and helped them maintain their privacy and dignity. Throughout the services there were multiple rooms which were used as quiet rooms or for private and sensitive conversations.

Staff understood the emotional and social impact that a child or young person's care, treatment or condition had on their, and their relatives, wellbeing. They offered continuity of care, as best as possible, from the same member of staff.

Senior leaders provided multiple examples where staff went above and beyond to provide individualised emotional support. For example, staff had helped families celebrate patients being cancer free with a "bell ring" and staff provided care to women, and birthing people, who had fostered babies.

Senior leaders told us play therapists were a "hidden gem" as they provided support to children and young people who were outpatients or inpatients, or visiting family members and would accompany them to theatres.

Understanding and involvement of patients and those close to them

Staff supported and involved children, young people, and their families to understand their condition and make decisions about their care and treatment. They ensured a family centred approach.

The service provided a wide range of information on the website and within welcome booklets on topics such as infant feeding and maternal bonding.

Services for children and young people

The neonatal unit booklet contained information on developmental care, understanding baby's cues and monitoring. It included a diary to document daily achievements and space for pictures and handprints.

Women, and birthing partners, were encouraged to participate in ward rounds to enable them to be fully involved in their baby's care.

Staff talked with children, young people, and their families in a way they could understand. We spoke with a child and their parent who confirmed they felt involved in every step of their care and reported that the information given by staff was comprehensive and age appropriate.

The neonatal service had access to a training document called Fi-care passport. This was commenced when babies had been born and was shared, and used, within the region. This helped women, and birthing partners, to gain experience, complete practical skills, and gain confidence with caring for their own baby on the unit. One parent reported that "everyone was clear in explaining" aspects of neonatal care for their baby who said they had the opportunity to shadow tasks such as changing nappies, syringe feeding and taking temperatures.

Staff supported children and young people to make informed and advanced decisions about their care. The 2020 NHS children and young people's patient experience survey showed the service scored better than the national average for; patients being involved in decisions and understanding information before an operation or procedure and parents / carers knowing what was going to happen next with their child's care when they left hospital.

Play therapists supported children and young people before surgical procedures and ensured the information provided was age appropriate and checked with them that they understood what was happening.

Neonatal unit positive feedback included;

- "Thank every single one of you who helped, supported and showed not just me but my whole family such wonderful professionalism and compassion"
- "My breastfeeding journey is so much more supported"
- "You really are angels in nurses uniform and from the bottom of my heart a thousand thank you's will never be enough".

Lactation team positive feedback included "it has been hugely emotional for me that the choice of how to feed my baby had had to be taken away from me and I really cannot explain how thankful I am for your support and understanding".

In June 2023 the service had recently introduced the neonatal community outreach team (NCOT) to promote care in the community. This was a pilot scheme which delivered personalised care and facilitated early discharge. Positive feedback for this service included;

- "Helped us through such an anxious time",
- "Taught me what I need to know",
- "Supporting us through a really tough time"
- "it's so important to have time at home and not back and forth to the hospital to scary appointments and the anxiety around this is taken away with the home visits"

Services for children and young people

Is the service responsive?

Requires Improvement 

Our rating of responsive went down. We rated it as requires improvement.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the changing needs of the children and young people who used the service. The service worked with others in the wider system and local organisations to plan care.

Paediatric clinics were led by a multidisciplinary team which included consultants and doctors, specialist nurses, advanced neonatal nurse practitioners (ANNP), advanced paediatric nurse practitioners (APNP), dietitians and psychologists.

Some clinics were tailored and specialised to meet multiple and complex needs. For example, there were combined appointments with a consultant visiting from a nearby hospital for medical, surgical, and cardiac conditions. On some occasions the visiting consultant would also complete surgery at this trust. This meant families did not have to travel to two different hospital locations for appointments if their child had been referred to a neighbouring hospital for surgical treatment. It also provided continuity of care at the same familiar hospital location and environment.

There were regular multiagency led community clinics for children or young people who were referred for attention deficit hyperactivity disorder (ADHD) or autism spectrum disorder (ASD). These were attended by representatives from schools, child, and adolescent mental health services (CAHMS) and other relevant services.

We heard about a pilot scheme to reduce the outpatient waiting lists for paediatric blood tests. In October 2022 the outpatient service started offering Saturday appointments and this had been so successful it was made permanent. The service now completes approximately 500 appointments a month. Staff were very experienced with distraction techniques whilst taking blood samples which meant families avoided paying any parking charges. This also meant families who worked during the week could access the service for their child.

The service offered a specialist service for children and young people with eating disorders (CHEDS). This included outpatient appointments and inpatient admissions on the children's ward for treatment.

Community nurses had set up additional community clinics for conditions such as respiratory and epilepsy. They could offer appointments at locations such as at the child's nursery, school or at home.

The service planned care for babies especially those who had complex and long-term conditions and also those whose families lived a distance away from the hospital. For example, allied health professionals would visit families on the ward before a child was discharged home to avoid unnecessary home visits. Specialist community nurses, health visitors and neonatal community outreach team (NCOT) service would visit families at home to offer personalised treatments and avoid unnecessary hospital or GP visits. The NCOT team had completed 214 home visits since July 2023 supported by allied health professionals and a lactation consultant.

The service had access to a senior well being practitioner who visited the service twice a week to provide psychological support to families, especially when children were discharged after a long admission period.

Services for children and young people

The service had a lactation consultant who offered dedicated tongue tie surgical procedures to improve the feeding outcomes for babies and infants. They regularly attended the neonatal unit to offer advice and guidance to women and birthing partners for breast, and bottle infant, feeding. There was a fridge and freezer to store breast milk and donor milk was also available. Breast pumps were available.

The service provided a neonatal transitional care service for babies who had care requirements greater than those of a normal newborn. This meant women, birthing people could support with the care of their baby on the postnatal ward and remove the need for admission to the neonatal unit. This also promoted family centred care and baby bonding time. Transitional care staff provided examples of how they gave personalised treatment to both mother and baby and how they linked in with community care and infant feeding teams.

Staff could access emergency mental health support 24 hours a day 7 days a week for children and young people with mental health problems and learning disabilities. We saw examples of referrals made and advice sought when required.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. There were separate adolescent wards for young males and females.

Facilities and premises were appropriate for the services being delivered. All paediatric services were delivered within the same building.

Meeting people's individual needs

The service was inclusive and took account of babies, children, young people and their families individual needs and preferences. Staff made reasonable adjustments to help them access services and coordinated care with other services and providers.

Staff provided individualised care to children and young people and their families to meet specific individual needs. This matched the experiences of the children, young people, and their families we spoke with who said they had been given personalised care and treatment.

At the last inspection in 2016 the neonatal unit lacked space and privacy for mothers who wished to breastfeed and parents who wanted to spend time with their baby. At this inspection there were multiple rooms available within all areas to facilitate these requirements such as infant feeding and baby changing.

At the last inspection in 2016 there were no facilities for parents to make hot drinks on the children's ward. At this inspection they had access to the kitchen and facilities to make hot drinks. Staff would provide them with snacks such as sandwiches, crisps or fruit and also a hot meal.

There was a weekly support group meeting on the neonatal unit called "Dinky Divas". Staff invited 5 women, birthing partners, or carers to this meeting whose baby/ babies had recently been cared for on the neonatal unit. This was led by a multidisciplinary team of specialised health professionals who offered individualised wellbeing support and integrated care such as supporting mental health, physiotherapy, psychology, physiotherapy, and breast feeding needs. They also encouraged infant bonding through play and activities.

Staff made sure children and young people living with mental health problems, learning disabilities and long term conditions received the necessary care to meet all their needs.

Services for children and young people

Children and young people, or their parent / carers could record their personalised care needs within a "health passport". This was especially important if they had complex health care needs or learning disabilities. Staff used this information to ensure that reasonable adjustments could be offered along with the continuity of care.

The service had access to the safeguarding and complex care service team (SACCT) who ensured there was a holistic approach to offer support to children, young children, and their families. They received a daily inpatient list of children or young people who had learning disabilities.

The SACCT had created a flowchart to provide staff with support and guidance around on the fundamental standards of care. They made sure staff activated a flag on the electronic patient record and checked reasonable adjustments were in place.

The service had a clinical lead on special educational needs provisions. They were supported by a consultant when they had to complete educational reports.

Wards were innovatively designed and highly personalised to meet the needs of children, young people, and their families.

The service ensured that it was possible for women, and birthing partners, to be with their child at all times and had suitable facilities to allow overnight stays. This included the Christopher Wing which was a residential facility commonly used by families who lived out of the area. It was situated next to the children's ward and had two bedrooms, kitchen, sitting room and shower room.

The new neonatal unit had been designed so that next to each cot, whether this be on the unit or in a room, there was a fold down bed and also a chair. This meant women, and birthing partners had their own area to rest and sleep next to their child during the night. In addition, there were ensuite rooms available on the unit.

The high dependency neonatal cots were designed on the ward so that the parents / carers and staff provided and delivered care on either side of the cot.

The neonatal service set a quiet time every day between midday and 2pm to help reduce stress to babies. This meant everyone on the unit had to speak quietly and the lights were dimmed, and blinds were lowered. During this period of time there was limited handling of babies except in emergencies.

All environments within the service were child friendly. There were multiple areas where children and young people, could play and had access to games, toys and activities appropriate to their age. There were large outside areas, a sensory room and an adolescent lounge which had games consoles and televisions. At all times the neonatal cots had covers over them to protect babies from the lights on the unit.

Managers made sure staff, children, young people, and their families could get help from interpreters or signers when needed. Staff gave multiple examples when they had accessed the interpreting services when children, young people or their families did not speak English as their first language.

Families of babies, children and young people could access information leaflets in multiple languages, larger print, braille, on compact disc via patient advice and liaison service (PALS).

Services for children and young people

Staff used transition plans to support young people moving on to adult services. They made sure this care and treatment was coordinated to help with this transition. For example, the service offered a diabetes clinic for young people aged between 16 and 19 years of age which was led by both paediatric and adult diabetic specialist staff. This helped with the continuity of care with similar staff and ensured a seamless transition into the adult service.

Access and flow

Babies, children, and young people could access urgent services when needed. Waiting times from referral to treatment and arrangements to admit, treat and discharge children and young people were in line with national standards. Systems had not always been effective to support the outpatient follow up process and there were delays with sending medical letters.

Neonatal unit

The unit was referred to by the North West neonatal operational delivery network (NWNODN) as a local neonatal unit (LNU). The unit had capacity for 12 special care cots and 2 high dependency cots. There was flex to open up to 16 cots. The trust's board papers continued to state there was an ongoing review of neonatal critical care which would determine the future status of the neonatal unit. It was not clear whether this was an ongoing local review or referred to the national neonatal critical care review which completed in 2019. We asked the trust to provide evidence of how the service had implemented the recommendations of the national review. The trust provided limited evidence to support that the national recommendations had been implemented by the time of our inspection.

For activity levels for 2021/2022 the unit was only compliant as a level 1 special care unit (SCU) in accordance with British Association of Perinatal Medicine (BAPM) Optimal Arrangements for Neonatal Intensive Care Units in the UK, 2021 and Neonatal Critical Care Transformation Review (NCCTR) 2019.

The trust told us the unit provided care and support to neonatal babies, who had a gestational age of 32 weeks and above, and who may require intensive care or high dependency care. There was a comprehensive admission criteria and most babies stayed for at least 24 hours on the unit. The monthly occupancy rate for neonatal intensive care cots was 19% and was 53% for high dependency care cots and 47% for special and normal care cots.

Between June and September 2023, the neonatal unit admitted 2% of all term babies born between 37 and 42 weeks. This was better than the national threshold ambition of up to 5%. For 23% of these babies, it was their first admission to the unit. The service was working collaboratively with the maternity teams, NWNODN and locality Local Maternity Systems (LMS) to continue to reduce these numbers.

The unit met the compliance for a level 1 SCU for the number of respiratory care days (RCD's). It provided 349 RCD's annually for babies who required invasive ventilation support (via an endotracheal tube or tracheostomy), or non-invasive respiratory support (via continuous positive airway pressure or high-flow nasal cannulae). To meet the compliance for a level 2 LNU the unit needed to deliver at least 365 respiratory care days annually.

The unit met the compliance for a level 1 SCU for the number of combined intensive and high dependency care days. Intensive care days, high dependency days and special care days were defined as described in the BAPM Categories of Care 2011. It provided 457 care days. To meet the compliance for a level 2 LNU the unit needed to deliver at least 500 combined days which was considered the minimum requirement to maintain expertise in line with neonatal critical care transformation review (NCCTR).

Services for children and young people

Staff supported children, young people, and their families when they were referred or transferred between services. They could arrange urgent transfers for babies who required longer intensive care treatment to level 2 local neonatal unit or level 3 neonatal intensive care unit. The trust confirmed post inspection that any intensive care provided was always discussed with the tertiary neonatal unit as part of collaborative working.

The maternity service would arrange urgent transfers for neonates born under the age of 32 weeks to level 2 LNU or level 3 neonatal intensive care unit.

Neonatal babies would be transferred with a specialised transport company who were staffed by a team of experienced medical and nursing professionals and paramedics. The company had specialist transport incubators which were equipped with all the necessary equipment to provide the appropriate level of care and safety for the transfer.

They would also transport neonates / babies to other units for tests or treatments which were not available at this trust. For example, babies born with a heart or surgical condition would be transferred for an urgent review at surgical or cardiac centres at neighbouring hospital trusts. Another example would be if babies needed to be transferred closer to their own home location.

The service completed regular audits for the transfer of neonates and staff completed a safety incident report for each transfer. From September 2022 and September 2023 there were 23 transfers made out of the neonatal unit.

Children's ward

Managers and staff worked to make sure children and young people did not stay longer than they needed to. There was a multidisciplinary approach for planning discharges as early as possible. The service worked well with the community nursing teams to complete safe discharges especially for those who had complex mental health and social care needs.

The service demonstrated a number of effective initiatives to help reduce the pressures of access and flow within the hospital and neighbouring services. For example, the hospital at home team provided care and treatment for children and young people within their own homes to avoid unnecessary admissions into urgent and emergency care, the children's assessment unit or the ward.

Managers monitored waiting times. Children, young people, and their families could access most services when needed and received treatment within agreed timeframes and national targets.

The divisional outpatient performance dashboard for the last 12 months showed 98% babies, children, and young people received treatment within 18 weeks. This met the referral to treatment national standard of 92%.

The performance report updated in October 2023 stated the service had over performed on new outpatient activity compared to the national standards mandated by NHS England. In September 2023 the service had 628 paediatric new referrals and 850 outpatient attendances. The average wait times for an initial paediatric appointment was 9 weeks and for a community paediatric appointment this was 25 weeks.

In terms of elective recovery, the service was over performing against the national target of 65 weeks. Therefore, they set their own internal target for all babies, children, and young people to receive treatment within 40 weeks. The performance reports showed a trajectory to meet this 40 week target by the end of March 2024.

Services for children and young people

From September 2022 to September 2023 there were 348 elective and 2 emergency day case admissions to the children ward. There were 83 elective and 5592 emergency non-day case admissions to the children's ward.

The service had a significant number of patients waiting for follow up appointments. This was either for a scheduled review or a medical review following a recent admission and / or treatment. The electronic patient record system had not always been effective to support with this process. The trust had not achieved their target for this for 2023/2024.

This had been identified as a theme from the inspection, complaints received by local Healthwatch, and incidents reported to the National Reporting and Learning System (NRLS) between September 2022 to September 2023.

There were 5 incidents reported when the service failed to send follow up appointments for babies.

There were 16 incidents relating to when the service was unable to provide a paediatric diabetic specialist outpatient appointments. This meant families of children with type 1 diabetes did not receive appropriate training or further support.

Following the inspection, the service confirmed there had been a 9 month gap from September 2022 to June 2023 for dietician specialist support and told us nurses had been covering this role. At the time of the inspection the service had two funded dieticians who worked 0.4 whole time equivalent (WTE) and a 0.6 WTE.

However, as part of the factual accuracy process the trust confirmed they had now achieved the reduction in follow ups in line with national guidance and performance was above the 5% target set nationally. The service confirmed the only back log for follow up appointments was within the allergy service.

Following the inspection, the trust confirmed they had identified significant data quality issues which had occurred during the implementation of the electronic patient record system in 2022. This meant that performance data from this date, including referral to treatment information had not always been accurate.

The trust's data validation team had completed clinical validation and harm reviews for all babies, children, and young people who were affected. At the time of the inspection 100% of paediatric patients and 49% of community paediatric patients had been clinically validated and all been sent appointments. Urgent patients had been prioritised and offered appointments.

Following the inspection senior leaders confirmed that all babies, children, and young people who had been affected by this had been clinically validated.

Senior leaders confirmed new processes were in place to ensure these issues did not happen again. There were plans to flex capacity to increase the number of follow up appointments. Some patients could be given several follow up appointments after the initial outpatient appointment to ensure they were reviewed at regular time intervals. Further staff training was also being implemented.

The service was able to offer telephone appointments instead of face to face appointments and in the last 12 months the service's highest month was 23% in May 2023. They completed 8% in September 2023.

There was a known fault on the electronic patient record system which meant managers had to manually check each patient's discharge letter to make sure it had been sent to the patients' GP and other health professionals.

Services for children and young people

The service did not always send medical letters in a timely manner to patients' GP and other health professionals. At the time of the inspection there were 766 hospital paediatric and 1097 community paediatric letters waiting to be transcribed / typed. This was listed on the risk register in August 2023 and graded as moderate risk. The reasons for this delay was due to secretarial staff sickness and ongoing junior doctor strikes. It was due for review in October 2023.

Babies, children, and young people who required surgery were managed under the care of the surgical specialities. The average referral to treatment wait time was 31 weeks from the date the patient was referred. The average wait for surgery was 21 weeks from the date the patient was added to the waiting list.

The Trust provided services to patients who lived in West Cheshire and had a registered Welsh GP. However, the trust was not commissioned by the Welsh health board to provide any community services for patients who had a registered Welsh GP. This included the hospital at home service. From April 2021 to March 2022 the service delivered care to 34 babies who were registered to GP within Welsh local health board (HLB).

Children, young people, and their families could access emergency services when needed but they did not receive treatment within agreed timeframes and national standards.

In September 2023, 86% of children and young people were seen in urgent and emergency care within the 4 hour standard. This did not meet the national standard of 95%. In the last 12 months the service only met the standard twice; in November 2022 and December 2022. However, the service had a separate children's assessment unit which accepted referrals from a number of ways. This included directly from GP's or community teams, outpatient's clinic appointments and from urgent and emergency care after triage and assessment. This unit was open 8am-9pm every day and after 9pm children were assessed and admitted onto the children's ward.

There were clear standard operating procedures for when paediatric patients were transferred from the emergency department to the children's ward. It included what to do in the event of any delay obtaining a bed however, there had been no incidents relating to this between September 2022 and September 2023.

Managers monitored the number of children and young people whose discharge was delayed and took action to reduce them. We heard that discharges were sometimes delayed because of difficulties in contacting medical teams to sign off the discharge and prescriptions.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received however not all staff were aware of this process. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included children, young people, and their families in the investigation of their complaint.

Children, young people, and their families could give feedback about their experiences on the service and knew how to complain or raise concerns. The services, booklets included information on how to raise concerns, provide comments or make suggestions for any improvements relating to their experience in a range of accessible ways.

There was a child friendly paper survey on the children's ward which asked them to rate their experience from very good to very poor. However not all staff were aware of this process to capture patient feedback using the trust's friends and family survey and did not have access to paper copies.

Services for children and young people

The service clearly displayed leaflets for the patient advice and liaison service (PALS) information about how to raise a concern or make a complaint.

Staff understood the policy on listening, and responding to concerns and complaints and knew how to handle them. It guided staff on how to respond if a child or young person made a verbal complaint and whether if the young person was competent staff would also discuss the complaint and outcome with their family.

Managers investigated complaints and concerns thoroughly and made appropriate recommended actions.

The service provided us with the number of complaints, concerns and compliments raised within the paediatrics, and any specific identified locations, for the last 12 months (September 2022 to September 2023).

- There were 3 paediatric concerns relating to the children's ward, 1 for the assessment unit and 1 for paediatric outpatients clinic.
- There were 2 paediatric complaints relating to the children's ward and 16 relating to the community service.
- There were 2 paediatric compliments relating to the children's ward and 1 for the paediatric outpatients clinic.

The service maintained effective oversight of concerns, complaints, and compliments. Senior leaders identified themes of concerns in relation to the complaints. The top three concerns across the division which included Maternity were; communication, appointments issues and delayed treatment. Most concerns had been closed within 14 working days.

Senior leaders had identified themes following the results of the 2022 national inpatient survey. These related to safety on admission, prevention of harm, learning from complaints and incidents, safe staffing and recruitment, and staff support and education. However, we were unable to identify which themes related specifically to paediatric or neonatal services.

Staff knew how to acknowledge complaints appropriately. Complaint responses included sincere apologies and provided an examples of how a specific practice and procedures would be improved to avoid the same issue from reoccurring.

The bereavement specialist nurse team provided support to families during investigations.

Managers regularly shared feedback from complaints with staff at various meetings such as the daily safety brief. Learning was shared as part of staff education within the division and also across the trust to all staff. Reflective practice offered opportunities for change within multidisciplinary teams.

The service used the learning from complaints and concerns as an opportunity for improvement to local practice and procedures.

There were many examples when staff used patient feedback to improve daily practice. For example;

- general rubbish collection times had been moved to a later time in the morning
- the phlebotomy service had created their own admission letter for blood sample testing
- the language line was used instead of relatives.

There were no reported qualifying cases made to health safety investigations branch (HSIB) or CQC since May 2023.

Services for children and young people

Is the service well-led?

Good 

Our rating of well-led stayed the same. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles. There were high levels of staff satisfaction.

The paediatric service was part of a newly formed women and children's division at the trust. There had been significant changes made in June 2023 to create a new senior leadership team and structure.

The women and children's division included the neonatal services, community and hospital paediatric services and the milk bank as well as maternity, gynaecology, and breast services.

Senior leaders told us that although recruiting to a whole new division had been challenging it meant they had a tighter governance structure and improved joint working.

The women and children's division leadership team were led by the divisional director (who had been in post since January 2023), associate medical director and director of midwifery. The new leadership structure chart was clear and comprehensive. This team directly reported to the executive team.

The director of finance was the executive lead for the division at board level.

The new leadership team had strengthened the positive culture and morale within the division. All staff we spoke with praised the leadership team especially ward managers and said they felt well supported. They reported that managers and senior leaders were visible and approachable and said they regularly visited different areas.

Senior leaders had a good knowledge of performance and understood, and recognised, the challenges of maintaining safety and quality. Quality and performance was monitored through divisional dashboards.

The recent changes in managerial roles meant some roles and responsibilities had changed, were still in their infancy and yet to be embedded within the service. We heard that staff still approached their previous manager for support due to familiarity.

Senior leaders supported staff to develop their skills and progress to more senior roles. The hospital was developing their own leaders to provide career progression and succession planning. There was 'aspiring clinical leaders' work being done to help support those who wanted to progress into leadership roles.

Vision and Strategy

The service did not have a fully developed or implemented vision and strategy at the time of our inspection. However, the service had a strategy development plan which involved staff and relevant stakeholders.

Services for children and young people

The trust had developed a vision and strategy for 2021 to 2026 called 'Five Year Strategy' with the vision of improving the lives of the community and provide excellence in healthcare, through partnership and innovation. This strategy focussed on four key areas including clinical, people, digital and value. The trust's new strategy was due to be launched shortly after our inspection. The trust values were to be safe, kind, and effective

The service was currently developing a women and children's strategy which was in its infancy and had not been translated into action in maternity services at the point of our inspection. However, the strategy development plan included feedback from staff and stakeholders at workshops to discuss strategic goals and objectives. These included purposeful leadership, positive patient, and family experience, adding value, and developing a positive team culture. The vision of the strategy was to be the hospital choice for women and children's healthcare in the North West providing the highest level of care with compassion.

The unit was referred to by the North West neonatal operational delivery network (NWNODN) as a level 2 local neonatal unit (LNU). The trust's board papers continued to state there was an ongoing review of neonatal critical care which would determine the future status of the neonatal unit. It was not clear whether this was an ongoing local review or referred to the national neonatal critical care review which completed in 2019. We asked the trust to provide evidence of how the service had implemented the recommendations of the national review. The trust provided limited evidence to support that the national recommendations had been implemented by the time of our inspection.

The trust had started construction of a new women and children's building which would be completed in 2025. Staff were reassured that it would mirror the newly built neonatal unit and staff had been involved in the planning. The plans included a full travel plan to the local planning authority to encourage the use of alternative forms of transport for staff, patients, and visitors to the new site.

Community nurses were hoping to expand their clinics so they could address a number of health related concerns such as managing medications, contraception, and sexual health. It was not clear how mature these plans were.

The service was going to expand their "V-Create" system to include physiotherapy and epilepsy team updates.

The service also wanted to set up nutritionist clinics within schools.

Culture

Staff felt highly respected, supported, and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. Staff at all levels were actively encouraged to speak up and raise concerns.

We looked at a range of information in relation to culture in services for children and young people. We also spoke with staff in the neonatal unit and children's ward. We found evidence of positive culture in all services.

Staff we met were friendly, welcoming, and confident. They worked together to benefit care and treatment for women, birthing people, and babies.

Staff told us the culture on the wards was highly positive and they reported good teamwork and excellent morale. They received high levels of support from their managers and colleagues.

Staff displayed a high level of resilience to continue to provide the care to meet the needs and

care of children and young people despite difficult circumstances. They spoke positively about

their roles and demonstrated pride in their work. Managers, including members of the board, regularly praised the hard work and commitment shown by staff.

All medical doctors praised the regular peer support, open access to each other and support for those who wanted to progress into leadership roles.

There was an open and honest culture in the service. Staff told us there was no barriers between clinical staff and managers and that they were encouraged to raise concerns and speak up without fear. They described reporting incidents as a 'no blame culture'.

Feedback from listening events demonstrated that staff felt "valued" and "good teamworking". Staff reported that the safety culture was good.

Staff were aware of the freedom to speak up guardians (FTSUG) across the trust and told us the freedom to speak up (FTSU) service was actively promoted. The trust had strengthened this and now had a lead executive director and non-executive director to support the guardian as well as FTSUG champions. The service planned to raise further awareness to staff and promote the various communication channels.

The website displayed a strong emphasis of care for babies, children and young people and their families.

The General Medical Council (GMC) national training survey 2023 for paediatric trainee doctors confirmed a significant increase from 2022 for the overall satisfaction with the training provided, clinical supervision and reporting systems.

The NHS staff survey results 2022 had a completion rate of 51% for the women and children's division. This included staff working within the community services. This was higher than the trust response rate of 38%. The responses were either better or similar to other areas of the organisation for all of the 9 elements. The highest scoring responses were 'we are compassionate and inclusive' and 'we each have a voice that counts'. The lowest scoring responses were 'we are always learning', 'we work flexibly' and 'morale'. However, the trust overall staff survey results were significantly lower than comparable acute community trusts.

The service was also implementing a well-being hub for staff in November 2023 which would promote key events and focus days throughout the year related to national health and wellbeing initiatives. The focus of events was physical, mental, financial wellbeing, safety, and welfare. Staff could access a wellbeing guardian (non-executive director) and a workforce wellbeing practitioner and manager.

There were leaflets and posters signposting staff to access services for counselling, physiotherapy, general advice, occupational health, spiritual care, and the well-being centre.

Governance

The service had made changes to implement effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. However, these changes were recent and were still being embedded.

The service had recognised the need to formalise the governance framework and processes to support the safe and effective delivery of care. The neonatal, community and hospital paediatric teams were now part of the women and children's division along with obstetrics, gynaecology, breast services.

The new governance structure showed clear lines of reporting.

At the time of inspection there was one vacancy for the governance lead which was being covered as an interim measure by the head of midwifery.

Leaders attended quality assurance meetings with changes to the agenda and structures. The divisional director attended weekly governance meetings including reviews for serious incidents and daily trust wide safety huddles.

Senior leaders attended monthly meetings to discuss performance and quality and safety. This included a monthly meeting for the neonatal incident review group (NIRG) and paediatric incident review group (PIRG). There was also monthly community, and paediatric and neonatal speciality meetings as well as a "think family" safeguarding steering group (SSG) meeting.

There was a clear escalation of risks for any concerns raised from these meetings up to the divisional operations and performance and governance board monthly meetings.

The divisional risk register, incidents, complaints summary and audit updates were examples of standard items at monthly clinical governance meetings for review and action planning. These were used to identify and manage known risks.

Senior leaders submitted a monthly integrated performance report to the board committees and the trust board. This highlighted and identified any safety concerns, performance, and progress on actions.

Senior leaders told us they felt well represented and listened to at board level.

Staff we spoke with understood what their individual roles and responsibilities were, what they were accountable for and to whom they were accountable. Staff told us that they were provided with information relating to learning and performance via themes of the week, safety huddles and staff meetings.

All staff were invited to share their personal experiences at the start of every governance meeting.

Management of risk, issues, and performance

Senior leaders used systems to manage performance effectively however, they did not always identify all risks or complete actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Senior leaders were aware of most risks and challenges to their service. They took immediate action with regard to the risks we raised with them at the time of the inspection. For example, they followed up the CCTV repair, ensured all doors were locked, safely stored the oxygen cylinders and medicines and other equipment. They completed an incident report for the door without a lock and the following day the door was fitted with swipe card access.

The risk of infection transmission due to poor state of repair of the environment across the trust was listed on the trust's corporate risk register. It had been categorised as moderate risk level in November 2022 and the next review date was due October 2023. A number of these concerns related to the age of the women's and children's building, and this would be mitigated with the move to the new building in 2025.

Following the inspection, the trust responded to the infection, prevention and control concerns raised on inspection. Senior managers quoted zero tolerance for the noncompliance of basic IPC principles. The IPC team had been deployed to all clinical areas to complete assurance walkabouts and challenge compliance. Managers would reinforce IPC standards within trust wide communications, team briefings, capacity meetings and safety huddles.

There were similar concerns as those found at the previous inspection in 2016 in relation to the service not completing a nutritional assessment. Senior leaders were already aware of the concerns we found in relation to the hospital food from recent PLACE inspections, incidents, and complaints. This was in relation to the poor choice of food available on the children's menu especially for those with a specialist dietary requirement or social, religious, or cultural needs. The catering team had plans to collaborate with the patient experience lead to offer an enhanced menu.

Senior leaders had good oversight of performance from a range of effective systems and processes to support safe quality care. The performance dashboard provided useful staffing information and mandatory training, and appraisal compliance. They were aware of the risks of staffing and met daily to discuss, escalate, and mitigate any staffing concerns.

Senior leaders were aware of the under establishment of registered nurses on the children's ward to meet the national guidance and recommended standards from the Royal College of Nursing (RCN). This had been listed on the risk register in August 2021 and was graded as moderate risk level. This was due to be reviewed in October 2023 and we were aware the ward had been piloting a new staffing acuity tool. We received satisfactory assurance that risks of staffing was mitigated appropriately as managers had access to additional staff to meet the demand on any service. In addition, staff did not raise any safety concerns for staffing levels.

Senior managers told us they add one extra nurse to increase their staffing levels during October 2023 and February 2024 as part of winter planning. This was because they normally saw an increase in children and young people requiring higher dependency care during this time.

The service had a successful combined paediatric and maternity recruitment day in February 2023 which had reduced the number of agency staff requirements.

There was evidence to show managers had acted appropriately to address risks presented by staffing shortfalls.

The service had a clear process for reviewing, escalating, and reporting incidents. For example, there were daily meetings to review and grade incidents and complete initial learning responses in line with the patient safety incident response framework (PSIRF) plan. Managers would escalate any emerging risks to senior divisional leaders who would undertake a senior led review meeting.

There was a weekly divisional patient safety panel meetings. Senior leaders would review all incidents, identify any themes and trends, and measure performance in line with NHS England. They would feed any recommendations and learning actions into improvement workstream groups and report appropriately.

Safety briefings were held daily on wards and provided information on topics such as safeguarding and clinical issues including implementing and monitoring care plans for high-risk patients.

Information Management

The service collected data however it was not always reliable. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were mostly submitted to external organisations as required.

The service identified significant data quality issues which had occurred during the implementation of the electronic patient record system which meant the performance data was not always accurate.

Senior leaders were able to review clinical performance against key metrics such as incidents, referral to treatment wait times and staffing information on their local dashboard. They also had access to the North West neonatal operational delivery network (NWNODN) dashboard which showed comparison data against each locality unit and region.

Families of babies and children, and young people could access information posters and the friends and family test using QR codes on their own mobile phones. However, this information was only available in English. When we shared this with senior leaders, they said they would escalate this as a high priority.

Mandatory training covered information governance and data security for staff to complete. Staff were 87% compliant which did not meet the trusts 90% compliance target.

The service was not able to submit national early arthritis audit data to external organisations. This was listed on the risk register in August 2023 and was due a review date in November 2023.

The information systems were integrated and secure.

Engagement

Senior leaders showed high levels of constructive communication and open engagement with children, young people and their families, staff, the public and local organisations to plan and manage services. The service was developed with the full participation of those who use them to help improve services for patients.

The service demonstrated that patient engagement was a high priority.

The trust's website recognised the importance of bonding, mental health and wellbeing and promoted a range of available services within the hospital and local community to encourage women, and birthing people to become partners in their child's care.

Staff proactively engaged with families of neonatal babies who were inpatients on the unit or who had been discharged home. They helped organise and lead the "Dinky Diva's" support group events such as the weekly meeting on the neonatal unit. There was a list of events which had been organised for 2023 including a Halloween walk. Staff volunteered once a month to lead a dinky diva support group walk. There was a "Dinky Divas" congratulatory certificate which was presented to the families of babies after their discharge from the unit.

Staff showed us examples of how they had designed and printed messages for baby related items such as baby grows and mugs. For example, we saw items for each season including Halloween and for celebratory occasions such as Father's Day and Mother's Day. Staff gave these to families of neonatal babies.

Services for children and young people

Staff throughout the trust could download a children's pack to share with children and young people who were inpatients or those who were visiting relatives. This contained colouring pages and activities.

The Cheshire and Merseyside neonatal network "partnership with parents agreement" (PiPA) detailed examples promises and commitments from both parent/ carer and staff. For example, staff would ensure that important "first events" such as bathing and dressing would be completed by the parent / carer. Also, that parents could ask any questions especially if they didn't understand and also provide contact details.

The service used the hub rooms on the neonatal unit for training, development, and meetings. Staff had an open door policy for family members if they needed additional support or guidance.

The trust encouraged families of babies, children, or young people to share their stories directly with staff as part of quality improvement. Examples of patient experience and stories were also shared with staff at governance meetings to implement changes and improve patient outcomes.

The service demonstrated that staff engagement was a high priority. Managers held regular team meetings to discuss feedback reviews, performance, safety, and ideas on how to improve the service. They shared information in a variety of ways such as social media and a monthly newsletter.

Staff reported feeling engaged with senior leaders and gave positive examples of when they had been listened to and their contribution respected. For example, staff had been consulted about the new women's and children's building. However not all staff who provided care to of babies, children, and young people and their families received divisional feedback, newsletters, or incident information.

There were celebrating success boards across all areas and thank you cards showing appreciation to staff.

One of the service's planned improvements was to embed the "five ways to communicate" for information to be shared to capture all staff irrespective of location or working pattern. The service had arranged drop in sessions with the senior leadership team. They had promoted mental health first aid training and offered available benefits to staff to support their wellbeing.

The service demonstrated that public engagement was a high priority especially during this difficult time. The service had collaborated and fundraised with a number of individuals, local companies, trusts, and community groups and they raised 2.4 million pounds for the newly built neonatal unit.

Learning, continuous improvement and innovation

All staff were highly committed to continually learning and improving services. They had a strong understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research and staff felt empowered to lead and deliver change.

The service was committed to improving by learning when things went well or not so well. They were involved in various research and innovation projects to develop the service.

The service promoted and coordinated the development of QI initiatives. For example, one QI project had been completed to improve the planning, multidisciplinary working and risk management of women who had caesarean sections. This was to improve the outcomes of babies being born.

Services for children and young people

Two QI projects were ongoing to improve the diabetic transitional services. One was the Royal College of Paediatrics and Child Health (RCPCH) quality improvement which started in 2020 and the other was the seamless transition project. Staff had completed a recent questionnaire for young people and had created a leaflet.

The service was taking part in a continuous improvement program for diabetes to reduce the percentage of patients diagnosed / treated with higher HbA1c compared to results in England and Wales.

Staff were working directly with NHS England on the NEW2/NEWTT assessment tool.

Staff who completed their advanced lean training as part of the leadership course continued to receive support from the continuous improvement team. One example of a project was to improve the early identification of high risk hip subluxation in children and young people with cerebral palsy. This meant in the future the service would be able to submit this data onto a national database to help monitor outcomes and improvements.

There is a strong record of sharing work locally and regionally within the network.

We heard positive examples where staff or teams could be nominated for an award.

The children's ward had an award for the employee of the month; they received a trophy, certificate and their name displayed on the staff noticeboard. Staff could use this information as part of their revalidation process.

The neonatal unit displayed a 2023 award for team spirit from the trust.

The outpatients manager has been nominated for an annual award for their phlebotomy work.

The trust had been awarded the best QI initiative on "parent focus" from the national patient safety improvement program in March 2023.

The trust had incorporated sustainability in the design for the new women and children's building with the use of ground heat pumps and solar panels to reduce energy consumption.

The hospital at home team would be using the fully electronic powered e-vehicles.

Urgent and emergency services

Inadequate ↓

Is the service safe?

Inadequate ↓

Our rating of safe went down. We rated it as inadequate.

Mandatory training

The service provided mandatory training in key skills including the highest level of life support training to all staff; however, not all staff had completed this in line with the trust target.

Staff were required to complete mandatory training modules. These were a combination of e-learning and face to face modules.

The overall compliance for mandatory training was below the trust target of 90%. Compliance was 78.4% for nurses in the emergency department (ED) and 63.6% in the urgent treatment centre (UTC). For medical staff overall compliance was 70.5% in the ED and 75.00% in the UTC. Compliance for specific courses was as follows:

- Department overall compliance for preventing radicalisation – basic prevent awareness was 93.55%, however estates and ancillary staff compliance was 66.67%.
- Preventing radicalisation – prevent awareness compliance was overall at 91.38%, however medical staff compliance was 70.84%.
- Overall compliance for fire safety was 90.6%, however, estates and ancillary were 66.67%, medical staff were 85.94% and registered nurses was 85.40%.
- Health and safety overall compliance was 94.16%, however medical staff were 75.53% and registered nurses were 84.46%.
- Moving and handling level 1 overall compliance was 95.45%.
- Moving and handling level 2 overall was 89.55%, however, additional clinical services were 84.21%, medical staff were 69.23%, registered nurses 87.83%.

There were 127 staff who had completed patient safety training. Of these, 90 were registered nurses, 22 were medical staff, one was estates and ancillary, three were administrative and clerical, 10 were additional clinical services and one was additional professional scientific and technic. The trust did not provide information to show how many staff needed to complete this training which meant compliance rates could not be assessed.

There were 145 staff who had completed deteriorating patient training. Of these 108 staff had completed level 1 as part of induction. There were 37 staff who had completed level 2. Of these, there were 22 registered nurses,13 medical staff and two additional professional scientific and technic.

Staff new to the department completed a supernumerary checklist for their initial two weeks working alongside a buddy.

Clinical staff were required to complete Oliver Magowan training on learning disabilities and autism part 1 eLearning. At the time of inspection there were five registered nurses, 16 medical staff and three administrative and clerical staff who had completed this training.

There were practice development nurses who supported staff with training needs, particularly junior nurses. They monitored mandatory training compliance and alerted staff when they needed to update their training.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Trustwide safeguarding policies included adults, children's, female genital mutilation (FGM) and prevent strategy.

They received training specific for their role on how to recognise and report abuse.

Staff could give examples of how to protect patients from harassment and discrimination.

There was a safeguarding lead within the department who worked with the trust safeguarding team to protect patients.

There was a designated doctor for safeguarding children on each shift.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Current safeguarding information was available on the trust intranet as well as on paper. Staff followed the England and Wales processes dependent on patient locality. Flow charts were available to signpost staff. The process for referrals had been updated to an electronic system.

Clinical staff were required to complete safeguarding level three training.

Compliance for level one training overall was 93.41%, however, estates and ancillary were 66.67% compliant.

Compliance for level two training for adults overall was 89.18%, however, medical staff were 70.84%, additional clinical services were 68.42% and registered nurses were 74.24% compliant.

There were no results provided for safeguarding level three for adults.

Compliance for level one training for children overall was 92.31%, however administrative and clerical were 75% and estates and ancillary were 33.33% compliant.

Compliance for level two training for children overall was 90.33%, however, medical staff were 85.94% and registered nurses were 73.07% compliant.

Compliance for level three training for children overall was 40.36%, however, medical staff were 29.17% and registered nurses were 64.69%.

Staff additionally completed safeguarding think family training. There were 66 staff who had completed the training, of these 52 were registered nurses, three were medical staff and 11 were health care assistants. The trust did not provide details of the total number of staff identified as requiring this training which meant compliance rates could not be determined.

The delivery of level three safeguarding training for the junior doctor workforce was included in the departmental risk register.

Cleanliness, infection control and hygiene

The service did not control infection risk well. Staff did not always use equipment and control measures to protect patients, themselves and others from infection. Equipment and the premises was not visibly clean.

The environment was difficult to keep clean. There were not always sufficient numbers of domestic staff to clean thoroughly. The trust could not provide evidence of cleaning schedules or show they would be completed. This was highlighted during our last inspections in 2016, 2019 and 2022 but had still not been resolved.

The service had sourced new patient trolleys, however; older trolleys were still being utilised, both in adult and paediatric areas, that were torn and difficult to clean due to the number of patients in the department.

There were areas that were in need of repair and these were difficult to keep clean.

There were sufficient numbers of clinical sinks, hand washing / sanitising equipment and personal protective equipment (PPE) available for staff to use.

Clinical staff did not follow infection control principles including inappropriate use of personal protective equipment (PPE). Staff did not always change gloves between patients and were not always bare below the elbows. Gloves were worn whilst using a computer. There were staff wearing jewellery (other than a wedding band), wrist watches and nail varnish.

Equipment was not always cleaned after patient contact or labelled equipment to show when it was last cleaned.

In paediatrics there were no checklists for the cleaning of toys.

The results of the CQC survey for urgent and emergency care services, in 2022, showed that the trust scored worse than expected, when compared to other trusts for: “In your opinion, how clean was the urgent treatment centre?”

Staff were required to complete mandatory training for infection prevention and control. Compliance with level one training overall was 98.35%. For level two training overall compliance was 88.55%, however additional clinical services were 84.21% and registered nurses were 87.12%.

Privacy curtains were disposable, and all dates indicated last changed within the three months prior to the inspection visit.

There was an audit programme that covered environmental areas, linen, waste, sharps, equipment, hand hygiene, PPE and isolation, however, there were no results for the emergency department.

The service completed cleaning audits. There was no data for July 2023 or August 2023. In September 2023 there was 96.07% compliance and 99.42% in October 2023.

Hand hygiene audits were completed monthly. Compliance was 89.2% in April 2023, 91.1% in May 2023, 98.6% in June 2023, 87% in July 2023 and 86.7% in August 2023.

There was poor compliance with commode decontamination in the department. Of the 17 commodes audited, in August 2023, only one was assessed as clean.

Each area had a nominated IPC link person, including in the emergency department, who supported with monthly environmental and hand hygiene audits.

The service was the lowest ranking clinical area, for IPC champion audits in September 2023 at 75% with an average of 76% for the previous 12 months. Hand hygiene was the lowest ranking in September 2023 at 80% with an average of 87% for the previous 12 months. The low compliance with audits matched the findings of the inspection which meant the action taken to make improvements was not effective.

The IPC team provided updates at monthly governance meetings.

We escalated our concerns about IPC standards during the inspection visit. Trustwide communications were disseminated to staff regarding expectations with the IPC team and champions monitoring compliance with daily electronic audits.

We carried out a follow up inspection visit to observe the department and review any immediate actions taken in response to CQC feedback to findings whilst on-site. Staff were utilising hand sanitisers and staff were bare below the elbows.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not keep people safe. Staff did not always manage clinical waste well.

The service did not have suitable facilities to meet the needs of patients' families. There were separate areas designated for treatment of adults or children.

Access to the paediatric area was secure with a separate entrance direct to the children's waiting room. The exit for families out of the waiting area had a button that was high on the wall to help keep children safe whilst in the department. However, we did observe that the door to triage 2, which backed on to the children's area was not always closing securely. This meant members of the public may be able to access the area. We escalated this during the inspection and were told that an adult patient had gone through this route.

There were three cubicles in the children's area. Daily checks were completed, and all equipment had evidence of portable appliance testing (PAT) in the 12 months prior to inspection. The children's area was located close to the adult majors area and close to where adult mental health patients were cared for. This meant if a child needed to go for an investigation, such as an x-ray, they needed to pass through the areas where seriously ill patients were.

Urgent and emergency services

In the main adult areas of the department, the service was at full capacity with patients being nursed in areas that were not bed spaces. Patients were cared for on trolleys, chairs and beds. Patients could reach call bells and staff responded quickly when called. Due to the high number of patients in the department, additional patient call bells had been installed in the corridor where 10 patients were cared for.

For patients receiving corridor care, there was insufficient space for a bed. Space was restricted in the corridor and trolleys could not be laid flat without crossing fire doors and exits. There were 10 spaces, including signage, assigned to patients nursed in the corridor. Some areas were not well lit, including the corridor which presented difficulties observing patients.

The Healthwatch report in September 2023 noted “The department as a whole looked a little tired. The glass panel in front of the reception area was very dirty and smeared. There were scuffed walls and skirting boards in the corridors and hazard warning tape on the floor in a couple of areas.”

The department was divided into areas dependent on clinical need, however, patients were treated wherever a space was available. An area designated as part of the urgent treatment centre (UTC) was being utilised for emergency department patients. This area did not include piped oxygen or suction. This meant in the event of an emergency, portable oxygen and suction needed to be sourced. The risk to patient safety for using this See, treat, assess and review (STAR) area for overnight admissions due to lack of oxygen and equipment was included in the risk register.

Patients were not always being cared for in the right area for the acuity of their condition. There were patients in the ambulatory majors area who should have been in the resuscitation area.

The service had three beds for critically ill patients designated as a resuscitation area. This was the area were seriously ill adults and children were cared for. For the number of attendances to the hospital the number of resuscitation beds did not meet Getting It Right First Standards (GIRFT). Patients were moved out of this area to accommodate new patients. However, there was not always a bed available in the majors area for the patient. Patients were nursed in open areas close to nurses’ stations. Patients that had been closely monitored were unable to continue monitoring if they were not in a designated space. Senior leaders told us that a business case had been submitted for more resuscitation bed spaces, however; the trust was clear that the estate was limited and it was not clear how additional resuscitation capacity would work within the current environment. The trust had experienced an increase in footfall since the department was originally designed.

The service did not have enough suitable equipment to help them to safely care for patients.

Staff carried out daily safety checks of specialist equipment. Daily checklists were completed. Checks of resuscitation trollies and their equipment was carried out electronically. Alerts were issued if checks were not completed in a timely manner. From the resuscitation trolley audit report from July 2023 to September 2023 compliance with checks was between 83.7% and 93.48%

Equipment was passed its expiry date despite checklists being signed as completed. A full inventory of equipment was carried out after we had escalated our concerns about insufficient equipment. We were provided with a copy of the asset register for the department. It showed that there were at least 133 items of equipment, in use, that were passed their date for planned preventative maintenance (PPM). These included twin oxygen flowmeters, suction controllers, a ventilator, patient monitors and trolleys.

Equipment for paediatric resuscitation was available in the main resuscitation area. A bed space was designated for caring for children, although not solely for paediatric care. In the event of the space being utilised if a child required the area, they would need to be treated in the paediatric department. There were trolleys designated for resuscitation purposes, however there was no trolley in the children's area. The trolley closest to the paediatric area did not include paediatric equipment. This meant equipment needed to be sourced from the main resuscitation area. The lack of paediatric resuscitation space was on the departmental risk register.

There was a room where adult patients with a mental health condition were treated. However, this room was not free from ligature risks. There was often a number of patients with a mental health concern in the department. The cubicles utilised for patients with a mental health concern were not with the Royal College of Psychiatrists (RCPSYCH) Psychiatric Liaison Accreditation Network (PLAN) standards; there was insufficient staff for one-to-one care over a 24 hour period and no evidence of patient centred risk assessments. This meant that patients were nursed in areas that had ligature risks and may not be suitable for patients at risk of self-harming.

There was no designated area for children with a mental health concern and the cubicles had not been risk assessed for potential ligatures. There was a reliance on family members to supervise their child in the department.

Some bins were overflowing. Doors to both sluice rooms and the domestic cupboard were unlocked despite keypads in situ. One of the sluices had the mechanism covered with tape to prevent locking. These rooms included cleaning products that were toxic if ingested. We escalated this for each of the three days we were on site, but the rooms continued to be open and the risk was not discussed at safety huddles during staff handovers. These rooms were close to where children and patients with mental health concerns were nursed. There were toxic substances, including fluids for use following procedures that were outside of these rooms that were not locked away and accessible to any patients or member of the public.

The major incident and decontamination equipment had not been checked since March 2022 and this was escalated to senior staff. Equipment was removed and a full check was initiated. Oxygen cylinders were on the floor and not secured either to wall brackets or carriers.

There were sundries that were past their date of expiry, such as venflons (including expiry dates of 2019) and items that were not stored securely such as eye drops (that were also passed their expiry date) and equipment such as scissors and tweezers in open trolleys accessible to anyone passing. We removed the items and escalated to staff on site.

The minor injuries area was at the far end of the department. This meant that patients with mobility issues due to injury had to go through the department. There was a short cut however this was narrow and could not accommodate a wheelchair.

Routine generator maintenance checks and tests were carried out throughout the year.

The risk to patient and staff safety due to damage of flooring was on the departmental risk register.

Assessing and responding to patient risk

Staff completed risk assessments for physically ill patients. They did not always remove or minimise risks for patients with a mental health concern or update the assessments. Staff generally identified and quickly acted upon patients at risk of deterioration.

Urgent and emergency services

In the emergency department we were told that there were 42 staff that were trained in triage of patients using the Manchester triage system (MTS) and on the external MTS register as signed off triage practitioners. This included six band sevens, nineteen band six nurses, ten band five nurses, five children's nurses and two practice development nurses.

There were also a further sixteen band five nurses who had been trained but awaiting sign off in practice. There were four MTS triage instructors who provided the training and signed off practitioners in practice.

The trust completed an audit review tool for triage. Between January 2023 and September 2023, the average times to triage, for all patients, was between 18 and 24 minutes. Between May 2023 and October 2023, the average time to triage for adults presenting with an acute physical condition was 29 minutes and for children it was 27 minutes. For patients presenting with an acute mental health condition the average time to triage was 28 minutes for adults and 27 minutes for children. These times were longer than the Royal College of Emergency Medicine (RCEM) recommended target of 15 minutes.

For patients waiting to be seen by a doctor, following triage, there was a dedicated member of staff who carried out vital signs checks for patients identified as requiring monitoring.

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. Staff checked patient allergy status.

The trust maintained a dashboard of compliance with patient risk assessments; however, the data was provided a divisional level. This meant we could not ascertain compliance with the department.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them. The trust completed national early warning score (NEWS2) for adults and paediatric early warning score (PEWS) for children. Records showed that generally vital signs and observations were recorded and escalated. However, we did observe two patients who were being cared for in the corridor had scored a six, on this tool. There would be a requirement to escalate this score to senior staff, however; these had not been escalated. We also observed a patient with mental health concerns, being cared for in the corridor, who had not had a risk assessment completed despite expressing suicidal ideation. We escalated our findings at the time of the inspection. There was a standard operating procedure (SOP) for patients cared for on the corridor. However, this SOP was past the date for review of January 2023.

There was a trust-wide critical care outreach team who could be contacted for support with deteriorating patients if required.

The escalation of elevated NEWS scores was raised with senior leaders during the inspection. Immediate actions were put in place as well as daily monitoring of compliance, audits and governance meetings.

During the inspection visit, there was an emergency event that required an immediate response. The event was attended by 19 members of staff and staff were not coordinated to respond appropriately. This also meant that there were patients left with insufficient numbers of staff to care for them in other areas of the department. We escalated this during the inspection visit. Following our feedback, the trust identified a lead for future similar events and clarified roles and responsibilities for staff.

There was a flag on the electronic patient record system that alerted staff if a patient had been assessed as having complex needs such as a mental health concern.

Urgent and emergency services

The service had 24-hour access to mental health liaison and specialist mental health support if staff were concerned about a patient's mental health. The liaison team were based in the department. Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide.

Staff knew about and dealt with any specific risk issues such as possible sepsis, although compliance audits with sepsis care were poor. There had been a sepsis improvement group since June 2022, across the division, who monitored compliance with sepsis guidance.

There were 117 staff who had completed sepsis training. Of these, 82 were registered nurses, 18 were medical staff, 16 were additional clinical services and one was additional professional scientific and technic.

The Trust participated in a regional programme for sepsis management. The advancing quality alliance sepsis improvement programme (AQUA) identified patients who have had a diagnosis of sepsis for the trust to audit. The metrics included within this bundle reflected the current NICE guidance. Between July 2022 and June 2023, the AQUA sepsis compliance were:

- National Early Warning Score (NEWS/NEWS2) recorded within 1 hour of hospital arrival. – 80.5%
- Blood cultures taken within 1 hour of sepsis diagnosis. – 58.8%
- Antibiotics administered within 1 hour of sepsis diagnosis. – 52.7%
- Serum lactate taken within 1 hour of sepsis diagnosis. – 55.7%
- IV fluids commenced within 1 hour of sepsis diagnosis. – 44.2%
- Senior Review or assessment by Critical Care within 2 hours of sepsis diagnosis- 65.6%
- Care pathway commenced following sepsis diagnosis. – 46.4%

The trust's training policy outlined requirements for nurses of all grades. This included that band 5 nurses were required to maintain compliance with deteriorating patient level 2, immediate life support (ILS),paediatric immediate life support (PILS) and trauma level 1. Band 6 nurses were required to maintain compliance with deteriorating patient level 2, ILS, PILS and trauma level 2. Band 7 plus nurses, including advanced nurse practitioners, were required to maintain compliance deteriorating patient level 2, advanced life support (ALS) and advanced paediatric life support (APLS).

At the last inspection, compliance rates for life support training were below the trust target of 90% for registered nurses and medical staff. At this inspection compliance for basic life support (BLS) overall was 77.98%. Medical staff compliance was 78.13%, registered nurses was 78.78% and additional clinical services staff at 47.37%. For paediatric basic life (PBLS) support overall compliance was 77.12%. Medical staff compliance was 76.57%, registered nurses was 80.26% and additional clinical services staff was 47.37%. There was limited improvement in the compliance rates.

There were 18 registered nurses who had completed ALS, as well as 10 medical staff and two additional professional scientific and technic.

There were six registered nurses who had completed APLS, as well as seven medical staff and two additional professional scientific and technic.

There were 19 registered nurses who had completed ILS and 11 who had completed PILS.

Urgent and emergency services

In the six months prior to inspection the trust told us there were no incidents where there was staff on duty without ALS or APLS training.

Failure to adhere to CQC regulations by ensuring there was a staff member APLS trained on each shift was included in the departmental risk register.

For patients who presented with symptoms of a stroke, there was a hyper-acute stroke unit (HASU) at the trust. This meant that patients could be treated with thrombolysis, if indicated, at the hospital. (Thrombolysis uses medication to break down and disperse a clot, that is preventing blood from reaching the brain.) For patients who needed a thrombectomy procedure, there was a need to be transferred to the regional NHS centre. (Thrombectomy is a treatment that physically removes a clot from the brain.) Both procedures are time critical.

The trust had identified a risk that there was a lack of stroke co-ordinators overnight; they were available daily between 8am and 8pm. The impact to patient safety due to a lack of stroke co-ordinators had been included on the trust risk register. During the onsite inspection visits, there was a patient waiting for thrombolysis. However, this had been delayed due to consultant availability which was a separate risk to the risk identified by the trust.

At the time of inspection there were patients both with acute physical conditions and patients with a mental health concern. There was a cubicle where patients with a mental health concern were cared for, and other cubicles close to this for other patients with a mental health concern. None of these areas were designated as 136 suites or were free from ligatures. The purpose of a Section 136 suite is to provide a place of safety for individuals who are detained under Section 136 of the Mental Health Act 1983. We were concerned that the areas in use were not appropriately risk assessed and not visible. There was poor assessment and management of patients with a mental health concern as they were being cared for in areas that were not easily observed. There were staff identified, by the neighbouring NHS mental health trust, to support patients on a one to one basis. However, staff were not always available 24 hours a day particularly if there were a number of patients that required close observation.

Some patients with mental health concerns were assessed as requiring enhanced care at times, with one to one care sourced from an independent provider. However, we were told that this external support was not always available meaning that staff in the department would need to provide this care. Patients were at risk of self-harm if insufficient staff were available. We requested a copy of the policy for enhanced care of mental health patients, however the policy provided referred to cognitive impairments rather than a mental health concern.

The potential risk for emergency department staff and mental health patients due to insufficient resource for the observation of mental health patients was included in the departmental risk register.

We escalated our concerns about care and treatment of patients with a mental health concern, during the onsite inspection. We were provided with assurances that immediate actions were taken with completion of risk assessments and patient reviews. Further actions included daily monitoring of compliance, audits and governance meetings. Staff demonstrated the improvements made to tools to risk assess and observe patients with mental health concerns in our follow-up visit to the service on the 16 November 2023.

The trust carried out electronic audits. For September 2023, the service was the lowest ranked for pressure ulcer management at 75% compliance and an average of 78% for the previous 12 months.

Urgent and emergency services

For the NEWS audits, the service was one of the highest performing clinical areas in the trust. For September there was 86% compliance with an average of 86% for the previous 12 months. For matrons' audits, the service scored 74% in September 2023 with an average of 74% for the previous 12 months. For falls management the service was ranked the lowest clinical area with 72% and average of 67% for the previous 12 months.

Staff we spoke with told us that access to magnetic resonance imaging (MRI) was limited particularly out of hours. This meant that patients admitted overnight for a condition that may require time-critical treatment, such as cauda equina, may have treatment delayed and affect their outcome (Cauda equina syndrome is a rare and severe type of spinal stenosis where all of the nerves in the lower back suddenly become severely compressed).

For mouth care matters the service scored 0% for September 2023 and 0% for the previous 12 months.

Staff completed a discharge checklist that included transport, letter, medication and safety netting information for those going home.

Shift changes and handovers included key information to keep patients safe, however; safety information that we had escalated was not shared at safety huddles to staff at handover times.

Following the inspection, we were provided with examples of completed nurse-in-charge daily checklists. These focused on the control of substances hazardous to health (COSHH) cupboard being locked, the resuscitation trolley being checked, wearing of uniform compliance and escalation of NEWS scores as appropriate. The checklists did not always include the area checked, however; they included any actions taken. We received copies of daily electronic audits completed for the escalation and on-going monitoring of NEWS compliance.

Meeting frequencies were increased since the inspection. There were core Huddles at 9.30am, 1pm and 4pm that required mandatory representation from nursing, medical and operational leaders following a standardised framework to ensure oversight of flow and safety throughout the department. A two hourly acuity and safety huddle was introduced.

We received copies of the emergency department two hourly acuity safety huddle checklists. These identified the medical team leader (MTL) and nurse team leader (NTL) for the shift, any immediate safety concerns, numbers of patient with elevated NEWS scores or sepsis suspected and any patients with a mental health concern. A list of daily actions required was included in this checklist.

We carried out a follow-up inspection to observe the department and review any immediate actions taken in response to CQC feedback to findings whilst on-site. The department was in OPEL 3 and the full capacity protocol (FPC) remained active. Senior staff we spoke with were not aware of any recent changes to the FPC, however the trust intranet showed that it had modified at the time of our initial visit. There were over 100 patients in the department; half were in the waiting room. There were plans in place for all patients. The safety huddle checklists were being completed but had gaps in timeliness when the department was busier. This meant there was a concern that oversight of any deteriorating patients could be reduced. The daily nurse in charge checklists were being completed but they too could be delayed during busy periods.

Nurse staffing

The service did not always have enough nursing staff and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix and gave bank and agency staff a full induction.

Managers calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift using a safer staffing tool. The department manager could adjust staffing levels daily according to the needs of patients.

The number of nurses and healthcare assistants matched the planned numbers.

The design of the department meant it was difficult for staff to see all patients in their care. Staff told us that there was a concern that junior staff did not have the experience to care for the acuity of patients assigned to them.

A nurse establishment review was completed in June 2023 trust-wide. The establishment for the department had been increased to support patients being nursed in the corridor. However the establishment was based on the maximum capacity for patients but there had been an increase in footfall.

The trusts safe staffing report for January 23 to June 23 showed that the fill rates for registered nurses was 126.3% and unregistered staff was 163.1%. The service used regular agency nurses, that had completed induction and understood the service, to support staffing numbers.

There was an average temporary staff usage of 35.7%.

There was an absence average of 7.87% for the emergency department (ED) and the urgent treatment centre (UTC).

The sickness rate for registered nursing staff had decreased from 11.3% in August 2022 to 5.7% in May 2023. This was lower than the same time the previous year.

The sickness rate for healthcare assistants had been higher than for medical and nursing staff, peaking at 23.4% in January 2023. The sickness rate decreased after this date, to 13.7% in May 2023. The most common reasons for sickness in May 2023 were “other musculoskeletal problems” and “cold/cough/flu”.

The turnover for registered nurses was 35.57%.

There was 0.61 whole time equivalent (WTE) vacancy for registered nurses, along with 9.68 WTE who were supernumerary. There were 14.19 vacancies for unregistered staff. The service was recruiting at the time of inspection.

In paediatrics there was not always two registered children’s nurses on each shift. The trust did not employ sufficient registered children’s nurses to cover two shifts day and night. We were told there had been challenges in recruitment and were reviewing rotation options with paediatric services.

This did not comply with the Royal College of Paediatrics and Child Health (RCPCH) Facing the Future: Standards for children in emergency care settings (2018). Shortfalls were filled by support from staff in the adult areas. The service had a requirement for band 7 nurses to be trained in advanced paediatric life support (APLS). The failure to comply with CQC regulation by ensuring the emergency department has two paediatric trained nurses on duty each shift was on the risk register. However the requirement for paediatric nurses is guidance from the Royal College of Paediatric and child Health (RCPCH) rather than the Care Quality Commission.

In the six months prior to inspection there were two incidents reported by staff in the children’s area who escalated a need for additional staffing support. There were no incidents reported for adult nurse staffing.

Urgent and emergency services

Medical staffing

The service did not have enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix, and gave locum staff a full induction.

The service did not have enough medical staff to keep patients safe although medical staffing matched the planned number. We were told that there were 9 emergency department consultants and three associate specialist doctors. The medical rota was calculated based on the number of clinical hours required and included all grades of doctors as well as advanced care practitioners (ACP) and emergency nurse practitioners (ENP). Consultant numbers were not sufficient for the number of attendances in the department as per royal college of emergency medicine (RCEM) consultant workforce guidance (2019).

The recruitment and retention of junior doctors was a continual challenge for the service. A business case was approved in January 2023 to increase the junior headcount by four whole time equivalent (WTE) doctors to support the rotas. The ED consultant team have reviewed the electronic rota platforms to improve the rota management.

For doctors new to the NHS there was an effective support package where there was a four to six weeks period of supernumerary time followed by sign off from two consultants.

Since the last inspection the Certificate of Eligibility for Specialist Registration (CESR) programme was now available for speciality doctors who were interested in progressing to the specialist register of the general medical council (GMC).

The potential risk to patient safety due to a lack of emergency department middle grade doctors was included in the departmental risk register.

In the three months prior to inspection there was one incident where there was one consultant covering instead of the three planned.

The sickness rate for medical staff in urgent and emergency care at the trust increased from 1.9% in January 2023 to 4.4% in May 2023. This has had an upward trend in 2023, though remains comparatively low overall.

At the time of inspection, the average absence rate was 4.23% and the turnover rate was 1.89%.

At the last inspection we highlighted a concern about lack of sufficient number of medical staff, particularly those with the necessary skills to treat children. Since the last inspection the trust had employed a trained paediatric emergency medicine (PEM) consultant. However, they were not actively working. There was a nominated consultant who was temporarily supporting this role. We were told that there was no dedicated time during their weekly time to complete tasks as per Facing the Future: Standards for children in emergency care settings (2018).

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, not always stored securely but easily available to all staff providing care.

Patient notes were comprehensive, and all staff could access them easily.

Patient records were recorded on an electronic system. Since the last inspection the system had been embedded and staff navigated with ease.

When patients attended triage, reasons for the visit as well as demographic information was recorded on paper. These records were placed in an area where the public were passing.

When patients transferred to a ward, there were no delays in staff accessing their records.

There was a trust-wide health records group. The health records performance report for August 2023 included an audit of case notes availability. This showed that notes were generally available for emergency admissions within half an hour.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed some systems and processes to prescribe and administer medicines safely. However, there were two people administered oxygen as a medical gas who did not have this prescribed.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Between Monday and Friday the department had a pharmacist and technician embedded in the department. This provided a review of medicines for those people for which a delay in their administration could result in potentially causing harm. Additional advice was also provided to people receiving new medicines.

Staff completed medicines records accurately and kept them up to date. However, the electronic prescription records showed missed doses of medicines on records. Further investigation showed these were showing as "missed doses" but had been in most cases seen to be administered. Staff were being vigilant and checking the time of previous administration before continuing. Following the on-site visit the trust confirmed, following testing, that once a dose was administered through either module, it was not able to be repeated.

Staff stored and managed some medicines and prescribing documents safely. However, the ambient storage temperature in the main clinic room had exceeded the manufacturer's guidance on most days between May and October 2023. The staff had tried to reduce the temperature in the room, however this included leaving the door open. This gave unsecured access to the room and any medicines stored outside the locked containers. The ambient temperatures were not monitored in any other areas or rooms in which medicines were stored.

Emergency medicines were stored on resus trolleys in accessible areas with regular checks on content and expiry dates. However, the trolley used as a backup for paediatric resus only contained an adult emergency medicine box.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. The department had a pharmacist and pharmacy technician as part of the team. Drs referred people to them for review of their medicines to ensure the correct medicines were prescribed.

The trust completed electronic audits for oxygen therapy. In September 2023, the service scored 59% with an average of 61% for the previous 12 months. For medicines management, the service was one of the highest in the trust and scored 99% in September 2023 with an average of 91% for the previous 12 months.

Urgent and emergency services

Incidents

The service did not always manage patient safety incidents well. Staff recognised and reported incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

The trust was transitioning to the new national patient safety incident response framework (PSIRF).

We were not assured that staff raised concerns and reported all incidents and near misses. .

The service had not reported any never events. Never events are serious, largely preventable safety incidents that should not occur if the available preventative measures are implemented.

Between 1 August 2022 and 13 July 2023, the trust reported 18 serious incidents in the department. Treatment delays was the most common type of incident, with 6 of these reported that included failed communication between hospital teams as well as delays in assessment.

Over the same period the trust reported 1,066 incidents. A high volume of those categorised as “other” that could indicate issues with classifying incidents. Where a category was used, medication was the most common incident type.

We were told there had been a delay in managing incidents reports, however; this had now been greatly reduced from about 800 to about 130 since March 2023.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong.

Staff met to discuss the feedback and look at improvements to patient care. There were trust-wide sharing and learning events. Staff shared an example of an incident where a patient had been discharged without a senior review that was being used as part of doctors’ induction training.

It was unclear if learning was embedded following a serious incident. There was a near miss of a recent serious incident, during the time of the inspection, where a mental health patient had taken their own life in the department. This meant we were not assured about the effectiveness of sharing of any learning or that on-going risks following an incident had not been mitigated appropriately.

We observed that managers debriefed and supported staff after a serious incident.

Is the service effective?

Inadequate 

Our rating of effective went down. We rated it as inadequate.

Urgent and emergency services

Evidence-based care and treatment

The service did not always provide care and treatment based on national guidance and evidence-based practice. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed trust policies and guidelines to plan and deliver care. At the last inspection it was not clear when policies had been written, ratified or reviewed. At this inspection some were the same, but others included dates of issue, ratification and version control. Some of the policies received as part of data requested only showed the date printed off.

Dates of policies, including those requiring review were monitored and shared at monthly governance meetings. This showed there were six outstanding ones for review assigned to the department.

There were a number of policies, procedures and pathways for certain conditions such as stroke and sepsis. The Thoracic injuries pathway was part of the major trauma centre collaborative.

The trust did not evidence that policies followed best practice guidance such as the Full Capacity Protocol. Full capacity protocol was not being utilised effectively. The policy stated that enactment was between 8am and 4pm and it was not clear what the process was out of these times.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice.

The medical staffing model did not meet Royal College of Emergency Medicine (RCEM) standards and the resuscitation area did not meet Getting it Right First Time (GIRFT) standards.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers.

The trust participated in a ward accreditation scheme. The department had been assessed in March 2023 and awarded white. They were assessed as gold for caring and responsive, bronze for safe and white for effective and well led. Themes of fire safety, staff training and appraisals, drug fridges, IPC and information boards were identified from negatively answered questions. An overall rating of white meant reassessment within 2 months. The department was reassessed in May 2023 and achieved bronze accreditation with bronze achieved in safe, effective and responsive. Caring and well led were assessed as silver. In September 2023, the department was assessed as bronze overall. Safe, caring and responsive were assessed as bronze, effective was white and well led was silver.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs.

We observed staff offering drinks and meals to patients and those close to them if experiencing long waits.

Staff generally completed patients' fluid and nutrition charts where needed.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. The service was not included in the electronic audit programme for nutrition although patients often spent several days in the department.

Urgent and emergency services

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice.

Patients received pain relief soon after it was identified they needed it, or they requested it.

Staff prescribed, administered and recorded pain relief accurately. We observed staff checking pain levels for patients.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The service participated in national Royal College of Emergency Medicine (RCEM) audits.

The trust audit plan for 2022 to 2023 in the department included Royal College of Emergency Medicine (RCEM) audits for fractured neck of femur, infection control, consultant sign off and pain in children. Other audits included paediatric sedation, vital signs in adults, Trauma Audit and Research Network (TARN), missed fracture and trauma call times to CT scan.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. At the last inspection findings from clinical audits were not always properly analysed and reviewed by appropriately trained staff. At this inspection it remained unclear if results were used to drive improvements.

The pain in children audit that ran from October 2021 to October 2022 and the report was completed in July 2023. For all of the four standards that related to assessment and administration of analgesia, results were below the national averages.

An action plan was in progress with a target date for completion of August 2024.

For the 2021/22 Infection Prevention and Control audit the interim report that related to screening on arrival and appropriate isolation processes was published in April 2023. For four of the standards performance was below the national average and above for two standards.

The trust audited the Time to Consultant Review via the Society of Acute Medicine Benchmarking Audit (SAMBA). Data was submitted for 2023 data showed there were no results available at time of inspection. Last year, overall, the trust met SAMBA standards (6 hrs daytime, 14hrs nighttime) time to consultant review target 59% of the time (median nationally is 52%), with SDEC Medical achieving target in 92% of cases and if patient's route of admission was ED, 52% of cases met the standard.

Competent staff

The service did not always make sure staff were competent for their roles. Managers had not always appraised staff's work performance or held supervision with them to provide support and development.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Staff did not always have time to compete eLearning modules during clinical shifts but were encouraged to request time back if completed out of working hours.

Managers gave all new staff a full induction tailored to their role before they started work.

Registered nurses completed a five day induction that included learning sessions such as oxygen therapy, learning disability, palliative care, wellbeing, care of a patient with dementia, speech and language, malnutrition universal scoring tool (MUST), infection prevention and control, discharge planning and rapid response, diabetes, mental health liaison, preceptorship, blood transfusion, tissue viability, falls, alcohol awareness, teletracking, hospital at home and deteriorating patient.

Preceptees completed a planned programme that included mandatory day courses in essential skills such as intra venous (IV) administration and IV drugs, infection prevention and control, anaphylaxis, drug calculations, pumps, diabetes and care of a peripherally inserted central catheter (PICC). There were additional courses such as immediate life support (ILS), acute kidney injury (AKI), cardiology and human factors training.

Internationally trained registered nurses had a bespoke induction programme. Sessions included life in the UK, NMC Code of Conduct, living the language and well-being as well as clinical modules.

Health Care Assistants completed a seven day course for their induction. Modules included patient experience, pressure area care, diabetes, infection control, teletracking, nutrition and dietetics, learning disability, care of a patient with dementia, rounding, national early warning scores (NEWS2), deteriorating patient, conflict resolution, death and dying and well-being. Further development days were available such as for AKI, sepsis and blood transfusion.

There were two practice development nurses (PDN's) who supported junior staff clinically in the department as well as delivering face to face training sessions. The PDNs maintained oversight of training and competency compliance rates for staff.

There was a concern that due to the demands of the department, PDNs were not always available to support staff and staff who were not qualified had been required to assess junior staff competencies as well as staff not always able to attend training. There was limited space for dedicated training areas in the department.

At the last inspection we told the trust that they should improve compliance in staff competencies. At this inspection we requested compliance for competencies, in the department. We were told that competencies for non-invasive ventilation (NIV), electro-cardiograph (ECG) and cardiac monitoring were not mandatory but an additional skill. This additional skill information was incomplete within staff electronic records. Additionally, we were told that further work would be undertaken to baseline and update the electronic record system to ensure that additional skill compliance would be fully recorded and monitored going forward.

Royal College of Nursing (RCN) competencies had not been rolled out in the department. The plan with the PDN nurses was for this to commence in January 2024. The plan included band seven and band six nurses to undertake level two competencies initially with them then being able to support the roll out of level one competencies for band five staff.

Threshold assessment grid (TAG) assessment competencies were not in place. The TAG is an assessment of the severity of an individual's mental health problems. However, the trust told us that TAG assessment had been incorporated into the action plan under the mental health risk assessment workstream.

Managers supported staff to develop through appraisals of their work. However, compliance levels were below the trust target of 90%. For medical staff, compliance was 82.35% and compliance was for nursing staff 65% with administrative and clerical at 33.33%.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. We attended a range of meetings throughout the day that involved nurse and medical leads, departmental senior managers and patient flow staff.

Porters were based in the department to support movement of patients. Ambulance staff we spoke with spoke positively about hospital staff. There was effective communication regarding on going care whilst awaiting access to the department.

Patients were referred to the required specialities promptly. Due to the numbers of patients with medical conditions, the doctors for medical care were based in the department to support their ongoing care and treatment.

The rapid response team in-reached into the department in order to ensure that patients were in the department appropriately.

Staff referred patients for mental health assessments when they showed signs of mental ill health. Staff worked well with colleagues from the neighbouring NHS mental health trust. There were weekly meetings with the liaison team and monthly meetings with the crisis board.

Clinical staff in the department worked with mental health liaison colleagues and sub contracted services to support patients with a mental health concern.

Seven-day services

Key services were available seven days a week to support patient care.

Staff could call for support from doctors and other disciplines and diagnostic services, including mental health services, 24 hours a day, seven days a week.

The department was close to diagnostic services such as x-ray. Staff we spoke with told us that access to magnetic resonance imaging (MRI) was limited particularly out of hours.

Pharmacy and laboratory services were available as needed for the department.

Health Promotion

Staff did not always give patients practical support and advice to lead healthier lives.

There was no information displayed to promote healthy lifestyles except for minor injury discharge advice. This was highlighted at the last inspection.

In the paediatric area there was information available via QR codes, however; these were only in English.

Urgent and emergency services

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.

There were trust-wide policies for the Mental Capacity Act and Deprivation of Liberties Standards.

Staff gained consent from patients for their care and treatment in line with legislation and guidance.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions.

Staff made sure patients consented to treatment based on all the information available.

Staff received training in the Mental Capacity Act and Deprivation of Liberty Safeguards. However, this was included in safeguarding think family training. Compliance rates were poor for this training. Staff understood Gillick Competence and Fraser Guidelines and supported children who wished to make decisions about their treatment.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness and took account of their individual needs.

Staff were discreet, where possible, and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Urgent and emergency services

Patients, and those close to them, we spoke with told us that staff treated them well and with kindness. They expressed how grateful they were for care received with a recognition that staff were busy and challenged. All patients reported that they were well looked after, and needs were met promptly.

We observed and confirmed with patients that they had received appropriate care and treatment that included positive one to one interactions with staff.

Between October 2022 and September 2023 the trust recorded 72 compliments from patients and for the department.

The service's environment made it difficult for staff to provide care in a way that respected the privacy and dignity of patients, although there were good examples of caring with staff taking time with those who needed extra support. For patients required to stay for extended amounts of time, they were assessed for changing from a trolley to a hospital bed and care needs were addressed through intentional roundings. We reviewed the patients who had spent in excess of 60 hours, in the department, and these were cared for in a bed. We did see that there were patients who were nursed on the corridor, on trolleys due to the lack of space.

The results of the CQC survey for urgent and emergency care services, in 2022, the urgent treatment centre scored worse, when compared to other trusts for: "Respect and dignity".

From the Healthwatch report in September 2023, 86% of patients questioned said they had been treated with dignity and respect during their time, 72% said they felt their privacy had been maintained as much as possible and 71% thought the service they received was good or excellent. The report highlighted positive themes included the service they received from the staff and the speed of being seen by triage. Negative themes included long wait times, general facilities and staff communication.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. However, this could be challenging due to the environment.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

There was a trust-wide chaplaincy service available for spiritual support.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment.

Patients and their families could give feedback on the service and their treatment.

Urgent and emergency services

Staff supported patients to make informed decisions about their care.

The feedback from the emergency department survey test was about the same, when compared to other trusts for seven of nine questions. This included care and treatment and respect and dignity.

Is the service responsive?

Inadequate 

Our rating of responsive went down. We rated it as inadequate.

Service delivery to meet the needs of local people.

The service provided care in a way that did not meet the needs of local people and the communities served. It worked with others in the wider system and local organisations to plan care.

Senior leaders, for the division had plans for the organisation of services. However external pressures, system-wide presented daily challenges to meet the needs of the local population. Commissioning arrangements in place meant that as well as serving the local area, there were patients from Wales who also used the services.

Facilities and premises were not appropriate for the demand for the service being delivered.

Senior leaders told us that the original capacity of the department was between 36 and 40 trolley spaces although this did not include patients being cared for on the corridor. There was a maximum capacity in the department of about 60 patients that included children.

The public car park was situated a distance away from the department, although there was good signage.

There were automatic doors meaning it was accessible for those with reduced mobility. There was a reception desk. There were two receptionists to greet patients and we did not see patients queuing. However, there was a screen between the desk and patients. This meant it was difficult to hear and confidential personal information could be overheard by other members of the public.

Reception had a hearing loop, however; it was not clear if this was effective as patients with hearing impairments checked if their name had been called. There was no portable hearing loop available.

There were separate waiting rooms and entrances for adults and children. The waiting room for adults was at capacity during the on-site inspection. There was a water machine and a vending machine with snacks. There was a machine with hot drinks, that was out of order, however; this had been fixed on the follow up visit. We did see jugs of water in other areas where patients were waiting or being cared for. There was a television in the children's area that displayed cartoons.

Patients were spending long periods of time in the waiting room on chairs and there was no display to indicate how long they were likely to be waiting. From the Healthwatch report in September 2023, 74% of those questioned said they had not been kept regularly up-to-date on waiting times and 52% had not been kept up to date with their treatment and care.

Urgent and emergency services

The results of the CQC survey for urgent and emergency care services, in 2022, showed that the trust scored worse than expected, when compared to other trusts for: “Were you given enough privacy when discussing your condition with the receptionist”, “While you were waiting, were you able to get help with your condition or symptoms from a member of staff?” and “Did hospital staff discuss with you whether you may need further health or social care services after leaving accident and emergency?

Meeting people’s individual needs

The service was inclusive but was not always able to take account of patients’ individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Patients were not always receiving care in areas that maintained their privacy and dignity. Assessments were undertaken for patients on trolleys in the corridor due to the limited capacity in the department. There were 10 patients being nursed in the corridor. These patients were allocated nurses, however, patients and those close to them had limited space with staff passing frequently. There was only enough space for a trolley rather than a bed. When offered food and drink there were difficulties to manage trays/hot drinks. Patients we spoke with told us it could be noisy at night. There was not always appropriate bed linen available.

The service was not designed to meet the needs of patients living with dementia or a complex need such as learning disability. There was limited calm space available either for adults or children. We were shared an example, however; of a patient, with a learning disability, who had sustained a minor injury and how the care was manged well. There were accessible showers and toilets, with blue seats and handrails.

There was an alert on the electronic system for patients who were identified as being vulnerable. There were staff identified as link nurses for complex needs such as for patients identified with a learning disability. They were promoting utilising the ‘This is me’ documents and patient passports, however; we did not see any in use.

Compliance with equality, diversity and human rights training was overall at 93.4%, however additional clinical services staff were 68.42%, estates and ancillary were 66.67%, administrative and clerical were 80%, medical staff were 78.65% and registered nurses were 83.69%.

Patients who identified as either male or female were cared for in open bay-type areas. The trust told us that they do not report on mixed-sex accommodation (MSA) breaches in the emergency department. There was the acute admissions bay area, where patients could be admitted to prior to being allocated a ward. This was designated as an escalation area and not reported externally as MSA breaches.

There was a relatives’ room, however; the area that been designated as a bereavement area was being utilised as an area to provide personal care for patients being nursed in the corridor.

Following the inspection visit we were told that palliative care link nurses and identified medical lead were to work with the palliative care team to put in place more robust processes around the care for patients in the department at the end of their life and support and care for their loved ones, utilising resources such as the Royal College of Emergency Medicine (RCEM) end of life toolkit (2020) and best practice from other organisations.

Staff understood the policy on meeting the information and communication needs of patients with a disability or sensory loss. There was a hearing loop in the reception area, however; this wasn’t effective particularly as plastic screens were still in place.

Urgent and emergency services

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. There was a trust-wide service to support patients whose first language was not English.

We did not observe any communication aids to help patients become partners in their care and treatment except for patients using their own mobile phones. There was a facility to charge phones in the waiting room that required payment. We did see staff supporting patients by charging phones in the reception area.

There were no leaflets available for any patients. This was raised at the last inspection in 2022.

There were toys in the children's waiting room in the paediatric area including child-friendly décor.

Access and flow

People could not always access the service when they needed it and there were significant delays in receiving the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards.

Between April 2023 and September 2023 there were 42,026 attendances to the department. Of these, there were between approximately 5,900 and 7,000 type 1 emergency department attendances per month at the trust over the six months up to August 2023. The number of patients had increased, about 20%, with patients and ambulances from Wales attending as well as those from the local area. During the inspection, on one day, there were 11 eleven ambulances waiting to bring patients into the department.

In 2022, there were 98 incidences when the trust had enacted the trust's full capacity protocol. In 2023, there had been 130 incidences up to October 2023. At the time of inspection, the trust had been continually using the full capacity protocol since 27 September 2023 and declared OPEL 4 during the inspection. OPEL 4 is when pressure in the local health and social care system continues to escalate leaving organisations unable to deliver comprehensive care. There is increased potential for patient care and safety to be compromised.

There was an increasing trend in the percentage of ambulance handovers taking more than 60 minutes. The trust had seen a decrease from 39.6% in December 2022 to 22.7% in July 2023. This is higher than the same time last year, which was at 7.4%. From October 2022 to June 2023, this had been higher than the percentage for the NHS ambulance service for the North West overall.

The trust's median time from arrival to initial assessment was mostly longer than the national average, at between 11 and 20 minutes since May 2022.

The trust consistently reported a longer median time from arrival to treatment compared to the England average from March to December 2022. However, there was no data for this measure after December 2022. In December 2022 the trust median was 2 hours and 1 minute, compared to 1 hour 32 minutes for the national average.

In July 2023 the median time was at 3 hours and 45 minutes, compared with the England average of 2 hours and 50 minutes.

The 95th percentile total time in the department had been consistently above the England average since October 2021. There was a considerable increase during the 12 months to July 2023 from approximately 15 and a half hours in June 2022 to over 27 hours in July 2023. This peaked in December 2022 at approximately 33 and a half hours.

Urgent and emergency services

The trust's percentage of patients admitted, transferred or discharged within four hours of arrival had generally followed both the regional and national average since September 2021, with variation. In August 2023, this dropped to 53%, compared to regional and national averages of 60%.

At the last inspection we told the trust that patients must receive care in a timely way and work towards improving performance against national standards.

However, the trust's percentage of patients waiting more than four hours from the decision to admit to admission increased (deteriorated) from June 2022. This peaked at 96.3% at September 2022 and although it fell to 54.6% in August 2023, remains worse than both the regional and England averages.

There was an increase in the number of patients at the trust waiting more than 12 hours from the decision to admit to admission, from 268 in June 2022, to 576 in August 2023. In December 2022, this figure peaked at 824 patients. Between April 2023 and September 2023, there were 3546 patients who had spent at least 12 hours following a decision the admit. Between May 2023 and October 2023, there was an average of 595 adult patients per month who had presented with an acute physical condition that spent longer than 12 hours in the department. There was a total of four patients with a mental health concern, for the same time period. There were no children who had spent longer than 12 hours following a decision to admit.

Patients waited long periods of time in the department after the decision to admit had been made; in excess of 60 hours. There was a patient with a mental health concern was in the department for over 125 hours despite a bed being allocated the previous day. The service had a live dashboard where all patient information could be accessed regarding referral and waiting times.

Between April 2023 and September 2023, there was a total of 518 patients referred to mental health colleagues following presentation with an acute mental health concern. Of these, there was an average of 17% of patients compliant for being referred within an hour of presenting.

The results of the CQC survey for urgent and emergency care services, in 2022, showed that the trust scored worse than expected, when compared to other trusts for: "Overall, how long did your visit to the urgent treatment centre last?"

The trust's percentage of patients that reattended the department within seven days of a previous attendance was lower than the England and regional averages from October 2021 to July 2023. Between April 2023 and September 23 there was a total of 3714 reattendances within 7 days of first visit and 1239 patients who left prior to initial assessment. Between May 2023 and October 2023, there was an average of 195 adult patients presenting with an acute physical condition per month who left without being seen and an average of 31 children. For patients presenting with a mental health condition there were four adult patients in total for this time period and no children.

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns, although we did not observe any information in patient areas.

There was a complaints policy that outlined staff responsibilities regarding handling complaints and timescales for response. There was an expectation of response within 25 working days although could be up to 65 working days for more complex complaints.

Staff completed conflict resolution training as part of mandatory requirements. Compliance was 54.64% overall. This included registered nurses at 20.33%, estates and ancillary at 0% and additional clinical services were 38.89%.

Between October 2022 and September 2023 there were a total of 20 complaints and 241 concerns. However, there were no details about individual complaints or if responses were timely.

Managers investigated complaints and identified themes. The top three concern themes identified from complaints, for the department, were communication, clinical treatment, and appointment issue.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service.

Is the service well-led?

Requires Improvement 

Our rating of well-led stayed the same. We rated it as requires improvement.

Leadership

Local leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. Local leaders, unlike trust senior leaders, were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The emergency department was part of the urgent care division at the trust. This included urgent and emergency care services and in-patient medical wards. There was a leadership team for the urgent care division that included nursing, operational and medical managers.

There had been recent changes to the divisional management team, who were starting to have a positive impact on the service. Locally the leaders understood priorities the issues the service faced. They were beginning to manage and respond to these issues. However there were still a significant amount of pressures and challenges to manage.

Staff we spoke with told us that the senior management were not visible in the department. There was no matron at the time of inspection although the head of nursing for the department was available, approachable and responsive on each day of our inspection visits.

There were two band seven nurses on duty; one of which managed recruitment, rotas and patient feedback. The other band seven supported the staff in the department. Due to the footprint of the service, each area was led by a band six nurse with the band seven responsible for oversight of all areas.

Urgent and emergency services

It was difficult to identify staff members, in particular who the shift leaders were, due to the number of uniforms worn, both medical and nursing. Following the onsite inspection visit, the medical team leader (MTL) and nurse team leader (NTL) were allocated for each shift. This meant they should be identifiable as leads to staff, patients and visitors to the department.

Vision and Strategy

The service had a vision for what it wanted to achieve; however, no strategy was in place. The vision was focused on sustainability of services. Leaders understood how to apply the vision and monitored progress.

We requested a copy of a strategy for the emergency department; we were told that there was no strategy. However, we were told that the division aspired to the clinical vision for how front door services and inpatient workload were delivered. We were provided with a copy of a presentation of the trust's clinical vision of non-elective flow. Goals included trust-wide reduced mortality and harms as well as promotion of 'home first' with a positive hospital experience for patients being in the right place at the right time. We were told that this should happen by efficient assessment in the department by streaming, senior decision maker planning, speciality in reach an appropriate reviewing.

There was an overarching strategy for the trust as well as the local urgent and emergency care place board.

Culture

Staff did not always feel respected, supported and valued. Staff were focused on the needs of patients receiving care.

The service had an open culture where patients, their families and staff could raise concerns without fear. However, staff did not always feel listened to.

Staff were hard working but were tired. Morale appeared low due to constant daily pressures in the department.

Staff told us they did not always feel valued by the divisional and board senior managers. Staff were encouraged to speak up about concerns but did not feel this was effective. Staff did not feel like actions were taken when they escalated to their immediate or more senior managers.

Staff, in the department, told us that their concerns were not always listened to by the managers for the service, and they were frustrated that there was a limited response to any escalated concerns. They talked about a disconnect between the department and the rest of the hospital especially board members.

The senior leaders told us that they felt listened to by the board but felt that the issues were national and difficult to manage locally as a trust alone with the issues requiring a system response.

A nurse performance support group had been set up by the head of nursing to provide additional guidance to those nurses who needed it. Nurses had varied amounts of experience, but support was individual to their needs. There were terms of reference (TOR) in place and meetings were minuted with actions to take forward.

There were 132 staff, across the department who had completed freedom to speak up core competency.

Urgent and emergency services

Governance

Leaders operated governance processes, but these were not always effective throughout the service or with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There was a governance framework in place that enabled a two-way flow of information to be communicated to and from the department to senor leaders at the trust. However, the trust did not evidence that these processes were robust following the findings during the onsite inspection such as the oversight of departmental checking processes and infection prevention and control concerns.

Leaders told us that there had been challenges regarding governance and quality. A new accountability framework was being developed.

There were weekly leadership meetings in the department, that were attended by the acute directorate manager, the service manager, the head of nursing and the matron. The focus of the meetings included performance and staffing as well as any feedback from divisional meetings. We were told that these meetings were not minuted. However, there were plans to maintain an action log of agenda items discussed with clear actions for attendees. Any concerns were escalated and discussed at the departmental monthly meeting.

There were weekly divisional operational team meetings where performance and compliance were discussed. These meetings included urgent and emergency care issues such as human resources, finance, exception reports, incidents, business continuity and any other key updates

Governance meetings were conducted across the division monthly. These were attended by a range of senior clinicians and managers across the emergency department and medical wards. There were standard agenda items that included review of the most recent meeting minutes, action log and review of the most recent quality and assurance report. There were updates from a variety of sources. These included the acquired kidney injury (AKI) group and the sepsis group. Other items included stroke, incident reviews, morbidity and mortality (M & M), infection, prevention and control, the CQC improvement plan for the department and division, any policy, guideline and audit updates, patient experience feedback and any other business required.

The divisional quality and safety committee minutes, held monthly, were shared at the governance meetings. Agenda items such as falls, pressure ulcers and medicines issues were reported as well as incidents and the risk register.

Mortality and morbidity meetings were held monthly. We were provided copies of lessons learned from these incidents and saw that these were related to areas such as ambulance handover delays, insufficient staffing, challenges with capacity, triage process, pathways use and failure to escalate.

The same day emergency care (SDEC) and frailty units were open for a limited period of hours and closed at 11pm. At the time of the inspection the available beds within the hospital were held during the day to accommodate patients that needed to be admitted to the hospital. We observed that there were plans for acutely ill patients in the department to be transferred to wards, however; there were patients in the frailty unit who required overnight beds. The trust were reviewing access to SDEC as part of the NHSE's same day emergency care group where opening hours were submitted. There were workforce and financial challenges achieving the required seven day service.

Urgent and emergency services

Management of risk, issues and performance

Leaders and teams used systems to manage performance; however, this was not always effective. Local leaders identified and escalated relevant risks and issues in order to identify actions to reduce their impact. They had plans to cope with unexpected events.

From the divisional risk register there were 14 risks included for the emergency department. One of these was categorised as high risk, nine were moderate and four were either low or very low. These included the impact to patient safety due to a lack of stroke co-ordinators, nursing management and prevention of pressure ulcers, risk of harm for avoidable falls and risk of patient harm due to patient / service demand outweighing capacity within the department. Staff we spoke with were concerned that there was no shared risk through the hospital; it was all held in the department. The copy of the risk register that we were provided with did not include details of mitigations taken to reduce risks. The risk register was included in the quality and assurance report that was discussed at governance meetings.

There was a range of bed meetings and safety huddles held throughout the day with shift leaders and operational leaders to review capacity in the department and throughout the hospital. We attended these meetings, but actions were limited following these. During a busy time when 11 ambulances were waiting outside the department, concerns were escalated with an outcome of increasing status to OPEL 4. Since September 2023, OPEL 4 had been declared four times.

The full capacity protocol had been enacted and on-going since 27 September. The protocol referred to enactment between 8am and 4pm. We asked senior leaders about why these times had been chosen. They told us that this was when more senior staff would be available to manage the situation within the trust and also external partners. Out of hours there were on call manager, senior nurse and executives onsite if required.

Senior leaders reported their main concerns in the department, as congestion due to the numbers of patients either in or waiting to be seen, numbers of patients with mental health conditions attending and delays in ambulance handovers. They highlighted that flow through the hospital was an issue that had impacted on their ability to transfer patients to ward areas, particularly to medical wards. Doctors assigned to medical wards were allocated to the department to see patients who had been waiting a number of hours for a bed.

Divisional managers told us that additional winter meetings had been stood up and planned to be in place until January 2024. Additional escalation areas were being considered that included the cardiac catheterisation area and the elective day surgery area.

Divisional leaders were asked if they had considered the Bristol model. This was a model to help with flow in a department out into the rest of the hospital. This had been reviewed and discussed with a previous executive team. The trust had developed their own accelerated transfer of care and enhanced boarding model. The ward environments were not suitable to accommodate the Bristol model ,therefore it was an on-going piece of work.

The service had created a new role of progress chaser. There were now two on each shift to support flow. Clinical staff reported that they were having a positive supportive impact

There was an incident coordination centre plan, a business continuity plan and prevent strategy policy. The business continuity policy and the incident response plan encompassed the critical incident plan, major incident plan and response to business continuity incidents. However, we were not assured these were completely embedded.

Urgent and emergency services

There had been a major incident declared in the weeks prior to the inspection when the department was on standby to potentially receive trauma casualties. Staff we spoke with told us that plans worked well. At that time the department was busy, but patients were swiftly relocated to create the space to receive casualties from the incident.

The trusts systems were working to sight leaders on the areas for improvement in the service. There was a range of audit data available, however actions were not progressed at pace to address identified risks.

The low compliance rates for audits such as for infection, prevention and control and emergency equipment checks matched the findings of the inspection which meant the action taken to make improvements was not effective.

Despite a sepsis improvement group since June 2022, across the division, performance had declined and compared poorly when benchmarked against other regional NHS trust hospitals.

Results from Royal College of Emergency Medicine audits showed the trust were below the national standard for a number of audit standards submitted.

Staff shared a concern regarding that if starting a shift in the middle of day often the nearest car park to the department was often full meaning a distance to walk at the end of a shift in darkness. Staff had escalated and been told to request escort from security staff. There was a trust wide lone working policy, but this only referred to management of an incident.

Information Management

The service collected data, however; this was not always effective. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The service monitored live activity in the department through an electronic dashboard that was accessible to staff and particularly shift leaders.

There were nurses' stations where computers were positioned, however staff told us there were insufficient numbers for the number of staff requiring access. At the last inspection a new electronic system had been implemented. This system was now embedded.

Staff completed information governance training as part of mandatory requirements. Compliance overall was 81.43%. For additional professional scientific and technic

compliance was 0%, additional clinical services were 73.68%, administrative and clerical were 83.33% and registered nurses were 80.97%.

The service submitted data regarding performance to external regulators as well as national audit information to external organisations. We requested additional data, following the inspection; this was either not available or not always in a format that was easy to assess.

Engagement

Local leaders and staff actively and openly engaged with staff but not patients. They collaborated with partner organisations to help improve services for patients.

Local leaders engaged with staff at handover times and throughout shift times as needed. Staff received communications at safety huddles and via email / trust-wide communications.

From the staff survey 2022, the urgent care division that includes the emergency department, responses were either better or similar to other areas of the organisation. There were a number of actions outlined in the divisional plan that included workforce, modelling, roles and responsibilities, culture and morale, sharing and learning from incidents, doctors on-boarding process review, culture and morale for nurses, 'walking the wards' for feedback. There was a renewed focus on staff wellbeing with head of nursing drop in sessions and weekly check ins. Junior doctors told us they felt supported by their seniors.

Trust-wide occupational health and psychological support were available for staff. 'Hot de-briefs' were held with staff in the event of a serious incident. There was a trust wide excellence report. This was included in the electronic systems where staff could show their recognition of good practices and care.

The service contributed to trust-wide engagement with external stakeholders locally, however; it was unclear about what engagement there was with stakeholders, in Wales, where a number of attending patients lived. This was impacting on the pressures in the service.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services although improvement projects were having limited impact.

The emergency department improvement strategies and plans were part of the trust's priorities to help improve quality and safety at the hospital. Updates were provided to the board via the trust quality and safety committee. There were monthly meetings with regular updates in their report.

There was a focus on the estates (optimising utilisation of estate to provide a safe environment to support patients, staff and effective flow), workforce (nursing and medical), culture and morale and processes. The overall aim was to improve the four hour performance to 76% by April 2024.

There was an extensive plan for this clinical vision project that included a timeline of all aspects of the trust's progress with the improvement work. This showed that some actions had been completed but others were in progress.

An improvement project was initiated in May 2023 for: "Eliminating delayed handovers and improving the initial assessment of patients at COCH". However, the project had had limited success as handovers continued to be delayed.

The trust had sought external support from NHS England's Emergency Care Improvement Support Team (ECIST) with the redesign of the department and more recently to help reduce ambulance handover times. A rapid improvement week was undertaken in October 2023 where conveyances were directed to same day emergency care (SDE) where appropriate.

The trust had been collaborating with the local NHS ambulance provider regarding options included 'fit2sit', increased direct conveyance to SDEC and improved handover times.

Other plans included relocating the urgent treatment centre and workforce away from the department along with minor injuries services. On the follow-up visit the UTC had moved to an alternate base at the hospital.

Urgent and emergency services

A project for improvements in the triage process had been carried out, however currently challenges due to patient numbers.

Medical care (including older people's care)

Requires Improvement ➔➔

Is the service safe?

Requires Improvement ➔➔

Our rating of safe stayed the same. We rated it as requires improvement.

Mandatory Training

The service provided mandatory training in key skills but not all staff completed it, this was particularly evident for resuscitation training.

Nursing staff and medical staff did not keep up to date with their mandatory training. At the time of our inspection, mandatory training compliance for staff within the urgent care division was 85% for nursing staff and 70% for medical staff. The trust target of 90% had not been achieved.

The mandatory training offer for staff was comprehensive and would have met the needs of patients and staff if compliance rates were met. The training covered topics such as infection prevention control, moving and handling, fire safety, equality diversity and inclusion, health and safety and information governance.

Staff received life support training for adults and children. However, the nursing staff compliance rate for basic life support (BLS) was 75%. The medical staff compliance rate for BLS was 65%. Trust data showed that some nursing staff and medical staff within the urgent care division had completed immediate life support (ILS) and advanced life support (ALS) training, however the trust did not provide overall compliance rates or details of the number of staff who were required to undertake this training. This meant the trust did not evidence that sufficient staff had the training required to undertake their role.

Clinical staff were required to complete Oliver McGowan training on learning disabilities and autism. Trust data showed that compliance across the trust was 66%.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. However, not all staff had completed training on how to recognise and report abuse.

Safeguarding training compliance for level 1 and 2 adults and children was 88% which was just below the trust's target. However, nursing staff compliance for level 3 safeguarding children was 30% and medical staff compliance was 9% which was significantly below the trust's target. The trust did not submit data for level 3 safeguarding adults.

Trust data showed that some nursing staff and medical staff within the urgent care division had completed safeguarding think family training, however the trust did not provide overall compliance rates or details of the number of staff who were required to undertake this training. This meant the trust did not evidence that sufficient staff had the training required to undertake their role.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Medical care (including older people's care)

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. They knew how to make a safeguarding referral and who they could contact if they had concerns.

The safeguarding and complex care team supported staff to keep patients safe. We saw examples of this in the patient records we reviewed.

Safeguarding information was displayed on notice boards throughout the hospital.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. Staff did not always use control measures to protect patients, themselves and others from infection. However, they kept equipment and patient areas visibly clean.

The service did not always control infection risk well. We were told that domestic staff were responsible for flushing water through hand wash basins, sinks, baths and toilets on the wards to reduce the risk of legionella bacteria and other harmful organisms in the water supplies. Each ward had a checklist to monitor compliance. However, during our inspection we saw toilets, sinks and showers that were not in use and looked as though no water had been flushed through them for a significant amount of time on ward 34, ward 50 and ward 51. On ward 51 there was a storage room with a toilet that was visibly dirty and had an unpleasant odour.

Staff did not always follow infection control principles. For example, on ward 50 and ward 51 we observed staff not routinely using hand sanitiser when entering and exiting the ward. In addition, we were told that medical staff had to be frequently reminded of 'bare below elbows' guidance when on the wards.

Infection prevention and control level 1 training compliance was 98%. Nursing staff compliance for level 2 infection prevention and control was 86%. Medical staff compliance was 76%.

Infection prevention and control audits of wards were carried out. They included inspections of the ward environment, ward kitchen, handling & disposal of linen, departmental waste, management of equipment, safe handling & disposal of sharps, hand hygiene, personal protective equipment and isolation precautions. From May to September 2023 results were between 82% and 98% and these audit scores contributed to overall ward accreditation scores.

Staff had access to adequate supplies of personal protective equipment (PPE).

Patient areas on the medical wards were visibly clean and we observed staff cleaning during our inspection. Cleaning records were up to date and demonstrated that all patient areas were cleaned regularly.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Staff used green 'I am clean' stickers to indicate equipment that had been cleaned and was ready for use.

The side rooms where patients were being treated for an infection, or were at risk of infection, had doors which could be closed. All doors were closed during the time of our inspection.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe.

Following the last inspection CQC issued a requirement notice for the medical care core service to ensure that fire exits were clear from obstruction and well maintained. The service had implemented fire exit door safety checklists across

the wards to monitor compliance. However, during this inspection we saw fire exit doors on ward 50 and ward 51 were obstructed with equipment. We were told this was due to lack of storage space. This issue was also noted in the trust's fire risk assessments. We escalated these concerns to senior leaders during our inspection and immediately again post inspection. Senior leaders told us that matrons were responsible for completing daily checks of fire exit doors. We were also told that 'keep clear' signage was to be fitted to all ground floor fire escapes across the hospital.

Some of the wards were cluttered with equipment. For example, on ward 50 the storage room was not accessible due to the door being blocked by a laundry trolley. Staff on some of the wards told us that the environment was challenging due to limited space. Results from the May to September 2023 ward environment audits showed an average of 78% compliance across the wards. However, ward 45 and ward 50 scored below 60% for the same time period.

The service had enough suitable equipment to help them safely care for patients. We reviewed a sample of equipment such as defibrillators, suction machines and blood pressure monitors which had stickers to indicate that they had been serviced within the last 12 months. We saw portable computers across the wards which allowed staff to access electronic systems in all areas.

In specialist areas such as stroke, cardiology and acute medical unit (AMU), there was monitoring equipment that was connected to central consoles so staff could monitor remotely. We observed any alarms being responded to promptly.

Staff mostly completed daily safety checks of specialist equipment. Resuscitation trolley checks were audited on a quarterly basis. Trust data showed that from July to September 2023 the medical wards achieved around 92% compliance.

Patients could reach call bells from their beds and call bells in the toilets and wash areas which were in suitable places for a patient to reach if they needed assistance. During our inspection we observed staff attending to patients promptly when a call bell had sounded.

Medical wards were made up of a mix of side rooms and bays. A number of medical wards had side rooms and bays which were not visible from the nurse's station. Staff told us that bay nursing was used as this allowed for increased observation of patients who may be at risk of falls.

At the entrance to each ward there was a notice board which displayed staffing numbers for each shift. There were care boards which highlighted the number of days since the last fall incident, hospital acquired pressure ulcer and healthcare-associated infection.

Staff disposed of clinical waste safely. Sharps bins were clean, not overfilled and were partially closed when not in use. However, not all sharps bins had been dated from the date they had first been used.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

The trust had a teletracking system that was an electronic system that showed the patients in each area. Patients were given a tracker, on admission, to wear alongside their wrist name band. This meant that if a patient left the ward, for example to attend x-ray, staff knew their location. Staff could also track movement on the ward.

Medical care (including older people's care)

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Observations of vital signs were recorded by staff and the national early warning score (NEWS2) were calculated. These were recorded electronically. In the records we reviewed we found that any rise in the score had been escalated appropriately. We were told that the electronic system alerted staff if the score was 3 or above. However, results from the monthly audits undertaken two months prior to the inspection showed an average of 72% compliance with NEWS2 processes within the urgent care division. Audits showed poor compliance with commenced fluid balance charts.

Patients who scored a NEWS2 of 5 or above were automatically assessed for sepsis, staff understood the importance of recognising the signs of sepsis early and knew how to escalate a patient so that they would receive treatment quickly. Medical wards had posters which alerted staff to the sepsis screening tool and the urgency for antibiotics of patients who had shown red flags.

From the trust's most recent sepsis screening and treatment of inpatients audit data provided, it was shown that for patients who had red flagged for sepsis 75% had NEWS2 recorded within one hour of hospitals admission and 75% had received antibiotics within one hour of being diagnosed.

Staff were able to describe the process for escalation of a deteriorating patient. They would continue to monitor the patient and escalate to a doctor and the nurse in charge.

Staff completed sepsis training as part of their mandatory training requirements. Nursing staff and medical staff compliance within the urgent care division was 80%.

Staff we spoke with knew about and dealt with any specific risk issues. Staff completed risk assessments for each patient on admission using a recognised tool, and reviewed this regularly, including after any incident. Risk assessments included falls, pressure ulcers and nutrition. Results from the most recent falls assessment and pressure ulcer assessment audits showed an average of 90% compliance within the urgent care division. Despite high compliance with falls risk assessments completion, the service continued to experience high numbers of incidents where patients experienced falls with harm.

The medical wards achieved around 71% compliance for VTE assessment completion from April to September 2023.

Patients who had a particular enhanced need were identified by discreet symbols on the teletracking boards. Symbols such as the dementia flower or footprints for pressure area care were used to alert staff that the patients had additional needs. Tissue viability nurses were available to advise, for example pressure relieving mattresses or frequency of need for repositioning.

Staff shared key information to keep patients safe when handing over their care to others.

Shift changes and handovers included all necessary key information to keep patients safe. We observed safety huddles and handovers where key information about patients on the wards was given to staff verbally and in written format including patients at risk of falls or confusion, patients with pressure ulcers, diabetes management, nutrition and hydration and patients who had a 'do not attempt cardio-pulmonary resuscitation' (DNACPR) in place.

The service had 24-hour access to mental health liaison and specialist mental health support. However, some staff told us that there were delays in accessing the service due to limited resources.

Patients requiring specialist support such as non-invasive ventilation (NIV), were nursed in areas where staff had the correct competencies.

In the endoscopy unit, staff completed the World Health Organisation (WHO) checklist. We received copies of audits from August 2023 that showed that there was 100% compliance except for one audit were a de-brief had not taken place at the end of the procedure list.

Nurse staffing

The service did not always have enough nursing and support staff to keep patients safe from avoidable harm and to provide the right care and treatment. However, managers gave bank and agency staff a full induction.

Managers calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift using a safer staffing tool.

We reviewed staffing fill rates from April to September 2023. For registered nurses, the average fill rate during the day was 101% and 102% at night. For unregistered staff, the average fill rate was 97% during the day and 111% at night.

Despite fill rates showing positive fulfilment, staff across the wards told us that recent staffing reviews had identified gaps in registered nurse to patient ratios. During our inspection, we saw some wards staffed between 1:10 and 1:12 nurse to patient ratios.

The trusts nurse safer staffing report for January to June 2023, identified 8 medical wards working outside of the recommended registered nurse to patient ratios of 1:8. The AMU, ward 34, ward 50, ward 51 and the modular ward were identified as areas of immediate concern. The report also identified gaps in the percentage of registered staff to unregistered staff within a ward establishment.

The trust had taken remedial actions to minimise risks. For example, a 28 bedded escalation area was closed in August 2023 resulting in staffing establishments being increased on the 5 wards identified as areas of immediate concern.

The service had a hyperacute stroke unit which was used to care for patients for the first 72 hours following a stroke. However, the service was an outlier locally and nationally in terms of provision of service hours and allocated staffing establishment. See the management of risk, issues and performance section of the report.

All newly qualified registered nurses undertook a period of preceptorship following the induction programme during which time a period of supernumerary status was applied and additional support was given by the practice development nurses.

The urgent care division had an over recruited registered nursing workforce by 14.69 whole time equivalent (WTE). However, there were 49.61 WTE vacancies for healthcare support workers.

From July 2022 to June 2023, the average staff turnover rate for this service for registered nurses was 8.4% and for unregistered staff 13.1%. This was higher than the trust's average.

The sickness rate across the division was 5.8%.

Medical care (including older people's care)

The trust had high rates of bank and agency nurse usage. However, data received from the trust was not broken down by division as requested. Therefore, the trust was unable to establish the percentage of shifts filled via bank and agency staff on the medical wards.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave locum staff a full induction.

The service had enough medical staff to keep patients safe.

From July to September 2023, there were 200 WTE doctors of all grades planned in the medical wards. The actual number was 189.2 doctors. We were told that gaps in medical staffing rotas were filled with regular locums and agency staff.

Staff we spoke with said there was sufficient cover during working hours and out of hours.

The junior doctors we spoke with told us they received good support and could easily access middle grade or consultant support if needed.

Managers made sure locums had a full induction to the service before they started work.

The service had a good skill mix of medical staff on each shift and reviewed this regularly.

The service always had a consultant on call during evenings and weekends. There was a physician of the week and a cardiologist of the week.

Ward rounds took place daily and more frequently in speciality areas. Consultants for speciality areas attended wards daily. There was medical presence on the acute medical unit throughout the day and doctors were easily accessible out of hours.

At the time of our inspection, there were 12.8 medical staff vacancies across the medical wards.

The staff turnover rate across the urgent care division was around 9%.

The sickness rate across the division was around 3%.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, and easily available to all staff providing care.

Patient notes were comprehensive, and all staff could access them easily. Records consisted of both electronic and paper notes. During our inspection of the medical wards we looked at a total of 26 patient records, and we found that records were completed comprehensively by staff.

The electronic system contained relevant risk assessments bundles such as falls, nutrition, pressure ulcers and sepsis. Risk assessments had been carried out when patients had been admitted to the wards and DNACPR and deprivation of liberty safeguard (DoLS) forms had been completed correctly if needed.

When patients transferred to a different area of the hospital, there were no delays in staff accessing their records. Staff told us that all patient records were easily accessible.

Electronic record systems were accessed through computers throughout the ward. These computers were username and password protected. Staff ensured that computers were locked when they were not attended. However, paper records were not always stored securely. During our inspection, we saw paper records left unattended on ward 44 and ward 60.

Staff were frustrated about how the electronic record system had been implemented and said that the training provided was not sufficient. Senior leaders were aware of these concerns and told us there were plans in place for additional staff training to be provided.

Medicines

The service did not always use systems and processes to prescribe, administer, record and store medicines safely. Staff did not always follow trust policy to ensure people were safe when given medicines that required additional monitoring.

Staff did not store and manage medicines safely. On AMU, we found infusion fluids stored on open shelving in a clinic room and accessible to non-nursing staff. The ambient temperature of clinic rooms was not monitored, meaning we were not assured medicines were stored in line with manufacturers guidelines. On ward 44, we found the medicines fridge had been outside of the required temperature range (2–8°C) on most days over a number of months with no action taken. This meant the trust could not be assured that the medicines in the fridge were suitable for use.

In addition, we found an unlocked storage room containing thickener, nutritional drinks and alcohol gel on ward 45. The door lock was broken, meaning patients and visitors could access this storage room. The dangers of this were shared in a national alert to all NHS trusts provided in 2015 in the '2015 Patient safety alert – Risk of death from asphyxiation by accidental ingestion of fluid/food thickening powder'. These concerns were escalated to the ward manager who was not aware of the patient safety alert.

An electronic system was used to prescribe and administer medicines. On two wards we visited, pharmacy staff supported the nursing teams with administering medicines to people. We found people's allergy status was recorded on prescription documents to reduce the risk of them receiving a medicine that had previously caused an adverse reaction. However, when we reviewed records for one person who had their medicines given covertly, hidden in food or drink, we found there was insufficient information to support staff to safely administer the medicines. The person's covert administration care plan had not been reviewed in a timely manner.

Staff did not always follow trust policy to ensure people were safe when given medicines that required additional monitoring. We saw two people were administered a medicine to control or restrain their behaviour, with one person given their medicine via injection. A policy was in place to ensure a person was monitored appropriately following administration of the medicine. However, we found staff did not always follow the policy. We were therefore not assured people were safe following an injection of a sedative medicine.

Medical care (including older people's care)

The wards we visited received a service from the pharmacy team who provided support with medicines where appropriate. The pharmacy team reviewed the monitoring of certain antimicrobials to support the clinical staff with the on-going prescribing of these medicines.

Staff used the trust's electronic system to record the administration of medicines. We reviewed seven people's records and saw they were all complete. We found one person's VTE assessment had not been completed. The nurse highlighted this to the doctor when we shared our observation.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. Pharmacy staff were present on a number of the wards to review and reconcile people's medicines to ensure the medicines they were prescribed were correct. The pharmacy team had processes in place to prioritise people prescribed medicines critical to their health, for example people with epilepsy or needing insulin.

The trust completed electronic audits for oxygen therapy. In September 2023, the urgent care division scored 66% with an average of 69% for the previous 12 months. Audits showed poor compliance with prescribing.

Incidents

Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

All staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy.

From August 2022 to July 2023, 13 serious incidents were reported in relation to medical care. The most frequent type of incidents were treatment delay and slips, trips and falls.

For the same reporting period, the service reported 2 never events. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

During our inspection, we saw on the ward performance boards that a high number of falls had occurred on the medical wards. Trust data showed that from April to September 2023, 412 falls had been reported on the wards. Around 53% of falls occurred on AMU, ward 34, ward 50 and ward 51. Senior leaders told us that patient falls had been identified as an issue and this was recorded on the divisional risk register. The trust had a falls reduction workstream as part of a wider harm reduction programme. The workstream had resulted in a 27% reduction in inpatient falls with moderate harm or above since January 2023. The trust's target was a 40% reduction by the end of December 2023.

Learning from incidents was shared with staff across the service and division through monthly sharing and learning forums. The objectives of the forums were sharing of initiatives to improve patient care, educational opportunities, identifying opportunities to learn from incidents and identifying opportunities to improve patient safety. Staff told us that incidents and learning were also discussed during handovers and safety huddles.

Medical care (including older people's care)

Staff understood the duty of candour. 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 'notifiable safety incidents' and provide reasonable support to that person. Staff we spoke with were aware of the term and the principle behind the regulation and could give examples of when the duty of candour would be applied.

Is the service effective?

Requires Improvement 

Our rating of effective stayed the same. We rated it as requires improvement.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed policies and guidelines to plan and deliver care. Staff could view policies on the trusts intranet system and on the wards. Most of the policies we reviewed during this inspection were in date and had a review date, however this was not clear in the healthcare waste policy and medicines policy.

A sample of pathways and guidelines were reviewed during the inspection, including stroke, sepsis and deteriorating patient; these were found to be in line with national guidance.

Stroke coordinators had received training in the National Institute of Health Stroke Score (NIHSS). This assessment tool is used to evaluate and document neurological status in acute stroke patients. In addition, 9 staff members on the acute stroke unit had completed Stroke Training and Awareness Resources (STARs) training.

The endoscopy service was accredited by the Joint Advisory Group on gastrointestinal endoscopy.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. During our inspection, we saw staff providing patients with food and drinks.

Nutritional status boards were situated on all the wards we visited which included information about patients' dietary requirements such as if they were "nil by mouth" or required soft food.

Notice boards promoting the importance of nutrition and hydration were displayed on the wards that we visited.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Staff completed the Malnutrition University Screen Tool (MUST) for each patient, this screening tool is used to identify patients who are malnourished or at risk of malnutrition. The tool includes management guidelines which can be used to develop a care plan. If a patient scored high on the assessment, then staff would request input from the dietetics team.

Results from the September 2023 MUST audit showed an average of 67% compliance across ward 34, ward 52 and AMU. Audits showed poor compliance with patients being weighed in the last 7 days and a MUST being recorded on admission / transfer to a ward.

Patients had choice of food they were given and there were optional menus for patients who had specific dietetic or religious requirements. The ward we visited had protected mealtimes, which allowed nurses and clinical support workers to be available to support patients who may need it.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice.

Patients we spoke with told us they had received pain relief soon after requesting it.

Staff prescribed, administered and recorded pain relief accurately.

Pain management information was displayed on notice boards on some of the wards we visited such as AMU.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes.

The service participated in relevant national clinical audits such as the national audit of myocardial ischaemia, diabetes, heart failure and falls. We saw evidence of action plans to show that any identified concerns were being addressed appropriately.

The service also participated in local clinical audits such as a dementia and delirium care in the general hospital, compliance against trust policy for mental capacity act & deprivation of liberty safeguards and processes for caring for patients with a learning disability and/or autism.

The service submitted their audit data for the Sentinel Stroke National Audit Programme (SSNAP) (measures the quality and organisation of stroke care in the NHS). Between April and June 2023 inclusive, the overall patient centred SSNAP level was B out of a scale A to E, of which A is the best. This level had improved from the previous quarter where the trust scored a C.

For patient centred and team centred indicators the trust had improved their score to a B. However, on both indicators the stroke unit was rated E which was the worst score available. This suggested there was an issue with patients receiving appropriate care through timely admission to the stroke unit. Trust data showed that only around 34% of stroke patients got to the stroke unit within four hours of arrival at the hospital in the last quarter. In addition, the national aspirational thrombolysis target rate of 20% had been achieved twice in the last 12 months.

The medical wards participated in the trust's ward accreditation programme. The programme measured performance in relation to the CQC 5 key domains of safe, effective, caring, responsive and well-led. Each ward was awarded a rating ranging from white, bronze, silver, gold and platinum. The awarded rating determined the frequency of assessments. At the time of our inspection, most of the medical wards were rated gold meaning they would be reassessed within a 12-month period. The ward accreditation programme did not fully reflect the findings of our inspection including the concerns in quality and safety on specific wards.

The urgent care division used standardised electronic audits to measure the quality of nursing care delivered by services and specialties across the trust. The audits covered topics such as patient safety, nutrition and hydration, pressure ulcers, medicines management and infection control. We requested audit results for the last 6 months, however we were told that the audits had been revised in August 2023 and no data was available prior to this period. The trust was able to provide examples of audits completed in August and September 2023.

Hospitals measure the average number of actual nursing care hours spent with each patient per day. On average similar trusts in the region spend 9.7 hours with patients per day. However, across the urgent care division at the Countess of Chester Hospital nurses spent 6.7 hours per day with patients.

Managers shared and made sure staff understood information from the audits. Managers told us that information gained from audits would be shared through staff meetings and group emails.

Competent staff

The service made sure staff were competent for their roles. However, there were gaps in management and support arrangements for staff, such as staff appraisals.

Managers gave all new staff a full induction applicable to their role before they started work. All staff employed by the trust attended an induction programme, designed with the necessary competencies for the relevant speciality and monitored on the trusts electronic systems. Staff training was assessed as part of the ward accreditation scheme.

The practice development nurses supported the learning and development needs of staff which included both newly qualified and international nursing recruits.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. If staff members were not able to attend a team meeting the meeting minutes were shared through group email, to allow staff the opportunity to keep up to date with any changes or learning which had been highlighted.

Managers identified any training needs their staff had and supported staff to improve. For example, we were told there had been several reported pressure ulcer incidents on ward 34, therefore a tissue viability nurse (TVN) had visited the ward to provide additional training.

Managers did not always support staff to develop through yearly, constructive appraisals of their work. The data provided showed that 68% of nursing and medical staff across the urgent care division had received an appraisal in the last 12 months.

Staff we spoke with on some of the wards said there were limited training opportunities due to training courses being fully booked. Staff felt this had an impact on patient care and treatment, for example discharges being delayed due to staff not being trained in taking blood samples.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care.

Staff worked across health care disciplines and with other agencies when required to care for patients such as with mental health liaison or community stakeholders.

Patients had their care pathway reviewed by speciality or general consultants dependent on the reason for admission. Ward rounds were multidisciplinary including doctors, advanced nurse practitioners, dieticians, occupational therapists, physiotherapists, discharge to assess staff and rapid response teams.

Staff we spoke with commented on the positive culture throughout the medical wards, they said they felt there was good team working across all clinical staff.

Seven-day services

Key services were not always available 7 days a week.

The urgent care division had systems to help care for patients in need of additional support or specialist intervention, but these services were not always available 24 hours a day, 7 days a week. The trust provided a dedicated stroke service to patients for Chester, Cheshire West and Flintshire, however the stroke coordinator service operated from 8am to 8pm with no cover out of hours. Any suspected stroke or delivery of stroke care out of hours was managed by the emergency department and wards with support from the non-resident on call stroke consultant.

Speech and language therapy teams were available 5 days per week, for stroke patients who had been admitted at the weekend the SALT team had trained stroke nurses to carry out swallowing and dysphagia assessments so that stroke patients could get assessments in a timely manner.

The hospital had a Same Day Emergency Care (SDEC) service to provide same day urgent assessment, tests, diagnosis and treatment for patients who would otherwise be admitted to hospital. The service was located at the front of the hospital, adjacent to the emergency department. The service operated from 9am to 11pm Monday to Friday and accepted GP referrals until 7pm, although there were occasions where the service closed to admissions earlier than 7pm during periods of high usage. This was observed during the inspection.

Consultants led daily ward rounds on all wards during weekdays. Patients were reviewed by consultants depending on the care pathway. We requested audit data for patients having a multidisciplinary assessment within 14 hours of admission but did not receive any data from the trust.

Staff called for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, 7 days a week.

The endoscopy service was available Monday to Friday.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on the wards and units. Information leaflets were readily available for patients.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. However, not all staff knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. We observed staff gaining informed consent before treatment or a procedure was carried out, such as taking blood pressure.

When patients lacked capacity to give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions.

Staff made sure patients consented to treatment based on all the information available.

Staff clearly recorded consent in the patients' records. During our inspection we reviewed 26 sets of patient records. Patient consent had been obtained and documented correctly where appropriate.

We reviewed five DNACPR forms during our inspection, the forms were all completed correctly. The forms included information on a reason why the DNACPR had been put in place, if a discussion had been had with the patient and where the patient lacked capacity a discussion was documented with a family member.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards.

On wards we saw flow charts explaining the mental capacity and deprivation of liberty safeguards processes. From August to October 2023, the trust's safeguarding and complex care team received 233 urgent Deprivation of Liberty Safeguards applications. However, results from the most recent Mental Capacity Act & Deprivation of Liberty Safeguards (DoLS) audit showed poor compliance with 67% of urgent DoLS applications not meeting the trust's standard. The main reasons for non-compliance where the assessment of capacity was not compliant with the act and all relevant sections of the urgent authorisation were not completed.

Staff received training in the Mental Capacity Act and Deprivation of Liberty Safeguards. However, we were told this was covered in the safeguarding think family training. See the safeguarding section of the report for compliance rates.

Medical care (including older people's care)

Is the service caring?

Good

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed kind, caring interactions between patients and staff. Staff explained to patients what they were doing when providing care and treatment.

Patients said staff treated them well and with kindness. Patients told us that communication was good and that staff knew a lot of information about their care and treatment which was shared with them.

We saw staff interact with patients who were living with dementia in a calm and caring manner.

During consultations with nursing or medical staff, curtains and doors were closed which ensured privacy for patients.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Between October 2022 and September 2023, the trust recorded 31 compliments from patients for the medical wards.

The results of the CQC survey for inpatient services, in 2022, showed that the trust performed well in 'information about medicines to take at home', 'communication between staff and patients', 'quality of food' and 'patients understanding their care after leaving hospital'. However, the trust did not perform well in 'patients waiting to get a bed', 'patients needing help when getting washed and dressed' and 'patients changing wards during the night'.

The service had implemented an action plan in response to the survey which included recommendations and actions.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it and supported patients who became distressed in an open environment and helped them maintain their privacy and dignity.

Staff utilised private rooms to discuss sensitive details or for breaking bad news.

The hospital had a chaplaincy service and a bereavement service which staff could access to provide support to patients and their relatives.

Medical care (including older people's care)

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

We saw comments on the wards notice boards which included positive feedback from patient relatives regarding the exceptional end of life care provided by staff.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. Patients we spoke with during our inspection understood their treatment plans and were involved in decision making about their care.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Information on how to provide feedback was displayed on notice boards across the medical wards.

Patients gave positive feedback about the service. Thank you cards from patients and their families were displayed on the wards we visited.

Is the service responsive?

Requires Improvement 

Our rating of responsive stayed the same. We rated it as requires improvement.

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

The services facilities and premises were not always appropriate for the services being delivered. The service did not always meet the needs of local people and the communities served.

Staff knew about and understood the standards for mixed sex accommodation (MSA), however during our inspection we saw MSA breaches on the stroke unit and AMU. Staff told us that MSA breaches were reported on the electronic reporting system. Trust data showed that there had been 23 reported MSA breaches across the medical wards in the last 12 months.

The service had wards with specialities such as cardiology, respiratory and endoscopy where staff with specialist skills were available including advanced nurse practitioners.

The premises and facilities were not always appropriate for the services being delivered. Significant demands on services caused some patients to be placed as medical outliers across the wards meaning care was not always being delivered to patients by the right ward speciality. At the time of our inspection there were 66 medical outliers across the medical wards. Senior leaders told us that medical outliers were one of the biggest challenges for the division however this was not recorded on the divisional risk register.

Medical care (including older people's care)

Staff were able to access emergency mental health support 24 hours a day, 7 days a week for patients with mental health problems. There was a mental health liaison service and the trust's main location was co-located with the mental health trust. However, some staff told us that there were delays in accessing the service due to limited resources.

The service had systems to help care for patients in need of additional support or specialist intervention. Appropriate notification systems were in place to 'flag' patients who had specific or complex needs, including a learning disability so staff could ensure the right support was in place.

The hospital had an integrated discharge team who supported patients with their discharge from hospital, where care and support needs had been identified. However, there were challenges for the provision of care in the community across the region, which impacted on the trust's ability to discharge patients.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff supported patients living with dementia and learning disabilities by using 'this is me' documents and patient passports that included the dementia flower. The service audited patient records to check information relating to dementia and delirium of care. However, results from the most recent audit showed 58% compliance. The service also audited patient records to check information relating to learning disabilities and/or autism. Results from the most recent audit showed 50% compliance. We saw evidence of recommendations in response to these audits.

The service made reasonable adjustments to allow additional visiting for some patients for example those in the last hours of their life, or who required a carer due to their condition. The service used signage to indicate if patients were at end of life and tried to provide a side room for them.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss.

We observed an area which had been adapted to meet the needs of dementia patients when approaching wards 50 and 51. This included a dayroom that was decorated in the style of a living room and there was an enclosed garden attached. We saw walking frames painted red to identify patients who may have a cognitive impairment.

The service had information leaflets that were easily accessible on all wards visited. On the stroke unit patients were given information packs from the Stroke Association to help with recovery.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. The trust had an interpretation and translation service which was available 24 hours a day, seven days a week.

Patients were given a choice of food and drink to meet their cultural and religious preferences.

We visited the discharge lounge where patients waited for transport after they had been discharged. Patients were offered hot and cold drinks and if there were long delays waiting for their transport then food was offered.

We received feedback from patients on some of the wards that they were experiencing boredom. During our inspection we saw limited evidence of activity coordinators supporting staff on the wards.

Medical care (including older people's care)

The results of the CQC survey for inpatient services, in 2022, showed that the trust scored worse than expected, when compared to other trusts for: “Noise from other patients, patients being bothered by noise at night from other patients”.

Access and flow

People could not always access the service when they needed it and receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards.

Managers did not always ensure that patients could access services when needed to receive treatment within agreed timeframes and national standards.

Data from quarter 2 in 2023/2024 showed that 55% of cancer patients received treatment within two weeks of referral from their GP. This was below the national target of 93% and below the national average performance for all regions which was 74%.

For the same time period 91% of cancer patients received treatment within 31 days of referral from their GP. This was below the national standard of 96% but above the national average of 90%. In addition, 66% of patients received treatment within 62 days of referral. This was below the national standard of 85% but above the national average of 59%.

The trust did not achieve the NHS England 28-day Faster Diagnosis Standard (FDS). Data showed that the trust treated 56% of patients within 28 days of referral. This was below the national standard of 75%.

The SDEC service opened in December 2022 and treated patients who had been referred by a GP or transferred from the emergency department. The service was split into medical, frailty and surgical specialties and had access to nursing and medical cover. In September 2023, SDEC treated 318 medical care patients with a hospital admission rate of 27%, 160 frailty patients with an admission rate of 38% and 347 surgical patients with an admission rate of 34%. Senior leaders told us that the SDEC service had a positive impact in avoiding unnecessary hospital admissions. However, they acknowledged that the service was still in the process of embedding patient pathways and extra resources were required to help relieve pressure on the emergency department.

The AMU was open 24 hours, seven days a week and had access to medical cover. The purpose of the unit was to allow patients to be ‘streamed’ in a timely way from the emergency department and to help reduce admissions to the main wards. However, we found from inspecting the emergency department that the trust experienced regular ongoing challenges in admitting patients in a timely manner to AMU. Large numbers of patients waited hours in the emergency department to be admitted. For example, we observed patients waiting in excess of 60 hours after the decision to admit had been made.

We were told that patients sometimes stayed too long in AMU due to bed capacity constraints on the other wards. Trust data showed that from April to September 2023 the average length of stay on AMU was 2.3 days. However, during our inspection we saw evidence of longer lengths of stay on AMU.

Bed management meetings were held three times per day. These were held online and included discussion on patient moves, discharge plans and use of escalation areas.

Medical care (including older people's care)

From April to September 2023, the average length of stay for elective and non-elective admitted patients at the hospital was 4.7 days. However, we saw evidence of much longer lengths of stay on the wards we visited. We were told that patients could spend several months on the medical wards.

Senior leaders told us the patient with no criteria to reside list was monitored daily. During our inspection on 17 to 19 October the trust identified between 123-145 patients as having no criteria to reside in the hospital. There were between 40-54 discharges per day which left an average of 87 patients per day still in hospital with no criteria to reside. There were weekly meetings to review those patients who had a long length of stay. At the time of our inspection we were told around 31% of patients were medically optimised to leave hospital but were unable to do so as they were waiting for further assessments or care packages.

From our observations and discussions with staff the trust was doing everything reasonably practicable to discharge patients. Senior leaders escalated concerns with the wider system and how it had impacted patient access and flow. The service produced a monthly no criteria to reside and long length of stay report which included data, trajectories, internal actions and system actions.

Staff we spoke with told us the biggest challenges to discharging patients were those who required ongoing care in a nursing home or who needed complex packages of care. There was some difficulty in accessing providers who could accept these patients.

Staff did not always plan patients' discharge carefully. This was evident from the number of patient discharges between 5pm and midnight. Trust data showed that in September 2023, 443 patients were discharged from the hospital after 5pm.

Staff moved patients between wards at night. Trust data showed that from April to September 2023, there were 1147 bed moves after 8pm within the urgent care division at the hospital.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns.

The service clearly displayed information about how to raise a concern in patient areas. The service had a patient advice and liaison service (PALS) and displayed information to direct patients how to make a complaint if they needed to.

From October 2022 to September 2023 the service received 31 formal complaints and 431 concerns. However, there was limited evidence about individual complaints or if responses were timely.

Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes. Information from the trusts most recent complaints and PALS quarterly report stated that the top three concern themes for the urgent care division were communication, clinical treatment and appointment issue.

Medical care (including older people's care)

The outcomes from complaints were shared at the daily safety huddle meetings so that staff could learn and improve patient safety and experience.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Managers told us about sharing the experience of people who have complained. They have recently brought people back to share their experiences with staff to enable them to identify what they could have done better.

Managers shared feedback from complaints with staff and learning was used to improve the service.

Staff could give examples of how they used patient feedback to improve daily practice.

Is the service well-led?

Requires Improvement 

Our rating of well-led stayed the same. We rated it as requires improvement.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The medical wards were part of the urgent care division at the trust. This included urgent and emergency care services and inpatient medical wards. There was a leadership team for the urgent care division that included nursing, operational and medical leaders.

The trust was developing leaders to provide career progression and succession planning. There were training courses including the lead for leaders programme.

Ward managers said they were supported by the senior leaders. We were told the head of nursing and matrons completed weekly walkarounds to communicate with staff on the wards and increase visibility.

We saw that wards recorded when members of the senior team had visited. Records showed that the head of nursing and matrons visited the wards weekly and the divisional director of nursing and director/deputy director of nursing had visited the wards in the last 3 to 6 months.

On the wards and units that we visited during the inspection we saw that there was strong clinical leadership from the ward managers and the matrons. Staff told us that they were supported and valued by these managers, and they were proud of the work that they did.

Vision and Strategy

The service did not have a fully developed or implemented vision and strategy at the time of our inspection.

Medical care (including older people's care)

The trust had developed a vision and strategy for 2021 to 2026 called 'Five Year Strategy' with the vision of improving the lives of the community and provide excellence in healthcare, through partnership and innovation. This strategy focussed on four key areas including clinical, people, digital and value. This strategy had limited impact on the direction of services and the trust was shortly due to launch a new strategy earlier than expected, and shortly after the inspection.

The urgent care division did not have a vision and strategy and senior leaders told us this was due to changes at trust executive level. Senior leaders told us the aim for the division was to support staff and continue to develop a range of networks to achieve this.

The stroke unit had a mission statement of 'committed to valuing every person and patient, family carer, relative and staff members.

Staff we spoke with during the inspection were not aware about the current strategy and objectives of the division.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff told us the culture on the wards was positive and they reported good teamwork and morale. We observed staff working together to benefit care and treatment for patients and those close to them. Staff supported each other and individual wards had social media groups to contact each other. Staff were recruited from the local areas and internationally and care was given to any pastoral needs.

The NHS staff survey results, in 2022, showed staff in the urgent care division scored similar to the overall trust score on being compassionate and inclusive, recognised and rewarded, having a voice that counts and being a team. The trust's staff survey results showed generally poorer levels of satisfaction in most questions compared to other trusts nationally.

The trust had numerous staff support networks including wellbeing, faith and belief, women, carers, LGBTQ+ and BAME (black and minority ethnic network which was a group for staff from the ethnic minority group). The trust had recently recruited an equality and diversity lead to promote all aspects of equality and diversity both clinically and non-clinically.

The division had a staff wellbeing lead and senior leaders told us there were plans in place to create a staff wellbeing hub off site.

The division offered incentives such as vouchers or gift cards for employee of the month. Staff could also nominate healthcare support workers for the 'STAR' awards which included categories for sensational service, tremendous teamwork, admirable attitude and remarkable dedication.

Most staff told us they felt able to raise concerns with their line manager and most felt they were supported and encouraged to develop.

Senior leaders commented on the high levels of resilience shown by staff, they believed staff had risen to the challenges that had been presented over the last 12 months. All staff were seen to be keen to get involved in improvement of the service.

Staff were committed to improving care for patients and learning from when things went wrong.

Medical care (including older people's care)

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There were effective governance processes in place in the service. Leaders attended governance committee and divisional committee meetings. The divisional governance committee meetings took place monthly and were led by the associate medical director, however meetings were stood down if unable to proceed due to operational pressures. We reviewed the minutes of a recent governance committee meeting. These included key discussions around workforce, current risks, clinical effectiveness, and performance issues in relation to each speciality area.

The divisional quality and safety committee minutes, held monthly, were shared at the governance meetings. Agenda items such as falls, pressure ulcers and medicines issues were reported as well as incidents and the risk register.

Learning from deaths meetings were held monthly where mortality indices were reviewed. There was senior executive representation as well as clinical staff from the trust divisions and the medical examiner. Mortality indicators were presented and reviewed at these meetings.

Senior leaders and consultants met with colleagues from the therapies and integrated community care division to discuss, share and identify learning.

Team meetings were held on the wards and staff had the opportunity to add agenda items.

Staff we spoke with understood what their individual roles and responsibilities were, what they were accountable for and to whom they were accountable. Staff told us that they were provided with information relating to learning and performance via themes of the week, safety huddles and staff meetings.

There were daily system overview meetings, trust wide. These monitored information such as numbers of patients who did not meet the criteria to reside and were awaiting packages of care in the community.

Management of risk, issues and performance

Leaders and teams had systems to manage performance, however, did not always identify relevant risks and issues and identify actions to reduce their impact.

Leaders were sighted on the areas for improvement in the service through effective auditing. There remained significant issues and risks in the service requiring further action from leaders. Recent audits flagging with low compliance included audits of the ward environment, NEWS2, sepsis, oxygen therapy, Mental Capacity Act & Deprivation of Liberty Safeguards (DoLS), dementia and delirium of care and learning disabilities and/or autism. Our inspection found most audits had an action plan although the actions were still to be started or needed more time to have an impact.

In July 2022, impact to patient safety due to lack of stroke coordinators was added to the urgent care division risk register and remained on the risk register at the time of our inspection. This risk was classified as high risk. A business case was submitted in August 2022 to outline the gaps in stroke coordinator provision and to deliver stroke care out of hours. Following a further 4 incidents associated with delay in treatment for stroke patients the business case was revised in June 2023 highlighting the significant clinical risk and impact to patient safety for those patients who attend the hospital out of hours when there is no stroke coordinator service present. We saw no evidence of actions taken to reduce the risk to patients.

The business case also stated that the hyperacute stroke unit was an outlier locally and nationally in terms of provision of service hours and allocated staffing establishment.

During our inspection staff told us they had escalated concerns around their ability to manage patients who were aggressive and violent on the wards. Trust data showed that from April to September 2023, 385 incidents had been reported within the urgent care division relating to security, for example 'abuse patient to patient' and 'abuse patient to staff'. We were told that conflict resolution training had only recently been made mandatory within the trust, however this training was not available until quarter 3 in 2024/2025.

Senior leaders were unable to confirm when de-escalation training would be provided to staff. This issue was not recorded on the divisional risk register.

The service faced additional risks due to low compliance rates with specific modules of mandatory training. Staff were not always provided with appropriate appraisal and supervision.

We were told the risk register was reviewed on a quarterly basis. However, the risk register did not include details of mitigations taken to reduce risks. There were 13 overdue risks on the register relating to medical care, with review dates ranging from July to September 2023. The risk register was included in the quality and assurance report that was discussed at governance meetings.

Senior leaders were able to describe their top risks which were access and flow, lack of stroke coordinators impacting service provision, patient falls and nursing and management of pressure ulcers.

The trust had issues with access and flow and delayed discharges and there was evidence of work ongoing across the urgent care division to make improvements. For example, the trust held regular Multi Agency Discharge Events (MADE) to bring together the local health system to support improved patient flow across the system and recognise and unblock delay challenges and improve and simplify complex discharge processes. The trust had developed community services such as the hospital at home service to provide care and rehabilitation for patients at their home. The trusts rapid response team provided input into the service to improve delayed discharges.

Ward managers were aware of the risks in their areas of work and were able to verbalise these and the plans in place to mitigate these risks. Whilst access and flow was an issue for ward managers, they told us about their risks specific to their ward which included pressure ulcers and falls. They had action plans in place to try to mitigate the risks.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Staff received training on information governance as part of their mandatory training, and the compliance rate across the urgent care division was 81%. Staff could access policies, procedures and clinical guidelines through the trust intranet site. Staff told us they could access patient information and up to date national best practice guidelines and prescribing formularies when needed.

Senior staff in the division used data to review performance of their wards. This provided oversight of patient safety and patient experience. Support could be given to areas where it was needed. This was disseminated to matrons and ward managers.

There was data available to ward managers that provided the outcomes of the ward accreditation outcomes. These formed the basis of the action plans for improvement for each ward which were monitored at division level.

In the 6 months prior to inspection, there were 25 incidents recorded for the medical wards for information governance. The trust reported 7 incidents to the NHS England Data Security and Protection Toolkit. All organisations that have access to NHS patient data and systems must use this toolkit to provide assurance that they are practising good data security and that personal information is handled correctly.

Engagement

Leaders and staff actively and openly engaged with staff and some stakeholders to plan and manage services.

Ward managers and matrons used feedback from patients as part of the ward accreditation process.

Leaders engaged with staff at handover times and throughout shift times as needed. Staff received communications at safety huddles and via email / trust wide communications.

There was limited evidence to show that the service engaged regularly with patients to plan and manage services.

The trust worked with Healthwatch to monitor and understand feedback about service provision and to make changes as necessary.

Trust wide occupational health and psychological support were available for staff. 'Hot debriefs' were held with staff in the event of a serious incident. There was a trust wide excellence report. This was included in the electronic systems where staff could show their recognition of good practices and care.

The service contributed to trust wide engagement with external stakeholders locally, however it was unclear about what engagement there was with stakeholders in Wales where a number of attending and admitted patients lived. This was impacting on access and flow throughout service.

The division had implemented action plans in response to the NHS staff survey results 2022. Actions included learning from incidents, sharing good practice and staff wellbeing. However, the actions were overdue with no updated information regarding progress.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them.

The trust had developed a 'Continuous Improvement Strategy' for 2020 to 2025. The strategy had been developed through a series of workshops with trust colleagues and users of trust services. The aim of the strategy was to create a culture in which staff working at the Countess of Chester Hospital NHS Foundation Trust come to work to 'do their work' and to 'improve their work'.

There was a culture of learning in the division and we saw that staff at all levels wanted to improve services for patients and their relatives.

Medical care (including older people's care)

We saw that there were quality improvement projects taking place across the division and that staff were participating in these projects. They were using plan do study act cycles to support the quality improvement. For example, improving suction check compliance in AMU and improving the evening medical handover across the wards.

The trust had a preceptorship programme for band 5 nurses. In addition, unregistered staff had the opportunity to participate in apprenticeship programmes for development and progression.

The ward accreditation process supported continual improvement to services.

Ellesmere Port Hospital

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Description of this hospital

Ellesmere Port Hospital is one of two hospital sites managed by the Countess of Chester Hospital NHS Foundation Trust. The hospital provides medical care services, outpatient services, rehabilitation and intermediate care to patients over 65 years age. Patients admitted to this hospital no longer require acute medical support.

There is a small outpatient facility shared with other community services and a community diagnostic hub containing X Ray, CT, and MRI. The x-ray department is close by with two rooms available.

The hospital has three inpatient rehabilitation wards.

The Bluebell Ward is a general rehabilitation ward with 24 beds across 5 bays and 3 side rooms.

The Stroke Ward is a stroke rehabilitation ward with 16 beds across 3 bays and 3 side rooms. Neurotherapy staff also work closely with patients on this ward.

The Poppy Ward is a general rehabilitation ward with 19 beds across 4 bays and 2 side rooms.

We visited Ellesmere Port Hospital as part of our unannounced inspection of the Countess of Chester Hospital NHS Foundation trust on 17 to 19 October 2023. During this inspection, the team inspected the following core service at Ellesmere Port Hospital:

- Medical care (including older people's care)

Medical care (including older people's care)

Requires Improvement ↓

Is the service safe?

Requires Improvement ↓

Our rating of safe went down. We rated it as requires improvement.

Mandatory Training

The service provided mandatory training in key skills but not all staff completed it, this was particularly evident for resuscitation training.

Nursing staff and medical staff did not keep up to date with their mandatory training. At the time of our inspection, mandatory training compliance for staff within the therapies and integrated community care division was 82% for nursing staff and 81% for medical staff. The trust target of 90% had not been achieved.

The mandatory training offer for staff was comprehensive and would have met the needs of patients and staff if compliance rates were met. The training covered topics such as infection prevention control, moving and handling, fire safety, equality diversity and inclusion, health and safety and information governance.

Staff received life support training for adults and children. However, the nursing staff and medical staff compliance rate for basic life support (BLS) was 74%. Trust data showed that some nursing staff and medical staff within the therapies and integrated community care division had completed immediate life support (ILS) and advanced life support (ALS) training, however the trust did not provide overall compliance rates or details of the number of staff who were required to undertake this training. This meant the trust did not evidence that sufficient staff had the training required to undertake their role.

Clinical staff were required to complete Oliver McGowan training on learning disabilities and autism. Trust data showed that compliance across the trust was 66%.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. However, not all staff had completed training on how to recognise and report abuse.

Safeguarding training compliance for level 1 and 2 adults and children was 89% which was just below the trust's target. However, nursing staff compliance for level 3 safeguarding children was 38% and medical staff compliance was 50% which was significantly below the trust's target. The trust did not submit data for level 3 safeguarding adults.

Trust data showed that some nursing staff and medical staff within the therapies and integrated community care division had completed safeguarding think family training, however the trust did not provide overall compliance rates or details of the number of staff who were required to undertake this training. This meant the trust did not evidence that sufficient staff had the training required to undertake their role.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Medical care (including older people's care)

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. They knew how to make a safeguarding referral and who they could contact if they had concerns.

The safeguarding and complex care team supported staff to keep patients safe. We saw examples of this in the patient records we reviewed.

Safeguarding information was displayed on notice boards throughout the hospital.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves, and others from infection. They kept equipment and the premises visibly clean.

Rehabilitation wards were visibly clean, and we observed staff cleaning during our inspection. Cleaning records were up to date and demonstrated that all areas were cleaned regularly.

There were hand wash sinks across all the rehabilitation wards we visited including posters which displayed the correct hand washing technique.

Staff followed infection control principles including the use of personal protective equipment (PPE). There was adequate supply of masks, aprons, and gloves. We observed staff wearing the correct PPE and donning and doffing before entering and on leaving a patient's room.

Infection prevention and control compliance was monitored as part of monthly audits. From April to September 2023 compliance across the rehabilitation wards was around 98%.

The side rooms where patients were being treated for an infection, or were at risk of infection, had doors which could be closed. All doors were closed during the time of our inspection.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Staff used green 'I am clean' stickers to indicate equipment that had been cleaned and was ready for use.

Infection prevention and control level 1 training compliance was 93%. Nursing staff and medical staff compliance for level 2 infection prevention and control training was 77%.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe.

During our inspection we saw fire exit doors on the stroke rehabilitation ward and bluebell ward were obstructed with equipment. There were fire exit door grilles on all fire exits across the rehabilitation wards. We escalated these concerns to senior leaders during our inspection and immediately again post inspection. They took prompt action by implementing risk assessments for the fire exit door grilles and adding fire exit door safety checks to daily checklists.

We found unlocked storage rooms and unlocked cupboards containing substances that were hazardous to health on bluebell ward and the stroke rehabilitation ward.

Some of the wards were cluttered with equipment. For example, on the stroke rehabilitation ward there was an area called memory lane cluttered with wheelchairs. There was equipment including chairs and a bed linen trolley on the corridors on poppy ward. We requested results from ward environment audits, but the trust could not provide this.

The service had enough suitable equipment to help them safely care for patients. We reviewed a sample of equipment such as defibrillators, suction machines and blood pressure monitors which had stickers to indicate that they had been serviced within the last 12 months. We saw portable computers across the wards which allowed staff to access electronic systems in all areas.

Staff mostly completed daily safety checks of specialist equipment. Resuscitation trolley checks were audited on a quarterly basis. Trust data showed that from July to September 2023 the rehabilitation wards achieved around 95% compliance.

Patients could reach call bells from their beds and call bells in the toilets and wash areas which were in suitable places for a patient to reach if they needed assistance. During our inspection we observed staff attending to patients promptly when a call bell had sounded.

Rehabilitation wards were made up of a mix of side rooms and bays: these were not visible from the nurse's station. Staff told us that bay nursing was used as this allowed for increased observation of patients who may be at risk of falls.

At the entrance to each ward there was a notice board which displayed staffing numbers for each shift. There were care boards which highlighted the number of days since the last fall incident, hospital acquired pressure ulcer and healthcare-associated infection.

Staff disposed of clinical waste safely.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. However, staff did not always identify patients at risk of deterioration.

Staff used the nationally recognised national early warning scores (NEWS2) tool to identify deteriorating patients. Observations of vital signs were recorded by staff and the national early warning score (NEWS2) were calculated. These were recorded electronically. In the records we reviewed we found that any rise in the score had been escalated appropriately. We were told that the electronic system alerted staff if the score was 3 or above. However, results from the monthly audits undertaken two months prior to the inspection showed an average of 14% compliance with NEWS2 processes within the therapies and integrated community care division. Audits showed poor compliance with commenced fluid balance charts, documentation of escalation and frequency of observations.

Patients who scored a NEWS2 of 5 or above were automatically assessed for sepsis, staff understood the importance of recognising the signs of sepsis early and knew how to escalate a patient so that they would receive treatment quickly. Rehabilitation wards had posters which alerted staff to the sepsis screening tool and the urgency for antibiotics of patients who had shown red flags.

From the trust's most recent sepsis screening and treatment of inpatients audit data provided, it was shown that for patients who had red flagged for sepsis 75% had NEWS2 recorded within one hour of hospitals admission and 75% had received antibiotics within one hour of being diagnosed.

Staff were able to describe the process for escalation of a deteriorating patient. They would continue to monitor the patient and escalate to a doctor and the nurse in charge. For patients requiring urgent and emergency care staff would call the emergency services to arrange for transfer to the Countess of Chester Hospital.

Staff completed sepsis training as part of their mandatory training requirements. However, nursing staff and medical staff compliance within the therapies and integrated community care division was 65%.

Staff we spoke with knew about and dealt with any specific risk issues. Staff completed risk assessments for each patient on admission using a recognised tool, and reviewed this regularly, including after any incident. Risk assessments included falls, pressure ulcers and nutrition. Results from the most recent falls assessment and pressure ulcer assessment audits showed an average of 97% compliance within the division.

The rehabilitation wards achieved 97% compliance for VTE assessment completion from April to September 2023.

On the rehabilitation wards there was a patient board in each nursing bay which provided a clear oversight of their individual risks. For example, there was information relating to NEWS2, nutrition and hydration, position changes, and one to one status. There was a system for highlighting patients who had complex needs, for example patients living with dementia had a flower on their board.

Staff shared key information to keep patients safe when handing over their care to others.

The service had access to mental health liaison and specialist mental health support Monday to Friday.

Nurse staffing

The service had enough nursing and support staff to keep patients safe from avoidable harm and to provide the right care and treatment. Managers gave bank and agency staff a full induction.

Managers calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift using a safer staffing tool.

We reviewed staffing fill rates from April to September 2023. For registered nurses, the average fill rate during the day was 101% and 102% at night. For unregistered staff, the average fill rate was 98% during the day and 129% at night.

Staff were frequently moved across the rehabilitation wards to meet skill mix requirements and to support the wards with the highest acuity level of patients when required.

Staff across the wards told us that the level of patient acuity at the hospital had increased. Senior leaders regularly reviewed their staffing establishment and a paper had been submitted to the executive team to increase the staffing establishment at night.

All newly qualified registered nurses undertook a period of preceptorship following the induction programme during which time a period of supernumerary status was applied and additional support was given by the practice development nurses.

The therapies and integrated community care division had a registered nursing vacancy gap of 1.49 whole time equivalent (WTE). However, due to supernumerary and maternity leave there was an actual working gap of 3.49 WTE.

For unregistered staff, the division had a vacancy gap of 12.02 WTE and a working gap of 13.02 WTE.

From July 2022 to June 2023, the average staff turnover rate for this service for registered nurses was 8.4% and for unregistered staff 13.1%. This was higher than the trust's average.

The sickness rate across the division was 4.5%.

The trust had high rates of bank nurse usage. However, data received from the trust was not broken down by division as requested. Therefore, the trust was unable to establish the percentage of shifts filled via bank staff on the rehabilitation wards.

Medical staffing

The service did not always have enough medical staff to keep patients safe from avoidable harm and to provide the right care and treatment.

The service had a medical workforce of 3 advanced clinical practitioners (ACP) and a middle grade doctor during working hours. The service had a registrar on call during evenings and weekends. This meant that nursing staff had clinical oversight of patients during evenings and weekends. Senior leaders told us there was minimal impact to patient safety as patients at the hospital were medically optimised and were on a rehabilitation pathway.

In the event of unexpected staff absences cover was provided by doctors or advanced clinical practitioners from the hospital at home team.

Staff we spoke with said there was not enough medical staff to provide care for the acuity of patients. ACP's were often required to provide cover across two wards during their shift.

Senior leaders told us that medical staffing was one of the biggest challenges for the division. There was a shortage of doctors and ACPs and this impacted patient discharges.

Ward rounds took place weekly and were led by consultants for speciality areas. We were told that consultants were available for support and advice throughout the week.

We requested medical staff vacancy, turnover and sickness data for the division; however, the trust could not provide this.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, and easily available to all staff providing care.

Patient notes were comprehensive, and all staff could access them easily. Records consisted of both electronic and paper notes. During our inspection of the rehabilitation wards, we looked at a total of 20 patient records, and we found that records were completed comprehensively by staff.

The electronic system contained relevant risk assessments bundles such as falls, pressure ulcers and sepsis. Risk assessments had been carried out when patients had been admitted to the wards and DNACPR and Deprivation of Liberty Safeguard (DoLS) forms had been completed correctly if needed.

When patients transferred to a different area of the hospital, there were no delays in staff accessing their records. Staff told us that all patient records were easily accessible.

Electronic record systems were accessed through computers throughout the ward. These computers were username and password protected. Staff ensured that computers were locked when they were not attended. However, paper records were not always stored securely. During our inspection, we saw paper records left unattended on the stroke rehabilitation ward.

Staff were frustrated about how the electronic record system had been implemented and said that the training provided was not sufficient. Senior leaders were aware of these concerns and told us there were plans in place for additional staff training to be provided.

Medicines

The service did not always use systems and processes to prescribe, administer, record and store medicines safely.

Staff did not store and manage medicines safely. We saw 2 different infusion bags were stored in the same drawer with no divider meaning there was a risk that the incorrect infusion might be given to a person. We also saw the temperature of the clinic rooms where medicines were stored were not monitored. The trust was working to have systems in place to monitor the clinic room temperatures.

An electronic system was used to prescribe and administer medicines. However, staff did not always prescribe and administer medicines safely. On bluebell ward pharmacy staff supported the nursing teams with administering medicines to people. However, we saw one person was prescribed insulin to be given before breakfast. Staff told us they had breakfast around 8am, however insulin was not given until 10am. We also saw one person was prescribed a medicine to be given before food, however they were given this medicine after breakfast which could reduce the medicine's absorption. We reviewed records for one person who received their medicines covertly, hidden in food or drink. The trust's process was not followed because the person's covert medicines administration care plan had not been reviewed. This meant there was no specific information available for all of their medicines to support staff to safely administer them.

People's allergy status was recorded on prescription documents to reduce the risk of them receiving a medicine that had previously caused an adverse reaction. We reviewed 4 people's records and saw they were all complete.

The wards we visited received a service from the pharmacy team who provided support in relation to medicines where appropriate. We saw people had a Venous thromboembolism (VTE) assessment completed and when appropriate were prescribed medicines to reduce the risk of them developing a VTE.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. There was a process in place to reconcile people's medicines on admission to the wards.

Incidents

Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

All staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy.

Medical care (including older people's care)

From April to February 2023 the service reported 149 incidents. Out of the 149 reported incidents, 8 were classified as moderate or severe harm. The most frequent type of incidents was 'lack of staff' (17 incidents), 'physical abuse' (13 incidents) and 'unwitnessed fall' (17 incidents).

The service had reported no never events on any wards. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

Learning from incidents was shared with staff across the service and division through monthly sharing and learning forums. The objectives of the forums were sharing of initiatives to improve patient care, educational opportunities, identifying opportunities to learn from incidents and identifying opportunities to improve patient safety. Staff told us that incidents and learning were also discussed during handovers and safety huddles.

Senior leaders told us there had been a decrease in the number of reported falls and pressure ulcer incidents as a result of quality improvement initiatives. Trust data showed from April to September 2023, 24 falls and 20 hospital acquired pressure ulcers had been reported on the wards. The service introduced the 'call don't fall' system, gave patients gripped socks and used red pillow cases for patients identified at risk of developing a pressure ulcer. Tissue viability nurses were available to support staff on the wards.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong.

Is the service effective?

Requires Improvement ↓

Our rating of effective went down. We rated it as requires improvement.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed policies and guidelines to plan and deliver care. Staff could view policies on the trust's intranet system and on the wards. Most of the policies we reviewed during this inspection were in date and had a review date, however this was not clear in the healthcare waste policy and medicines policy.

A sample of pathways and guidelines were reviewed during the inspection, including stroke, sepsis and deteriorating patient; these were found to be in line with national guidance.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. Staff were able to explain what mental capacity was and how they assessed for this. At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers.

Medical care (including older people's care)

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. During our inspection, we saw staff providing patients with food and drinks.

Nutritional status boards were situated on all the wards we visited which included information about patients' dietary requirements such as if they were "nil by mouth" or required soft food.

Notice boards promoting the importance of nutrition and hydration were displayed on the wards that we visited.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Staff completed the Malnutrition Universal Screening Tool (MUST) for each patient, this screening tool is used to identify patients who are malnourished or at risk of malnutrition. The tool includes management guidelines which can be used to develop a care plan. If a patient scored high on the assessment, then staff would request input from the dietetics team.

The service did not provide audit data relating to MUST compliance.

Patients had choice of food they were given and there were optional menus for patients who had specific dietetic or religious requirements. The ward we visited had protected mealtimes, which allowed nurses and clinical support workers to be available to support patients who may need it.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice.

Patients we spoke with told us they had received pain relief soon after requesting it.

Staff prescribed, administered and recorded pain relief accurately.

Patient outcomes

There was limited evidence that the therapies and integrated community care division monitored the effectiveness of care and treatment and used the findings to make improvements and achieved good outcomes for patients.

The service participated in some local clinical audits. However, the trust did not provide data to evidence how the therapies and integrated community care division monitored patient outcomes and effectives of care and treatment to achieve good outcomes for patients on the rehabilitation pathway.

Senior leaders told us they reviewed patient outcome data in monthly governance meetings. However, we did not see evidence of this in the meeting minutes we reviewed.

The rehabilitation wards participated in the trust's ward accreditation programme. The programme measured performance in relation to the CQC five key domains of safe, effective, caring, responsive and well-led. Each ward was awarded a rating ranging from white, bronze, silver, gold and platinum. The awarded rating determined the frequency of assessments. At the time of our inspection all 3 rehabilitation wards were rated gold meaning they would be reassessed within a 12-month period. The ward accreditation programme did not fully reflect the findings of our inspection including the concerns in quality and safety on specific wards.

The division used standardised electronic audits to measure the quality of nursing care delivered by services and specialties across the trust. The audits covered topics such as patient safety, nutrition and hydration, pressure ulcers, medicines management and infection control. We requested audit results for the last 6 months, however we were told that the audits had been revised in August 2023 and no data was available prior to this period. The trust was able to provide examples of audits completed in August and September 2023.

Managers shared and made sure staff understood information from the local audits. Managers told us that information gained from audits would be shared through staff meetings and group emails.

Competent staff

The service made sure staff were competent for their roles. However, there were gaps in management and support arrangements for staff, such as staff appraisals.

Managers gave all new staff a full induction applicable to their role before they started work. All staff employed by the trust attended an induction programme, designed with the necessary competencies for the relevant speciality and monitored on the trusts electronic systems. Staff training was assessed as part of the ward accreditation scheme.

The practice development nurses supported the learning and development needs of staff. The hospital had practice development nurses in place who had assisted in the development in both newly qualified and international nursing recruits.

Managers did not always support staff to develop through yearly, constructive appraisals of their work. The data provided showed that 72% of nursing and medical staff across the therapies and integrated community care division had received an appraisal in the last 12 months.

Staff we spoke with on some of the wards said there were limited training opportunities due to training courses being fully booked. Staff felt this had an impact on patient care and treatment particularly at weekends.

On review of meeting minutes, we saw no evidence that managers made sure staff attended team meetings or that staff had access to full notes when they could not attend.

Managers did not always support medical staff to develop through regular, constructive clinical supervision of their work. Medical staff said they often had to work on wards that were outside of their speciality and were frustrated about the lack of opportunities of working across both hospital sites.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care.

Medical care (including older people's care)

Staff worked across health care disciplines and with other agencies when required to care for patients such as with mental health liaison or community stakeholders.

Patients had their care pathway reviewed by speciality or general consultants dependent on the reason for admission. Ward rounds were multidisciplinary including doctors, advanced nurse practitioners, dieticians, occupational therapists, physiotherapists, discharge to assess staff and rapid response teams.

Staff we spoke with commented on the positive culture throughout the rehabilitation wards, they said they felt there was good team working across all clinical staff.

Seven-day services

Key services were not always available 7 days a week.

Rehabilitation services were not accessible to patients 7 days a week. The therapy team worked Monday to Friday. The service had systems to help care for patients in need of additional support or specialist intervention. Staff told us they worked closely with therapists and were aware of each patient's goals and they would encourage and assist patients with these.

Consultants led weekly ward rounds on all wards during weekdays. Patients were reviewed by consultants depending on the care pathway.

Staff called for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, 7 days a week.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on the wards and units. Information leaflets were readily available for patients.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. However, not all staff knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. We observed staff gaining informed consent before treatment or a procedure was carried out, such as taking blood pressure.

When patients lacked capacity to give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions.

Staff made sure patients consented to treatment based on all the information available.

Staff clearly recorded consent in the patients' records. During our inspection we reviewed 20 sets of patient records. Patient consent had been obtained and documented correctly where appropriate.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards.

On wards we saw flow charts explaining the mental capacity and deprivation of liberty safeguards processes. From August to October 2023, the trust's safeguarding and complex care team received 233 urgent Deprivation of Liberty Safeguards applications. However, results from the most recent Mental Capacity Act & Deprivation of Liberty Safeguards (DoLS) audit showed poor compliance with 67% of urgent DoLS applications not meeting the trusts standard. The main reasons for non-compliance where the assessment of capacity was not compliant with the act and all relevant sections of the urgent authorisation were not completed.

Staff received training in the Mental Capacity Act and Deprivation of Liberty Safeguards. However, we were told this was covered in the safeguarding think family training. See the safeguarding section of the report for compliance rates.

Is the service caring?

Good ➔➔

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed kind, caring interactions between patients and staff. Staff explained to patients what they were doing when providing care and treatment.

Patients said staff treated them well and with kindness. Patients told us that communication was good and that staff knew a lot of information about their care and treatment which was shared with them.

During consultations with nursing or medical staff, curtains and doors were closed which ensured privacy for patients.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

The trust collected data for the NHS Friends and Family test. From April to September 2023, the average satisfaction scores were 95.5% positive and 8.8% negative out of 239 responses. There were no CQC inpatient survey results for this service.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Medical care (including older people's care)

Staff gave patients and those close to them help, emotional support and advice when they needed it and supported patients who became distressed in an open environment and helped them maintain their privacy and dignity.

Staff utilised private rooms to discuss sensitive details or for breaking bad news.

The trust had a chaplaincy service and a bereavement service which staff could access to provide support to patients and their relatives.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

We saw comments on the wards notice boards which included positive feedback from patient relatives regarding the quality of care provided by staff.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. Patients we spoke with during our inspection understood their treatment plans and were involved in decision making about their care.

The hospital supported John's campaign, which supports the rights of people living with dementia to have a carer to advocate for them and be with them whenever they most need it.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Information on how to provide feedback was displayed on notice boards across the rehabilitation wards.

Patients gave positive feedback about the service. Thank you cards from patients and their families were displayed on the wards we visited.

Is the service responsive?

Requires Improvement ↓

Our rating of responsive went down. We rated it as requires improvement.

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

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Facilities and premises were appropriate for the services being delivered.

Medical care (including older people's care)

Leaders planned and organised services, so they met the changing needs of the local population. The hospital had 1 stroke rehabilitation ward and 2 general rehabilitation wards.

The service worked closely with the trust's rapid response team and hospital at home team which included specialist nursing and therapy assessments. The teams consisted of community support workers, nurses, physiotherapists and occupational therapists and provided care and rehabilitation for patients at their home.

Senior leaders told us that the hospital at home team managed around 50 patients in the community and helped avoid admissions to the emergency department.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. All wards inspected were adhering to the guidance regarding mixed sex accommodation.

Staff were able to access emergency mental health support 24 hours a day, 7 days a week for patients with mental health problems. There was a mental health liaison service and the trust's main location was co-located with the mental health trust.

The service had systems to help care for patients in need of additional support or specialist intervention. Appropriate notification systems were in place to 'flag' patients who had specific or complex needs, including a learning disability.

Significant demands on services caused medical outliers across the wards meaning care was not always being delivered to patients by the right ward speciality. At the time of our inspection there were 4 medical outliers on the stroke rehabilitation ward.

The trust had an integrated discharge team who supported patients with their discharge from hospital, where care and support needs had been identified. However, there were challenges for the provision of care in the community across the region, which impacted on the trust's ability to discharge patients.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff supported patients living with dementia and learning disabilities by using 'this is me' documents and patient passports that included the dementia flower. The service audited patient records to check information relating to dementia and delirium of care. However, results from the most recent audit showed 58% compliance. The service also audited patient records to check information relating to learning disabilities and/or autism. Results from the most recent audit showed 50% compliance. We saw evidence of recommendations in response to these audits.

The service made reasonable adjustments to allow additional visiting for some patients for example those in the last hours of their life, or who required a carer due to their condition. The service used signage to indicate if patients were at end of life and tried to provide a side room for them.

On the stroke rehabilitation ward, there was a room called 'Kate's Corner' which was a home from home environment created for dementia patients with the opportunity for family members to learn how to look after their loved ones. Relatives or carers could stay in the room alongside patients to learn relevant techniques under the supervision of hospital staff. The room had appropriate facilities including two beds, a television, bathroom and kitchen appliances. The décor had been designed to look and feel different from traditional clinical environments.

The hospital had an outside secure area with seating for patients and their relatives to sit if they chose.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss.

The service had information leaflets that were easily accessible on all wards visited. On the stroke rehabilitation unit patients were given information packs from the Stroke Association to help with recovery.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. The trust had an interpretation and translation service which was available 24 hours a day, seven days a week.

Patients were given a choice of food and drink to meet their cultural and religious preferences.

During our inspection we saw patients dressed and out of bed taking part in physiotherapy and therapeutic therapy. There were planned activities across all the wards. Activities included music reminiscing, baking, board games and art and crafts.

Access and flow

People could not always access the service when they needed it and received the right care promptly. During our inspection we saw evidence of long lengths of stay.

The service had a standard operating procedure (SOP) for the transfer of patients from the Countess of Chester Hospital to Ellesmere Port Hospital. The SOP outlined the main operating steps and admission criteria. All patients admitted to the hospital were medically optimised and had been identified as requiring ongoing rehabilitation by the trust's therapy teams.

The care coordinator was responsible for managing hospital admissions and discharges. Daily meetings were held to review capacity and admissions were planned 1 day in advance to ensure all necessary arrangements were in place. The service aimed to admit patients during the day, however staff told us that were occasions were patients were admitted to the hospital at night. Trust data showed that from April to September 2023, 65 patients were discharged from the hospital after 5pm.

Patients who deteriorated or required an enhanced level of care and treatment were discharged from Ellesmere Port Hospital and transferred to the emergency department at the Countess of Chester Hospital. However, we found from inspecting the emergency department that large numbers of patients waited hours in the emergency department to be admitted. For example, we observed patients waiting in excess of 60 hours after the decision to admit had been made.

We were told that the expected length of stay at the hospital was between 7 to 21 days. However, trust data showed that from April to September 2023, the average length of stay for admitted patients on the general rehabilitation wards was 38 days. For the same reporting period, the average length of stay for patients on the stroke rehabilitation ward was 52.5 days.

Bed management meetings were held three times per day. These were held online and included discussion on patient moves, discharge plans and use of escalation areas.

Senior leaders told us the patient with no criteria to reside list was monitored daily. In addition, there were weekly meetings to review those patients who had a long length of stay. At the time of our inspection we were told around 28% of patients were on the no criteria to reside list.

From our observations and discussions with staff the trust was doing everything reasonably practicable to discharge patients. Senior leaders escalated concerns with the wider system and how it had impacted patient access and flow. The service produced a monthly no criteria to reside and long length of stay report which included data, trajectories, internal actions and system actions.

From April to September 2023, the trust's rapid response team supported with around 35% of hospital discharges.

Staff we spoke with told us the biggest challenges to discharging patients were those who required ongoing care in a nursing home or who needed complex packages of care. There was some difficulty in accessing providers who could accept these patients. There were additional issues presented due to delays in assessments to access social care.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns.

The service clearly displayed information about how to raise a concern in patient areas. The service had a patient advice and liaison service (PALS) and displayed information to direct patients how to make a complaint if they needed to.

From February to October 2023 the service received 3 formal complaints and 16 concerns. However, there was limited evidence about individual complaints or if responses were timely.

Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes. The outcomes from complaints were shared at the daily safety huddle meetings so that staff could learn and improve patient safety and experience.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Managers told us about sharing the experience of people who have complained. They have recently brought people back to share their experiences with staff to enable them to identify what they could have done better.

Managers shared feedback from complaints with staff and learning was used to improve the service.

Staff could give examples of how they used patient feedback to improve daily practice.

Is the service well-led?

Requires Improvement 

Medical care (including older people's care)

Our rating of well-led went down. We rated it as requires improvement.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The rehabilitation wards were part of the therapies and integrated community care division at the trust. The division was established in 2022. There was a leadership team for the division that included therapy, nursing, operational and medical leaders.

The trust was developing leaders to provide career progression and succession planning. There were training courses including the lead for leaders' programme.

Ward managers said they were supported by the senior leaders.

We saw that wards recorded when members of the senior team had visited. Records showed that the lead nurse and matrons visited the wards daily and the divisional director of nursing and director/deputy director of nursing had visited the wards in the last 3 to 6 months. We were told that the trust's Medical Director visited the hospital once per month and met with different staff groups.

On the wards and units that we visited during the inspection we saw that there was strong clinical leadership from the ward managers and the matrons. Staff told us that they were supported and valued by these managers, and they were proud of the work that they did.

Vision and Strategy

The service did not have a fully developed or implemented vision and strategy at the time of our inspection.

The trust had developed a vision and strategy for 2021 to 2026 called 'Five Year Strategy' with the vision of improving the lives of the community and provide excellence in healthcare, through partnership and innovation. This strategy focussed on four key areas including clinical, people, digital and value. This strategy had limited impact on the direction of services and the trust was shortly due to launch a new strategy earlier than expected, and shortly after the inspection.

The therapies and integrated community care division did not have a vision and strategy and senior leaders told us this was due to changes at trust executive level. Senior leaders told us the aim for the division was to support staff and continue to develop a range of networks to achieve this.

Staff we spoke with during the inspection were not aware about the current strategy and objectives of the division.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff told us the culture on the wards was positive and they reported good teamwork and morale. We observed staff working together to benefit care and treatment for patients and those close to them. Staff supported each other and individual wards had social media groups to contact each other. Staff were recruited from the local areas and internationally and care was given to any pastoral needs.

The NHS staff survey results, in 2022, showed staff in the therapies and integrated community care division scored higher than the overall trust score on being compassionate and inclusive, recognised and rewarded, having a voice that counts and being a team. The trust's staff survey results showed generally poorer levels of satisfaction in most questions compared to other trusts nationally.

The trust had numerous staff support networks including wellbeing, faith and belief, women, carers, LGBTQ+ and BAME (black and minority ethnic network which was a group for staff from the ethnic minority group). The trust had recently recruited an equality and diversity lead to promote all aspects of equality and diversity both clinically and non-clinically.

The division had a staff wellbeing lead and senior leaders told us there were plans in place to create a staff wellbeing hub on site.

The division offered incentives such as vouchers or gift cards for employee of the month. Staff could also nominate healthcare support workers for the 'STAR' awards which included categories for sensational service, tremendous teamwork, admirable attitude and remarkable dedication.

A nurse on bluebell ward had recently won the trusts 'Rising Star' award.

Most staff told us they felt able to raise concerns with their line manager and most felt they were supported and encouraged to develop.

Senior leaders commented on the high levels of resilience shown by staff, they believed staff had risen to the challenges that had been presented over the last 12 months. All staff were seen to be keen to get involved in improvement of the service.

Staff were committed to improving care for patients and learning from when things went wrong.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities. However, staff did not always have regular opportunities to meet, discuss and learn from the performance of the service.

Leaders attended governance committee and divisional committee meetings. The divisional governance committee meetings took place monthly and were led by the associate director or service delivery lead. However, meetings were stood down if unable to proceed due to operational pressures. We reviewed the minutes of a recent governance committee meeting. These included key discussions around workforce, current risks and performance issues in relation to each speciality area.

Senior leaders and consultants met with colleagues from the urgent care division to discuss, share and identify learning.

Staff we spoke with understood what their individual roles and responsibilities were, what they were accountable for and to whom they were accountable.

There were daily system overview meetings, trust wide. These monitored information such as numbers of patients who did not meet the criteria to reside and were awaiting packages of care in the community.

There was limited evidence that team meetings were regularly held on the wards. For example, there was no evidence of a team meeting being held on the stroke rehabilitation ward in 2023. No meetings had been held on Bluebell ward or Poppy ward in the last 6 months. We were told a professionals group had been created to discuss, share and identify learning, however we saw no evidence of this.

Ward managers told us that they felt Ellesmere Port Hospital was an afterthought and they did not feel involved in the trust's planning and review of services. Ward managers told us there were limited opportunities to attend management meetings due to them being held at the trust's headquarters.

Management of risk, issues and performance

Leaders and teams used systems to manage performance. They identified and escalated relevant risks and issues but actions to reduce their impact were not always effective.

Leaders were sighted on the areas for improvement in the service through effective auditing. There remained significant issues and risks in the service requiring further action from leaders. Recent audits flagging with low compliance included audits of NEWS2, Mental Capacity Act & Deprivation of Liberty Safeguards (DoLS), dementia and delirium of care and learning disabilities and/or autism. Our inspection found most audits had an action plan although the actions were still to be started or needed more time to have an impact.

The service faced additional risks due to low compliance rates with specific modules of mandatory training. Staff were not always provided with appropriate appraisal and supervision.

There was a division risk register with titles, risk levels and review dates. All risks were within the review date. However, the risk register did not include details of mitigations taken to reduce risks. We were told the risk register was reviewed on a monthly basis. The risk register was included in the quality and assurance report that was discussed at governance meetings.

Senior leaders were able to verbalise their top risks which were risks to patient safety for those patients who were discharged from the hospital and transferred to the Countess of Chester Hospital emergency department, medical staffing and delayed discharges.

Ward managers told us the biggest risk in their areas was delayed discharges. They escalated these concerns to the matron and the trusts integrated discharge team.

The trust had issues with access and flow and delayed discharges and there was evidence of work ongoing across the therapies and integrated community care division to make improvements. For example, the trust had developed community services such as the hospital at home service to provide care and rehabilitation for patients at their home. The trusts rapid response team provided input into the service to improve delayed discharges. Senior leaders told us about the work they were doing with system partners and local authorities to improve delayed discharges, however they acknowledged that there were gaps in relationships.

Medical care (including older people's care)

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure.

Staff received training on information governance as part of their mandatory training, and the compliance rate across the therapies and integrated community care division was 82%. Staff could access policies, procedures and clinical guidelines through the trust intranet site. Staff told us they could access patient information and up to date national best practice guidelines and prescribing formularies when needed.

Senior staff in the division used data to review performance of their wards. This provided oversight of patient safety and patient experience. Support could be given to areas where it was needed. This was disseminated to matrons and ward managers.

There was data available to ward managers that provided the outcomes of the ward accreditation outcomes. These formed the basis of the action plans for improvement for each ward which were monitored at division level.

Engagement

Leaders and staff actively and openly engaged with staff and some stakeholders to plan and manage services.

Ward managers and matrons used feedback from patients as part of the ward accreditation process.

The division used friends and family data for service improvement.

Leaders engaged with staff at handover times and throughout shift times as needed. Staff received communications at safety huddles and via email / trust wide communications.

The trust worked with Healthwatch to monitor and understand service provision and to make changes as necessary. Healthwatch had conducted an enter and view visit across the rehabilitation wards in quarter 4 2022/2023. The report highlighted areas of good practice such as ‘patients felt their health had improved during their stay’, ‘wards were clean and generally tidy’, ‘staff were highly regarded by the patients’ and ‘patients were treated with dignity and respect’. The report also included recommendations around discharge plans, notice boards, communal areas and activity plans. The service had implemented an action plan in response to the report.

The division had implemented action plans in response to the NHS staff survey results 2022. Actions included increased learning and career development opportunities, improved communication, staff wellbeing, upgrading of the staff canteen and flexible working.

Trust wide occupational health and psychological support were available for staff. ‘Hot debriefs’ were held with staff in the event of a serious incident. There was a trust wide excellence report. This was included in the electronic systems where staff could show their recognition of good practices and care.

Senior leaders represented the trust in engagement with external stakeholders in Cheshire. Leaders met with stakeholders in Flintshire at a number of levels at least twice per week. The service provided care to a significant number of patients from Wales and this impacted on access and flow throughout the service.

Medical care (including older people's care)

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them.

The trust had developed a 'Continuous Improvement Strategy' for 2020 to 2025. The strategy had been developed through a series of workshops with trust colleagues and users of trust services. The aim of the strategy was to create a culture in which staff working at the Countess of Chester Hospital NHS Foundation Trust come to work to 'do their work' and to 'improve their work'.

There was a culture of learning in the division and we saw that staff at all levels wanted to improve services for patients and their relatives.

We saw that there were quality improvement projects taking place across the division and that staff were participating in these projects. They were using plan do study act cycles to support the quality improvement. For example, one of the ward managers was planning to introduce a "no pass zone" where staff of all grades could respond to a call bell alert.

The trust had a preceptorship programme for band 5 nurses. In addition, unregistered staff had the opportunity to participate in apprenticeship programmes for development and progression.

The ward accreditation process supported continual improvement to services.