Care Quality Commission

Wrightington, Wigan and Leigh NHS Foundation Trust

Royal Albert Edward Infirmary

Quality Report

The Elms, Royal Albert Edward Infirmary
Wigan Lane
Wigan
Greater Manchester
WN1 2NN
Tel: 01942 778858
Website: info@wwl.nhs.uk

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

Ratings

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

Summary of findings

Outpatients and diagnostic imaging	Good 

Summary of findings

Letter from the Chief Inspector of Hospitals

The Royal Albert Edward Infirmary is one of three locations providing care as part of Wrightington, Wigan and Leigh NHS Foundation Trust. It provides a full range of hospital services including emergency care, critical care, a comprehensive range of elective and non-elective general medicine (including elderly care) and surgery, a neonatal unit, children and young people's services, maternity services and a range of outpatient and diagnostic imaging services.

Wrightington, Wigan and Leigh NHS Foundation Trust provides services for around 320,000 people in and around Wigan and Leigh with 696 beds. In total, the Royal Albert Edward Infirmary had 497 beds.

We carried out an announced inspection of the Royal Albert Edward Infirmary on 8–11 December 2015 as part of our comprehensive inspection of Wrightington, Wigan and Leigh NHS Foundation Trust.

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

Our key findings were as follows:

Cleanliness and infection control

- The trust had infection prevention and control policies in place which were accessible to staff.
- We observed good practices in relation to hand hygiene and 'bare below the elbow' guidance and the appropriate use of personal protective equipment, such as gloves and aprons, while delivering care.
- 'I am clean' stickers were used to inform staff at a glance that equipment or furniture had been cleaned and was ready for use.
- Overall, patients received care in a clean, hygienic and suitably maintained environment. Staff were aware of and applied infection prevention and control guidelines.

Nurse staffing

- Care and treatment were delivered by committed and caring staff who worked hard to provide patients with good services.
- Nurse staffing within the paediatric services was inadequate. Nurse staffing levels on rainbow ward did not reflect Royal College of Nursing (RCN) standards and on the neonatal unit did not always meet standards of staffing recommended by the British Association of Perinatal Medicine (BAPM). Also staffing rotas on Rainbow ward did not identify an appropriately trained member of staff for the High Dependency Unit (HDU) for each shift.
- There were no paediatric trained nursing staff available in the department between 1.30am and 7:30am. Across the department only 18% of staff were trained in paediatric life support (PLS) and 13% in advanced paediatric life support (APLS) which meant that it could not be guaranteed that there would be a sufficient number of staff trained to resuscitate a child when the CED was closed.
- On the medical wards we found there were occasions where nurse staffing levels were not overall sufficient to meet the needs of patients. Staff vacancies had been identified on the departmental risk register.
- Current long-term sickness and interim staffing requirements within maternity, during recruitment processes, were being covered by bank staff. The trust target for bank nurses was less than 5%, however 14% were employed in November 2015 and 8.9% in December 2015.

Leadership and Management

- The senior team, in the majority of core services, were visible and accessible and well known to the staff.
- Midwives were not clear about the trust vision and strategy.There were regular senior meetings that were cascaded to staff but staff felt that meetings with them needed to be more formal.

Summary of findings

- Clinical cabinet meetings took place monthly and were well attended by a managers and clinicians.
- Within children and young peoples services there was a corporate and a divisional risk register in place. However managers were not fully aware of all the risks in their department. Risks regarding nurse staffing levels had been recognised by managers in September 2015; however this was not recorded on the risk register. It was recognised again on a leadership 'walk around' on 1 December 2015 but no immediate action was taken.
- Lack of coherence between the executive team, service managers and staff meant identified risks were not clearly escalated, documented or robust actions taken to mitigate them within children and young people's services. There was also a lack of proactive action in the case of nurse staffing on Rainbow ward. The lack of protected management time for the ward manager limited their ability to address managerial duties including addressing the staffing concerns.

Access and Flow

- Between April 2015 and September 2015, the trust exceeded the 90% standard for the proportion of patients waiting 18 weeks or less from referral to treatment. The latest figures for October 2015 showed the trust's performance was at 92%, with the exception of general and oral surgery. WWL is in the top 10% nationally for RTT performance as at October 2015, ranking 5th out of 139 Acute Trusts.
- General surgery and trauma/orthopaedic wards had medical outliers (medical patients that were not nursed on a medical ward due to bed shortages) each month between January 2015 and August 2015. The number of patient outliers for June 2015 was 141. Staff reported daily review of these patients by medical staff.
- Between March 2015 and the time of inspection, the departments performance in meeting the Department of Health target for 95% of patients to be seen, treated, discharged or admitted within 4 hours was mixed. The service met the target in six of the nine months. However, performance was consistently better than the national average in that time.
- National targets to achieve 92% for referral to treatment for patients on incomplete pathways between April 2015 and October 2015 were achieved overall within the paediatric specialities. Individually two specialities missed the target on one occasion in this period but this accounted for a total of two children only.
- Children referred to child and adolescent mental health services (CAMHS) were usually seen within 24 hours however staff reported long delays to access specialist inpatient beds. Between 17 August 2014 and 16 August 2015 the trust had 178 admissions receiving care from the CAMHS team.
- Within outpatients, the 18-week referral to treatment performance between January 2015 and October 2015 showed the trust had exceeded the trust's 95% target and was better than the England average and standard with an overall average of 98%.

We saw several areas of outstanding practice including:

- The end of life service had a visible person-centred culture. are was provided by compassionate, caring staff who were sensitive to the needs of seriously ill patients. People were respected and valued as individuals, and staff throughout the service demonstrated a commitment to recognising the needs of the patients at end of life, and of their families. There were systems in place to support this, including the use of the swan logo. The use of the logo was seen to be identified universally and promoted high quality care to patients at the end of life and their families.
- The emergency department used an electronic dashboard (A&E APP) that constantly monitored flow through the department. It used predictive information based upon seasonal variances and data from previous years to generate likely numbers of attendees to the department. The system also used live data of ambulances on route to the department. Where demand was strong at particular times of the day the department was able to flex staff from other areas to ensure response rates were maintained. Meetings were held several times per day to discuss flow throughout the hospital to avoid delays in patients moving through the Hospital system.
- The trust recognised that an important element of achieving high quality care was to ensure that the staff had the capacity and capability to deliver improvement. The trust had set up a 'Quality Champion' programme to support the delivery of service improvement and recognise the achievements of the staff. All Quality Champions who had

completed the training programme and commenced an improvement project were awarded a bronze badge. Silver and gold badges were awarded to those Champions who sustained their improvements and disseminated them to other organisations. The department had a number of staff of various grades who were quality champions, and had identified staff who were about to start the programme.
- Within radiology there was effecting in-sourcing of staff to cover shortfalls.
- Staff were supported to undertake a counselling qualification in order to improve the staff support network.

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

Importantly, the trust must:

In Emergency Department:

- Ensure that there are sufficient numbers of staff who are trained to resuscitate children at all times.

In Medicine:

- Deploy sufficient staff with the appropriate skills on wards.
- Ensure that all staff receive appraisals and complete mandatory training to enable them to carry out the duties they are employed to perform.
- Ensure that records are kept secure at all times so that they are only accessed by authorised people.

In Children and Young People:

- Ensure staffing levels are maintained in accordance with National professional standards.
- Ensure that there is one nurse on duty on Rainbow ward trained in Advanced Paediatric Life Support each shift.
- Ensure that staff are trained and competent to deliver the care required by patients with a tracheostomy.
- Ensure that risk rating and escalation is robust to ensure mitigating actions are taken in a timely way.
- Ensure the ward manager has sufficient time to perform the managerial tasks associated with the role.
- Ensure the senior leaders of the service are cited on the risks and actions being taken.

In addition the trust should:

In Emergency Department:

- Improve incident reporting by ensuring all staff are aware of the types of incidents they should report.
- Improve the reviewing of risk assessments to manage and mitigate them in a continuous and timely way.
- Improve documentation in patient records to ensure it is accurate and fully completed.
- Take action to improve performance in the monitoring of vital signs for children.
- Take action to improve the provision of leaflets in different languages to reflect the needs of the local population.
- Improve the screening for infectious diseases, such as Ebola, across the department.
- Review the compliance with policies and procedures relating to the time patients should spend in the clinical decision unit (CDU).
- Review compliance with the cleaning regime in the children's emergency department (PECC).

In Medicine:

- Improve the timeliness of discharge when patients are fit to do so.
- Reduce the moves between wards that patients are experiencing and the number of patients receiving care on a ward not specific to their needs.
- Consider implementing formal procedures for the supervision of staff to enable them to carry out the duties they are employed to perform.
- Review the gaining of consent for the use of bedrails and the application of the Mental Capacity Act (2005) principals where appropriate. Supported by procedures and relevant mental capacity act training.

Summary of findings

- Review the prescribing of oxygen for patients when required.
- Maintain patients' privacy and dignity at all times in the discharge lounge.

In Surgery:

- Maintain that trolleys containing patient's notes are kept locked.
- Maintain that records are fully completed with name and designation always clearly recorded and printed.
- Display dated green 'I am clean' stickers on all equipment.

In Maternity:

- Review and maintain that emergency equipment and medicines are checked in line with trust policies and procedures and that a record is held.
- Review and maintain that equipment is checked and records are kept to ensure equipment is maintained and fit for purpose.
- Review accessibility procedures into the maternity unit.
- Review procedures related to temporary staff and ensure that there are robust monitoring arrangements in place.
- Review and maintain that guidelines are up to date and include evidence of the use of latest recognised publications.
- Review communication methods used to deliver key messages to midwifery staff.
- Review the on-going problems with the drainage problem on the maternity unit to seek resolution.
- Review and maintain that there are robust systems in place to ensure the security of both the postnatal ward and delivery suite.

In Children and Young People:

- Consider the provision of accredited Newborn Life Support training for junior Doctors working on Rainbow ward and the neonatal unit.
- Take steps to ensure that resuscitation equipment is available and fit for use.
- Record the maximum and minimum fridge temperatures for each medication fridge.
- Maintain equipment within the required timeframes.
- Review the checking of controlled medicines is in line with trust policy.
- Develop a current Female Genital Mutilation policy which includes the mandatory reporting requirements and a domestic abuse policy and training that includes modern slavery, human trafficking and domestic violence prevention orders.
- Identify staff learning needs through the trusts appraisal process.
- Consider employing a Registered Mental Health Nurse to care for children requiring Child and Adolescent Mental Health Services.
- Ensure shower facilities for parents staying with their children are in good working order.

In End of Life:

- The service should improve their compliance with the regional DNACPR standards particularly with regards to the use of MCA and best interest decisions.
- The service should consider improving access to medical devices out of hours. At the time of our inspection syringe drivers which may be required at the weekend were kept in a loan store in the basement.
- The service should improve the review and updating of the risk register in a timely manner, with target dates for actions, to ensure all risks are being managed effectively and are not left on the register without being addressed for an extended time.

In Outpatient:

- Consider improving outpatient facilities such having drinking water available and children's facilities in the outpatient waiting area.

Summary of findings

- Consider the implementation of the use of the Safety Checklist for Interventional Radiology.
- Review the outpatient area in proximity to the reception desk to explore options for improving privacy for patients.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Good	Overall we rated urgent and emergency services as "Good". However, we found further improvements that were required to improve safety. The department used national guidelines and evidence based practice on a consistent basis in providing treatment and developing pathways and audits. The average rates of re-attendance within seven days were better than the national average. Regular audits were undertaken and where areas for improvement were identified, action plans were put in place and re-audits generally showed an improving picture. Patients spoke positively about their care and treatment. They were treated with dignity and respect. Data for patient satisfaction surveys showed most patients were positive about recommending the department to friends and family. Patients and their relatives were supported with their emotional needs, and there were services in place to provide support for patients, relatives and staff. National targets patients to be seen, treated, discharged or admitted within four hours were generally met and performance was consistently better than the national average. At the time of the visit WWL were ranked 7th in country for performance against the 95% standard. The department had identified areas for improvement, such as meeting the national standard for triaging patients within 15 minutes and had put action plans in place to improve this. The senior team were visible and accessible and well known to the staff. There was a positive culture throughout the department. Staff were very positive about their managers and felt supported to carry out their roles. Staff felt confident in raising concerns, they felt they were able to suggest improvements and were proud to work for the trust. There were a range of reward and recognition schemes to recognise the work that staff completed in ensuring quality of care and patient safety.

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Incident reporting was completed on a regular basis and staff were aware of how to do this. However, there were occasions during the inspection that we had to prompt staff to report incidents, which presents a risk that incidents may not always be recognised or reported.
The accident and emergency department was visibly clean and tidy. However, staff informed us that routine screening for Ebola was not being carried out at the reception as patients were booked in.
We looked at a sample of patient records and found that whilst the majority were up to date and completed appropriately, there were some that did not contain all of the required information.
There were a sufficient number of nursing staff at the time of the inspection. However, the compliance with required training was mixed, potentially leaving some staff without the competence or up to date skills to provide safe care to patients. For example, across the department only 18% of nursing staff were trained in paediatric life support and 13% in advanced paediatric life support which meant that it could not be guaranteed that there would be a sufficient number of staff trained to resuscitate a child when the CED was closed between 1am and 7.30am.
A risk register was in place and monitored regularly with actions and review dates. However, not all department risks assessments to mitigate impact of risk were routinely updated in a timely way, or completed.

Medical care (including older people's care)

Good

We found that the Royal Albert and Edward Infirmary was delivering good medical services to patients but some areas of the service, particularly those relating to safety, required improvement.
All staff knew the trust vision and behavioural framework and said they felt supported and that morale was good. All staff were committed to delivering good, compassionate care and were motivated to work at the hospital.
The hospital had implemented a number of schemes to help meet people's individual needs, such as the forget-me-not sticker for people living with dementia or a cognitive impairment and a red label to indicate that a patient was frail or elderly.

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This helped alert staff to people's needs. However, we found on the discharge lounge patients' privacy and dignity was not always being maintained and this was due to the facilities available not being fully used.

People were supported to raise a concern or a complaint and lessons were learnt and improvements made. Medical services captured views of people who used the services with changes made following feedback. A survey showed that people would recommend the hospital to friends or a relative.

There were governance structures in place which included a risk register. Some actions on the register had no timeframes for completion and it was unclear if these were being managed in an effective way to lower the risk.

There were concerns in relation to nursing staffing on some of the wards during the day and at night, especially on Ince ward and Astley ward. Clinical staff had access to information they required, for example diagnostic tests and risk assessments. However, we found records were left unsecured on the wards we visited and whilst records did include a treatment plan for each patient, there were standards for record keeping that required improvement.

Clinical waste was not always being stored in the designated places and there were concerns over the design of the endoscopy unit leading to the use of the discharge lounge to recover patients. There were also concerns about the decontamination facilities on the unit.

Nursing staff were unclear about the procedures to follow when reaching decisions about using bed rails which are a form of restraint. This was due to the assessment paperwork not including the recording of consent or best interest decisions but staff knew about the key principles of the mental capacity act. Incidents were reported by staff through effective systems and lessons were learnt and improvements made from investigations where findings were fed back to staff. There were systems in place to keep people safe and staff were aware of how to ensure patients' were safeguarded from abuse. The hospital was clean and staff followed good hygiene practices.

Summary of findings

There were a number of patients being cared for in non-speciality beds but there were clear protocols in place to help manage care for these patients. Best practice guidance in relation to care and treatment was usually followed and medical services participated in national and local audits. Action plans were in place if standards were not being met.

Surgery

Good

Overall, we found that the Royal Albert Edward Infirmary delivered 'Good' surgical services. Staff were committed and proud of the services they provided. Staffing levels were sufficient and a safer nursing care staffing tool was utilised to ensure staffing levels were adequate. Medical staff rotas were in place and locum agency staff filled any gaps when the service was short staffed. Staff morale was good and staff felt well supported. Incidents were reported and lessons learnt shared amongst staff. Staff knew how to access the incident reporting system and could tell us about incidents they had reported. There were low incidents of pressure ulcers and infections. Risk assessments were completed and staff implemented measures to reduce risks.

The environment was clean and tidy and staff had access to the equipment they required to do their jobs. Medicines were managed safely and stored securely.

Referral and discharges worked well and staff shared relevant information. Services worked in coordination and patients were appropriately referred to specialist services. Staff treated patients with respect and dignity, offered support and included them in care planning. Patients received a caring service and staff discussed treatment plans with patients to ensure a person-centred approach. The trust 18 week referral to treatment times were similar to or above the national average of 90% for all surgical specialities except general and oral surgery. WWL is in the top 10% nationally for RTT performance as at October 2015, ranking 5th out of 139 Acute Trusts.

Risk registers were in place and discussed at team meetings. Staff were aware of the trust's values and vison. Staff felt well-supported by managers and colleagues.

Summary of findings

Critical care

Good

We rated the critical care services at the hospital as good. This was because patient safety was monitored and incidents were investigated to assist learning and improve care. Patients received care in safe, clean and suitably maintained premises. The staffing levels and skill mix was sufficient to meet patients' needs. Patients were supported with the right equipment. Patients received care and treatment by trained multidisciplinary staff that worked well as a team.

Medicines were stored and administered appropriately. However, fridge temperatures were not always maintained below 8ºC. Staff minimised the risk to patients by taking additional steps such as reducing the expiry date of medicines stored in the fridges.

The services provided care and treatment that followed national clinical guidelines and staff used care pathways effectively. The services performed in line with expected levels for all performance measures in the Intensive Care National Audit and Research Centre (ICNARC) 2013/14 audit. This meant the majority of patients had a positive outcome following their care and treatment.

There was sufficient capacity to ensure patients could be admitted promptly and receive the right level of care. Bed occupancy levels were consistently lower than the England average. The number of out-of-hours discharges, delayed discharges and patients transferred out for non-clinical reasons were within expected levels when compared to other critical care units nationally.

The relatives of patients spoke positively about the care and treatment provided. Patients were treated with dignity, empathy and compassion. Staff involved patients or their relatives in their care and supported them with their emotional and spiritual needs.

There were systems in place to support vulnerable patients. Complaints about the service were shared with staff to aid learning. There was effective teamwork and clearly visible leadership within the department. Staff were positive about the culture within the critical care services and the level of support they received from their managers.

Summary of findings

Maternity and gynaecology

Requires improvement

The maternity and gynaecology services at Royal Albert Edward Infirmary (RAEI) required improvement in the safe, effective and well – led domains.

We rated Maternity services at RAEI as 'required improvement' in terms of being safe.

Staff knew how to report incidents. Lessons were shared and learned using techniques such as roleplay scenarios that included both midwifery and medical staff, however; there was no integrated trustwide learning system. All areas were visibly clean and tidy and staff followed hygiene procedures.

Safeguarding processes were in place and under review. We found that door entry systems to both the postnatal ward and the delivery suite did not adequately protect patients. We observed some visitors let other people gain access to the unit who had not used the intercom system to identify themselves to staff members.

Medicines were stored in secure cupboards and daily checks completed, however out of date items were identified. On the delivery suite, the controlled drug cupboard was on the open corridor behind the nurse's station rather than behind a locked door.

There was a lack of assurance about the recording and maintenance of equipment including that used in an emergency. There were ongoing maintenance issues related to sewage coming up through the drains on the maternity unit which had been reported and investigated several times but not resolved. Staff reported that this happened on a monthly basis requiring patients in the area to be re-located.

In the maternity unit, we reviewed care records for seven patients and prescription charts for five patients. We found them to be legible and completed appropriately. However on Swinley ward, we found records showed that patient care had not been carried out within expected timescales for a patient whose condition was deteriorating. The processes on that ward to obtain consent for surgical procedures did not always follow best practice guidance.

Midwifery and nursing staff had completed the majority of mandatory training to the trust's target of 95% with the exceptions of basic life support at

Summary of findings

84%. Medical staffing numbers were adequate for the patient needs. Any shortfall in staffing levels was supported by bank nurses; however the monitoring of locums was not robust.
Maternity services at RAEI required improvement in terms of being effective.
Trust guidelines were in place; however these were not always clear or adhered to. However guideline reviews were not robust in that they did not always identify required changes and updates. The trust participated in a number of local and national audits. The national neonatal audit (NNAP) showed that the trust performed below the NNAP standard for four out of five indicators.
Women were assessed for pain relief and supported individually whether in labour or post operatively. There was a choice of meals available and patient's breast feeding was supported in the wards and in the community. Midwives were annually assessed by their supervisors and other staff had been appraised to be competent. Midwives did not routinely rotate between the various areas which meant there was no formal process to keep all their skills up to date. Services were available seven days a week on the wards; however no routine antenatal or gynaecology clinics were available at RAEI.
Maternity services at The Royal Albert Edward Infirmary (RAEI) were good in terms of being caring. Patients and their families were positive about their care from the nurses, midwives and doctors. They felt involved, were given good explanations and felt that staff were helpful and kind. We observed staff actively engaging with patients and families in a kind and compassionate way. Patients were accommodated sensitively, where possible, if a side room was appropriate. Emotional support was available if needed.
When in ward bays, with curtains around the beds, conversations were overheard during examinations.
Maternity services at the Royal Albert Edward Infirmary (RAEI) were good in terms of being responsive.
The service had been planned across the geographical location. There were maternity and gynaecology inpatient services, however no routine antenatal or gynaecology clinics onsite. Each

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maternity patient was allocated a named midwife, both in the community and as an inpatient. The busiest of the antenatal clinics was Thomas Linacre Centre (TLC) that was close to RAEI.
There were specialist midwives including public health, safeguarding and a mental health nurse. In addition, diversity and dementia champions were available. Any patient identified with a learning disability or mental health issue were supported on an individual basis as needed.
Midwives were not clear about the trust vision and strategy. There were regular senior meetings that were cascaded to staff but staff felt that meetings with them needed to be more formal. Staff felt that they were supported by their managers, however hospital midwives felt there were fewer opportunities for them to develop than midwifes in the community.

Services for children and young people

Requires improvement

Staffing levels did not reflect Royal College of Nursing Standards (RCN August 2013) on Rainbow ward and did not always meet the British Association of Perinatal Medicine (BAPM) standards on the neonatal unit.
Resuscitation equipment was not consistently checked and a ligature risk was identified on Rainbow ward.
Only one member of the nursing staff was compliant with Advance Paediatric Life Support (APLS) training on Rainbow ward and no members of staff were trained to care for patients with tracheostomies.
The trust had no defined paediatric strategy.

End of life care

Outstanding

We found that there were good EOL services across all five domains of Safe, Effective, Caring, Responsive and Well Led.
Incident reporting systems were in place and actions were followed up at ward level via handover. There had been no recent serious incidents related to EOL care. Anticipatory EOL care medication was prescribed appropriately and training for the use of syringe drivers was included in mandatory training for which the SPC team were 100% compliant. EOL services were adequately staffed and as well as the SPC team which was

Summary of findings

clinically led by a consultant in palliative medicine, there was a bereavement specialist nurse, a gold standards framework (GSF) facilitator and two EOL champions on each ward.

There was evidence of the service delivering treatment and care in line with best practice, including the individual plan of care (IPOC) document which facilitated support for the dying person in the last days and hours of life. The service was starting to implement the gold standard framework (GSF) and had appointed a facilitator to introduce and embed this in the two pilot wards.

We saw that the service had made changes to their practice to address some of the targets not met in the last National Care of the Dying Audit of Hospitals (NCDAH), May 2014 and there was evidence that some actions were in place as a result of other clinical audits however there were not always action plans in place which met the criteria for being specific, measurable, achievable, realistic and timely (SMART). This meant there was a potential risk that some recommendations or findings from audits may not be translated into actions in a timely manner or may be missed altogether.

We saw evidence that pain relief and nutrition and hydration needs for patients were being met. The SPC team provided a seven day service and worked well, across all the hospitals, with other teams and disciplines.

EOL care services were provided by compassionate, caring staff who were sensitive to the needs of seriously ill patients. The service was delivered by staff who were committed to providing a good service and there was good clinical leadership from a consultant in palliative medicine. There was a coordinated approach across the Wigan borough to design EOL services to meet the needs of the local population. There were systems in place to prioritise EOL patients for side rooms at RAEI and this was working well. Facilities and systems were in place to minimise stress for families staying with their EOL relatives and to allow them to spend as much time as they wished with them in their last days and hours. This included the use of the swan logo which identified EOL patients and their families, enabling staff to treat them accordingly.

Summary of findings

The visibility of senior management was good and staff felt well supported and there was an open door policy by senior staff.
Areas for improvement included completion of uDNACPR forms which were inconsistent in their quality. An action plan should be developed to address the shortcomings identified in the trust's uDNACPR audit.

Outpatients and diagnostic imaging

Good

We found the services of the outpatients and diagnostic imaging to be good overall. Patients had clear access to the clinics and radiology, though car parking was an issue. Areas were visibly clean and waiting times for appointments were short. The departments had sufficient staff and where shortfalls existed there were plans in place to ensure continuous service. There was some weekend clinics and acute radiology services was open 24 hours a day. The outpatient waiting area was dated but the new cancer centre, opened in January 2015, was bright and spacious in comparison.
Staff at Royal Albert Edward Infirmary told us they were proud of where they worked and would recommend it as a workplace and a place to treat their family. Staff training was up to date and the trust encouraged learning. Incidents and errors were treated as a learning opportunity to keep patients safe in the future. Patients told us that staff were caring and compassionate and they were given sufficient information about their treatment. The management were visible and approachable to staff. Audits to assess the departments were continuous and innovation and change was promoted. Staff felt supported by the managers.

Royal Albert Edward Infirmary

Detailed findings

Services we looked at

Urgent and emergency services; Medical care; Surgery; Critical care; Maternity and gynaecology; Services for children and young people; End of life care; Outpatients and diagnostic imaging

Detailed findings

Contents

Background to Royal Albert Edward Infirmary

The Royal Albert Edward Infirmary (RAEI) is the main district general hospital site, located in central Wigan that hosts the Accident and Emergency department.

Medical care services at the hospital provide care and treatment for a wide range of medical conditions, including general medicine, cardiology, respiratory and gastroenterology.

The critical care services hosted the Royal Albert Edward Infirmary. The intensive care unit provides care for up to seven level three (intensive care) patients and four level two (high dependency) patients. The service also provides a 24-hour outreach service to the hospital by a team of trained nurses and support outreach staff.

A range of paediatric services are provided at the Royal Albert Edward Infirmary (RAEI). These include critical care, high dependency care and special care for new born babies in the neonatal unit and high dependency care, medical care and paediatric surgery for children and young people aged 0-16 years on Rainbow ward. Emergency care is provided in the Paediatric Emergency Care Centre (PECC) within the Emergency department and outpatient services for children with ongoing medical needs are provided at the Thomas Linacre Centre.

The specialist palliative care (SPC) multi-disciplinary team is based at the Royal Albert Edward Infirmary (RAEI) but also covers Wrightington hospital, Leigh Infirmary and Thomas Linacre Centre if required.

The SPC team accepts referrals for patients with progressive life threatening illness when life expectancy is likely to be less than one year. Referral criteria include difficult pain and symptom control, complex psychosocial problems and/ or specialist needs related to EOL care and support.

Chemotherapy and supportive treatment to patients with breast, bowel & haematological cancers is delivered in the new cancer care suite at the Royal Albert Edward Infirmary site and is in partnership with a local cancer specialist hospital. The chemotherapy administration area is a 12 bedded area with one isolation room. The cancer centre opened in January 2015. Patients were involved at the planning stages and created a building with counselling rooms and a patient garden.

The outpatients department offers a range of clinics including trauma and orthopaedic, diabetes, oral surgery and orthodontics as well as general medical and surgical conditions. Most outpatient departments operate between Monday and Friday with some Saturday clinics. The trust offers a comprehensive service providing diagnosis and treatment in one attendance, where possible.

Detailed findings

Our inspection team

Our inspection team was led by:

Chair: Bill Cunliffe, Consultant colorectal surgeon with six years' experience as a medical director

Acting Head of Hospital Inspections: Lorraine Bolam, Care Quality Commission

The team included a CQC Inspection Manager, 14 CQC inspectors and a variety of specialists including Junior doctor, Practice Development Matron, Consultant physician, Clinical Nurse Specialist: Infection Prevention & Control, Consultant Haematologist, Vascular Surgeon, Matron for Theatres, Midwife, Consultant Obstetrician, Consultant Paediatrician and Paediatric Nurse Consultant, a Head of Safeguarding, a Senior Governance and Risk Manager, Clinical Governance lead, Emergency Department nurse specialist and consultant, a Critical Care nurse, an End of Life Care Consultant and Nurse Specialist and a Health Care Assistant.

We did not have any Experts by Experience on the team but held a listening event on 2 December 2015 which was attended by a number of local people who had experienced the services at Wrightington, Wigan and Leigh. It was also attended by the local Healthwatch team who shared information they had received about services.

How we carried out this inspection

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

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

The inspection team inspected the following core services at the Royal Albert Edward Infirmary:

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

Prior to the announced inspection, we reviewed a range of information we held and asked other organisations to share what they knew about the hospital. We interviewed staff and talked with patients and staff from all the ward areas and outpatient services. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment.

We received feedback through focus groups. We would like to thank all staff, patients, carers and other stakeholders for sharing their balanced views and experiences of the quality of care and treatment at Wrightington, Wigan and Leigh hospitals.

Facts and data about Royal Albert Edward Infirmary

Between September 2014 and September 2015 there were 88,133 accident and emergency attendances at this trust. Around 22% of attendances were from children aged 0-16 years old, and there were 28,603 Accident and emergency attendances from this age-group between April 2014 and August 2015.

Wrightington, Wigan and Leigh NHS Foundation Trust provides services for around 320,000 people in and around Wigan and Leigh with 696 beds. In total, the Royal Albert Edward Infirmary had 496 beds. Between January 2014 and December 2014 there were around 31,818 admissions. In 2014, there were 35,277 surgical spells

Detailed findings

trust wide serving a population of around 320,000 people in the Wigan and Leigh area. At RAEI 50% of surgical stays were emergencies, 31% were day cases and 19% were elective.

There were 221 admissions to critical care and 171 discharges between April 2014 and March 2015. There were 93 deaths in critical care during this period.

Hospital episode statistics data (HES) showed there were 2,247 children and young people seen between January 2014 and December 2014. At The Royal Albert Edward Infirmary 91% of cases were emergency admissions, 6% were elective admissions and 2% of admissions were day cases.

Between November 2014 and December 2015 there were 1164 deaths at the Royal Albert Edward Infirmary (RAEI) and two deaths at Wrightington Hospital. These figures include all deaths for patients over the age of 7 years. Between January 2015 and October 2015 there were 982 referrals made to the specialist palliative care team.

Outpatient services employ over 140 whole time equivalent nursing and clerical staff across four sites and sees approximately 500,000 patients per year trust wide which includes many out of area referrals. Approximately 122,000 patients attended the outpatients at the Royal Albert Edward Infirmary between January and December 2014, 29% of which were new patients and 55% were follow up appointments. The remaining 16% of appointments made were either cancelled (3% were cancelled by the hospital, 7% were cancelled by patients) or the patient failed to attend (6%)

Radiology operates across all four trust sites and undertakes in excess of 250,000 examinations per year. More than 150 whole time equivalent staff are employed including 16 consultant radiologists.

Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

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

Urgent and emergency services

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

Information about the service

Wrightington, Wigan and Leigh NHS Foundation Trust (WWL) provides district general hospital services for the local population of over 320,000 people and specialist orthopaedic services to a much wider regional, national and international catchment area.

Royal Albert Edward Infirmary is the main district general hospital site, located in central Wigan that hosts the Accident and Emergency department. The department operates 24 hours per day, 7 days per week. Between September 2014 and September 2015 there were 88,133 accident and emergency attendances at this trust. Around 22% of attendances were from children aged 0-16 years old, and there were 28,603 Accident and emergency attendances from this age-group between April 2014 and August 2015.

The accident and emergency department comprised of:

- A majors area with sixteen cubicles
- Eight minor injury consultation cubicles with an additional suturing/minor procedure room.
- A five bay resuscitation room (with one designated trauma and paediatric resuscitation bay each). Each bay is equipped with integrated mobile X-ray units.
- An eleven bedded clinical decision unit (CDU). This unit is primarily used for those people who are not ready to be discharged home but do not require a prolonged hospital admission and should be discharged within 48 hours.
- An x-ray unit.
- A dedicated eye unit, and ears nose and throat (ENT) room.
- Two Clinic/Emergency nurse practitioner (ENP) rooms suitable for consultation and treatment.
- A room to provide support for relatives.

There was a separate paediatric emergency care centre (PECC) that opened from 7.30am to 1am the following day. Care outside of these times was provided in the main adult majors' area. The PECC was a purpose-built area, which provided emergency care for sick and injured children and young people up to the age of 16. The clinical areas were equipped to provide a high dependency unit (HDU), a private examination room, six cubicles, a triage room and a waiting area.

A designated room was provided for the assessment and treatment of those people with mental health disorders. The department was supported 24 hours a day by the rapid, assessment, interface and discharge team (RAID), which was a specialist multidisciplinary mental health service that worked with people aged over 16. The team were based on site and referrals could be made via the hospital, with a response time within 1 hour.

As part of the inspection we spoke to ten patients, we observed the daily practice of staff providing care and treatment to patients, and reviewed 20 patient records.

We also spoke with a range of staff from various grades including managers, nurses, doctors and consultants.

Prior to, and following the inspection we reviewed further information provided by the trust.

Urgent and emergency services

Summary of findings

Overall we rated urgent and emergency services as "Good". However, we found further improvements that were required to improve safety.

The department used national guidelines and evidence based practice on a consistent basis in providing treatment and developing pathways and audits.

The average rates of re-attendance within seven days were better than the national average. Regular audits were undertaken and where areas for improvement were identified, action plans were put in place and re-audits generally showed an improving picture. However, in some areas of treatment such as the management of sepsis, and cognitive screening for patients over 75, improvements still needed to be made.

Patients spoke positively about their care and treatment. They were treated with dignity and respect. Data for patient satisfaction surveys showed most patients were positive about recommending the department to friends and family. Patients and their relatives were supported with their emotional needs, and there were services in place to provide support for patients, relatives and staff.

National targets patients to be seen, treated, discharged or admitted within four hours were generally met and performance was consistently better than the national average. The department had identified areas for improvement, such as meeting the national standard for triaging patients within 15 minutes and had put action plans in place to improve this.

The senior team were visible and accessible and well known to the staff. There was a positive culture throughout the department. Staff were very positive about their managers and felt supported to carry out their roles. Staff felt confident in raising concerns, they felt they were able to suggest improvements and were proud to work for the trust. There were a range of reward and recognition schemes to recognise the work that staff completed in ensuring quality of care and patient safety.

Incident reporting was completed on a regular basis and most staff were aware of how to do this. However, there were occasions during the inspection that we had to prompt staff to report incidents, which presents a risk that incidents may have not always been recognised or reported.

The accident and emergency department was visibly clean and tidy. However, staff informed us that routine screening for Ebola was not being carried out at the reception as patients were booked in.

We looked at a sample of patient records and found that whilst the majority were up to date and completed appropriately, there were some that did not contain all of the required information.

There were a sufficient number of nursing staff at the time of the inspection. However, the compliance with required training was mixed, potentially leaving some nursing staff without the competence or up to date skills to provide safe care to patients. For example, across the department only 18% of nursing staff were trained in paediatric life support (PLS) and 13% in advanced paediatric life support (APLS) which meant that it could not be guaranteed that there would be a sufficient number of nursing staff trained to resuscitate a child when the PECC was closed between 1am and 7.30am.

A risk register was in place and monitored regularly with actions and review dates. Department risk assessments were up to date at the time of inspection, however we saw that prior to them being completed in 2015 they were last updated in 2012. Also the security of the children's gates on the PECC had not been highlighted as an area of risk on the risk register.

Urgent and emergency services

Are urgent and emergency services safe?

Requires improvement

There were a sufficient number of nursing staff at the time of the inspection. However, the compliance with required training was mixed, potentially leaving some staff without the competence or up to date skills to provide safe care to patients. For example, across the department only 18% of nursing staff were trained in paediatric life support (PLS) and 13% in advanced paediatric life support (APLS) which meant that it could not be guaranteed that there would be a sufficient number of nursing staff trained to resuscitate a child when the PECC was closed between 1am and 7.30am. In addition, only 56% of staff had received training in mental capacity and deprivation of liberty, this potentially placed those patients who have a cognitive impairment at risk of not receiving care to meet their needs.

Incident reporting was completed on a regular basis and staff were aware of how to do this. However, there were occasions during the inspection that we had to prompt staff to report incidents, which presents a risk that incidents may not always be recognised or reported.

We looked at a sample of patient records and found that whilst the majority were up to date and completed appropriately, there were some that did not contain all of the required information such as a patients' modified early warning score (MEWS) and allergy information. We also found one instance where a patients MEWS score indicated potential sepsis but the sepsis pathway was not followed.

There was evidence to demonstrate that patient risk was assessed and there were appropriate tools in place to support staff in completing this.

The accident and emergency department was visibly clean and tidy. However, staff informed us that routine screening for Ebola was not being carried out at the reception as patients were booked in.

Equipment was stored and maintained appropriately. Records indicated that daily checks of resuscitation equipment were completed.

We found that medicines were generally well managed but there was an unlocked drugs box stored on top of a resuscitation trolley that was accessible to the public and there were some instances where the required checks were not recorded.

Incidents

- Incidents were recorded and documented using an electronic incident reporting system that the trust used to capture data on incidents or near misses, which occurred across the department. Most staff were clear on its use, and could identify types of incidents that should be recorded and could clearly demonstrate how to use the system.
- A policy for incident reporting was in place, which was located on the trust's intranet, and staff knew how to locate it.
- Staff told us that they were encouraged to report incidents. Feedback from incident reporting was optional. However, staff reported that feedback was given quickly if required.
- When incidents were reported, they were investigated by the risk and governance team.
- From August 2014 to July 2015 the accident and emergency department reported 1,198 incidents on to the NRLS (national reporting and learning system). The NRLS is a national database to record information in relation to incidents. The majority of reported incidents for the department were for community acquired pressure ulcers and moisture lesions.
- We reviewed incident reports between April 2015 and September 2015 and found that staff routinely reported incidents such as patients presenting with pressure sores and falls. However, there were three occasions as part of the inspection where we had to prompt staff to report incidents. For example, an issue was raised at the morning handover about a batch of arterial lines that had no date and were not to be used. This wasn't recorded on the incident reporting system and we had to prompt staff to report it. This leads to a risk that incidents may not always be recognised or reported.
- Incidents were reviewed in governance and team meetings with actions identified. For example, staff reported an increase in incidents of violence and aggression and security was increased as a result. Violence and aggression to staff was included on the risk

register with clear actions to be taken. These included the provision of resilience training and for all staff to report incidents of violence and aggression using the incident reporting system.
- Where errors relating to patients care were identified, staff were encouraged to also complete a reflective practice document. Managers and staff thought this was a positive idea and would help to reduce the likelihood of a similar event occurring.
- We reviewed individual incidents and found that where errors were made, open and honest letters were sent to the patients, meetings took place, apologies given, and actions taken.
- Mortality and morbidity were discussed as a set agenda item on a monthly basis at governance meetings with discussions minuted and actions identified.

Cleanliness, infection control and hygiene

- All areas of the department were visibly clean and tidy. Cleaning records were completed and were up to date. However, nursing staff on the PECC told us that they were responsible for cleaning patient equipment including toys. A rota was in place for them to do this but records indicated that there were a number of occasions throughout November 2015 where things such as blood trolleys, dressing trolleys and toys for children had not been consistently cleaned on a weekly basis.
- Throughout the inspection we saw that cleaning staff maintained the environment. Floors and bed areas were free from hazards.
- There were no incidences of methicillin-resistant staphylococcus aureus (MRSA) or contracted colostrum difficile (CDIFF) in 2015.
- We found that procedures were in place for patients who attended the department with infectious diseases. If patients needed to be isolated due to infection, side rooms were available across the department. The department had a large decontamination room with equipment safely stored and an escalation plan.
- The divisional risk register recorded that identification of patients with infectious diseases such as Ebola were to be screened at reception/ triage, however we found that the system in place was not robust as the booking form lacked clarity in that it only asks if a patient is an overseas visitor and staff told us that they did not regularly screen patients for infectious diseases such as Ebola.
- We observed that mattresses and linen were visibly clean across the department. Curtains around the bays had recently been replaced. However, we found two curtains in the majors' area with no date as to when they were last changed. When we alerted staff they rectified the situation immediately and new curtains were put in place.
- Hand gel was available on all entry and exit points, and in individual bays.
- Staff were aware of and adhered to current infection prevention and control guidelines such as the 'bare below the elbow' policy. We observed staff using appropriate hand-washing techniques and protective personal equipment, such as gloves and aprons, whilst delivering care.
- Hand hygiene audits were completed in line with the world health organisation (WHO) 'five moments of hand hygiene' which describes the key points at which hand hygiene should be completed by health care staff. Between April and September 2015, the department was fully compliant in all areas.
- There were arrangements in place for the handling, storage and disposal of clinical waste, including sharps.
- Cleanliness and infection control audits took place on a weekly basis, and the monthly results were clearly presented on the walls of the department for staff and visitors to see. The results for November 2015 showed that compliance with the cleanliness audit across the department ranged from 98.3% to 99.6% and the compliance with infection control was 100%.
- Patients reported that they were happy with the cleanliness of the department.
- In the 2014 CQC Accident and emergency survey, the trust scored 9 out of 10 when patients were asked how clean they thought the department was.

Environment and equipment

- The department was well maintained; it was clear of clutter or hazards, and provided a suitable environment for treating patients.
- The patient areas were open plan which allowed nurses a clear line of sight to observe patients. However, the PECC was segregated from the main area by low gates (similar to baby gates) with a slide lock. They did provide some security for young children but it was limited and there was a risk of children leaving

unsupervised or unauthorised persons entering the department. The safety of children generally relied upon staff and parent vigilance and there was no risk assessment in place for this.
- Emergency resuscitation equipment was available in all areas we inspected. From July to December 2015 records indicated that the daily checks for this had been completed.
- Medical equipment was stored appropriately and staff had regard to checking dates of last service or expiry prior to use. For example, at the time of inspection a member of the nursing team discovered that arterial lines delivered to the department had no date. These were removed immediately and replaced.
- We checked a sample of electrical equipment and found that they had all been recently tested for electrical safety. Portable appliance test (PAT) stickers were present on the items we looked at.
- The department had a secure room for the assessment of people with mental health disorders. The room had been commissioned to comply with the Royal College of Psychiatry safety requirements.
- In the 2014 CQC accident and emergency survey, the trust scored 9.7 out of 10 for how safe patients felt when asked if they felt threatened by other patients or visitors while in the department.
- There was an on-site security team 24 hours per day. We saw security staff in the department.

Medicines

- Medicines including controlled drugs were generally stored securely and in line with legislation. However, we found some emergency drugs in an unlocked box on top a resuscitation trolley in the ED that were accessible to the public. Staff told us they were located there so that they could be shared across the department. We informed senior staff about our concerns and the drugs box was removed immediately and stored in an appropriate place.
- Records indicated that staff carried out checks on controlled drugs to ensure compliance with their medicines policy and the checks were completed correctly on the majority of occasions. However, we saw four instances between July 2015 and December 2015 where the daily controlled drugs checks had not been signed.
- Pharmacy staff were responsible for maintaining stock levels of medicines across the department on a daily basis.
- The medication we checked was within expiry dates, except for one item of saline in the clinical decisions unit (CDU) that expired in October 2015. We raised this with staff and it was immediately removed.
- We reviewed the medication charts of 20 patients across the department and found them to be complete, up to date, and used appropriately.
- Medicines requiring storage at low temperatures were kept in fridges. Fridge temperatures across the department were found to be in the correct range and checked regularly. However, we found some gaps in the majors' area where fridge temperatures were not recorded on three occasions from July 2015 until the date of the inspection.

Records

- The trust used a combination of electronic and paper based records to record patient treatment information.
- Paper records were appropriately stored at nurses' stations and easy to locate. The electronic system recorded patient history and previous attendances so that staff could look back at any previous attendance to assist with diagnosis.
- We reviewed 20 patient records and found that they were clear, legible and there were regular entries. However, we found that not all records were fully complete. For example, allergies were missing from three records, MEWS (modified early warning score) scores were missing from four records and two records did not have a falls risk assessment. This could lead to a risk that information was not available to help staff provide the right care or treatment for patients.

Safeguarding

- The department had an up to date safeguarding policy which was located on the intranet and staff knew how to find it.
- There was a safeguarding team based at the hospital with a lead clinician. There were procedures in place to contact external organisations such as social services and external safeguarding teams. There was also a set procedure for staff to follow outside of normal working hours.

- Staff were able to give examples of occasions what a safeguarding concern could involve. They were able to describe what actions they have taken in cases where they had suspected abuse.
- The department had a robust electronic system in place which supported staff with safeguarding issues. The system allowed staff to access records. Safeguarding issues could be added to the system through set pro-formas. If a patient re-attended the department, the system would alert staff immediately to the previous safeguarding issues.
- Staff told us that if a patient was transferred to another department or ward within the hospital, a verbal and written handover was given to share safeguarding information as other departments did not have access to the same system.
- There was one serious incident recorded that occurred in June 2015 which involved safeguarding concerns. This was still being investigated at the time of the inspection.
- We saw evidence that weekly safeguarding meetings took place within the department through a review of meeting minutes.
- A safeguarding pro-forma was at the front of all records for children. It was mandatory for this to be completed and we were told that this was implemented as a reminder for staff to consider safeguarding issues for every patient. We reviewed seven records, of which, all were completed appropriately. Staff were able to explain and demonstrate how to complete the pro-formas.
- All paediatric nursing staff had completed level 3 safeguarding training. We were told that some adult nursing staff were yet to complete this but plans for this were in place. Overall, 96.5% of nursing staff in the department had received safeguarding training.
- We were told that all senior doctors (ST4 and above) were trained to safeguarding level 3. However, the trust did not provide any records to confirm this when we asked.

Mandatory training

- Mandatory training was delivered in two ways, either by e-learning, which was accessible to all staff on the intranet or through face-to-face learning.
- There was a practice development lead based in the department who was responsible for monitoring mandatory training and personal development review completion for nursing staff.
- We observed a database which listed all nursing staff, highlighting whether they were up to date with relevant training. Where training was overdue, it was raised with staff through individual personal development reviews.
- The trust's target was for 95% of staff to have completed mandatory training but performance in achieving that target was mixed. For example, adult basic life support and level 3 safeguarding were both over 95%. However, there were some examples of low compliance such as paediatric life support (18%), advanced paediatric life support (13%), medical devices training (26.5%), major incident training (18.5%) and mental capacity and deprivation of liberty safeguarding (56%).
- Following the inspection we were informed by the trust that they held different figures to those given by the department, for example for mental capacity and deprivation of liberty safeguarding (81%).

Assessing and responding to patient risk

- The service used different tools to triage patients and assess their clinical condition. These included the Manchester Triage System (MTS), a modified early warning score (MEWS) system, a paediatric early warning score (PEWS) system and a sepsis indicator warning system.
- The MTS tool aims to reduce risk through triage, ensuring patients are seen in order of clinical priority and not in order of attendance. We saw evidence of MTS being used to triage patients.
- The MEWS system used clinical observations within set parameters to determine how unwell a patient may be. When a patient's clinical observations fell outside certain parameters they produced a higher score, which meant they required more urgent clinical care than others. A MEWS score was required as part of the patient's initial assessment, and at intervals for routine monitoring for example every two hours.
- The sepsis indicator warning system helped identify a patient with sepsis. This was important as it would allow treatment to be started as soon as possible. This pathway was triggered if a patient had a MEWS score of

over 3. We identified one set of records where a MEWS score of over 3 had been recorded but this protocol had not been followed correctly meaning that the patient was not screened in a timely manner.
- We looked at 20 records and found that the MEWS and PEWS were being used appropriately on most occasions. However, we observed two instances were MEWS scores had not been completed.
- Records contained individual risk assessments. We also saw that observations were being done on a regular basis which means that patients were being reassessed by nursing staff.
- Guidance issued by the Royal College of Emergency Medicine (April 2011) recommends that rapid initial assessment (triage) of patients should take place within 15 minutes of arrival. Between September 2014 and August 2015, the service continuously struggled to meet this target. In this period, the monthly average for triage times ranged between 18 and 27 minutes.
- We were told by reception staff that although there was no formal training process in place, they relied on 'experience' in recognising patients who needed assistance and were able to give us examples of patients whom they would notify nursing staff of immediately.
- An escalation process was in place for staff to implement if the department started to exceed capacity.
- As a result of incidents of verbal and physical aggression, an initiative had been developed called 'operation connect', which ensured a police presence on site at times that had been considered to have the most need.

Nursing staffing

- Safer staffing reviews had been completed for all areas of the department using the baseline emergency staffing tool (BEST). A safer staffing review was completed in August 2015 which indicated that the staffing establishment was below what was required. The report stated that a recruitment process had been completed to fill vacancies for both qualified nurses and healthcare assistants. We were told that following this recruitment process, the total number of registered nurses had increased from 79 to 101 and that they had just finished a recruitment process for healthcare assistants, which meant at the time of inspection there were no vacancies.
- We saw that the department was fully staffed at the time of the visit. We reviewed staff rotas over a four week period prior to the inspection. Throughout this period, these areas of the department did not meet their targeted level of staffing on only three occasions.
- From the hours of 1am to 7:30am there were no paediatric trained nursing staff available in the department. Across the department only 18% of nursing staff were trained in paediatric life support (PLS) and 13% in advanced paediatric life support (APLS) which meant that it could not be guaranteed that there would be a sufficient number of staff trained to resuscitate a child when the PECC was closed. We were told that there was a system in place where an adult nurse could be exchanged for a paediatric nurse from the children's (Rainbow) ward if needed but there was a shortage of staff trained in PLS and APLS in that area also. We were also told that medical staff (ST4 and above) were trained in these areas.
- Between January and September 2015, sickness and absence levels within the department had varied between 1.25% and 6.7%. The latest figures available at the time of inspection was for September 2015 for which the sickness rate was 3.99%.
- The department had access to bank staff if needed in order to ensure that staffing establishment was met. We were told that agency staff were being used less following a recent recruitment but when it was necessary, they tried to use the same staff and who had an appropriate induction.
- There was a robust handover system in place for nursing staff, which happened twice a day. We observed one of these taking place. There was clear communication from the shift coordinator during this time. The handover was used to pass on reminders to staff to complete pro-formas and incident report forms on a more regular basis. Patient information was handed over on a one-to-one basis.
- Staffing levels were visible in all areas of the department for people to see.

Medical staffing

- Medical staffing rotas were completed by the medical secretaries. We observed a 'live' rostering system being used where sickness and absence was recorded so that gaps in staffing could be filled when required.
- The department had ten consultants, nine of which were substantive and one was a locum.

- There were twelve middle grade doctors in the department, nine of which were substantive and three were locums.
- We looked at medical rotas over a four week period leading up to the inspection. We saw that during this time there was sufficient medical cover.
- Consultants were visible through the department and staff told us that they felt that clinical support and supervision was good.
- Handovers were completed by medical staff, which was normally consultant led. This was done verbally with any issues being able to be addressed.
- There was a consultant presence in the department between 8am and midnight. Outside of these hours there was a consultant on call. The department ensured that there was a senior doctor in the department over a 24 hour period.
- Medical staff for children were available between the hours of 9am and midnight in the department. Outside of these hours, children were seen by the adult medical staff and there was access to a paediatric consultant on call.

Major incident awareness and training

- The trust had a policy to deal with major incidents and had carried out a major incident planning exercise within the last 12 months. The department employed two major incident planning trainers. The training they provided focused on setting up the equipment in the event of contaminated patients arriving. Staff informed us that scenario based training was beneficial and allowed them the opportunity to practice setting up and using the equipment.
- There were key contact details displayed in the event of a major incident occurring.
- The accident and emergency department had a large decontamination room with doors leading directly outside. There was a decontamination tent available for screening and treatment of contaminated patients.
- We checked the storage area for major incident equipment. There were two storage rooms, one of which was situated just outside the main building.
- We reviewed inventory records that indicated major incident equipment such as sterile gloves were checked monthly, and found them to be up to date. However, no expiry dates were included in the inventory. This was confirmed by a member of staff and could result in the equipment being used when out of date.
- A resilience plan had been developed to ensure that the hospital would be able to manage the pressures associated with winter. The plan involved partnership working with other agencies to ensure patients were quickly seen and safely discharged. The plan highlighted the actions and responsibilities of each partner agency.

Are urgent and emergency services effective?

(for example, treatment is effective)

Good

The department used evidence based national guidelines and pathways to determine the treatment the provided. There was evidence of multi-disciplinary work with colleagues as well as other agencies.

The average rates of re-attendance within 7 days were better than the national average. Regular audits were undertaken and where areas for improvement were identified, action plans were put in place and re-audits generally showed an improving picture. However, in some areas of treatment such as the management of sepsis, and cognitive screening for patients over 75, improvements still needed to be made.

Staff received an annual appraisal and this had been undertaken for a high proportion of medical and nursing staff at the time of the inspection. Staff were supported to develop themselves and there was a preceptorship programme was in place to support new staff.

Patients were offered pain relief, and their pain scores were recorded appropriately. However, a review of a patients' nutritional requirements was not always documented.

There was limited evidence in the records that staff sought consent, assessed mental capacity when appropriate.

Evidence-based care and treatment

- Care and treatment was delivered in line with evidence based practice and national guidance such as those from the National Institute for Clinical Excellence (NICE) and Royal College of Emergency Medicine (CEM).

- The service had numerous pathways available for staff to follow when needed, such as those for stroke, head injury and chest pain. Staff told us that these pro-formas were easy to access, mainly through the department's IT system.
- There were examples of evidence based audits and care pathways being completed. These included, but were not limited to the fitting child, renal colic, fractured neck of femur, asthma in children and sepsis.
- Medical staff we spoke to had a good understanding of how evidence based practice impacted on their daily responsibilities.
- There were three audits completed for using the pro-forma for cognitive assessment in older people between November 2014 and November 2015. The initial study used a sample of 100 patients and the results showed that these were completed in less than 50% of cases. The performance in this area did not improve in the subsequent two audits. In addition, we reviewed 10 records for patients who met the criteria for this pro-forma to be completed but only one out of these was done.
- The department completed an audit recommended by CEM in August 2015 in relation to the monitoring of vital signs in children. This was completed to identify how the department was performing and identify areas for improvement. The audit was based on a sample of 88 children which found that there was only 65.9% compliance with recording the required vital signs (this includes blood pressure, oxygen saturation, pulse rate, respiratory rate and blood glucose). There was 56% compliance with the documentation of a clinician recognising abnormal vital signs and following this 0% compliance with the vital signs being re-done within a standard of one hour.

Pain relief

- We were shown the result of audits which reviewed the pain relief pathway. There were two audits; the first took place in March 2014 and the second in March 2015. The audits demonstrated a slight improvement between these periods. However, the first audit indicated less than 50% compliance. An action plan was implemented as a result of this. The pain relief pathway was re-audited in March 2015 which showed an improvement in compliance to between 50% to 75% of cases. We asked the trust for a breakdown of the audit and compliance with specific parameters but this information was not provided.
- The department completed a separate nurse documentation audit in October and November 2015. In October, all patients had an initial pain assessment completed although 20% were recorded as not being given appropriate pain relief. Figures from the November audit showed improvement, with all of patients having a pain assessment completed and all of them receiving the appropriate pain relief.
- We reviewed a sample of 20 patient records. Pain scores were appropriately documented in all of these records. Medication was given when required and the effectiveness of the medication was reviewed.
- The 2014 CQC accident and emergency survey showed that the department only scored 5.4 out of 10 when patients and relatives were asked if pain relief was received in a timely manner. However, this was similar in comparison to information obtained from other trusts.
- Patients told us that staff had asked about pain and that they had been given pain relief as required.

Nutrition and hydration

- The department used a 'MUST' (malnutrition universal screening tool) as part of an individual patient assessment. This was to help identify patients that may be at risk of malnutrition and to refer them to appropriate professionals for ongoing support. However, on reviewing patient records we saw that this was not completed in 4 out of 13 cases.
- Staff provided food and drink to patients on several occasions throughout the inspection. There were a set number of health care assistants on every shift who were available to help with this.
- There were vending machines available in the reception area which provided hot and cold drinks along with snacks.
- Results from the 2014 CQC accident and emergency survey showed that this department scored 7.8 out of 10 for providing suitable food and drink, which was better than the performance of similar trusts.

Patient outcomes

- Unplanned re-attendance rates were monitored on a monthly basis. Between September 2014 and November 2015, the rates of re-attendance varied from 3% in June

2015 to 4.5% in November 2015 which were better than the national average of 5%. Unplanned re-attendance rates relate to the number of patients who re-attend the department within 7 days of their last visit.

- There was a consultant audit lead within the department. We saw minutes from audit meetings that were held every four months and in each of these, four audits were selected for study.
- We saw an overview of audits completed between March 2014 and July 2015. Most of these were benchmarked against National Institute for Clinical Excellence (NICE) or CEM guidelines. However, some audits were developed by the department if they had a specific interest or risk in the department.
- The department participated in a national clinical audit of the fitting child in 2014. This showed that the department met the majority of standards. However, as part of this, documentation stating if the parents had been given written information on discharge was 0% against a target of 100%. This was below the national standard. In addition, documentation discussing if the fit had been witnessed was completed in 92% of cases which was marginally below the national standard of 100% but similar to the national average. We saw actions in place for this including leaflets for parents being available on discharge and reminders for staff to complete documentation.
- The department took part in a national clinical audit for the management of patients with a fractured neck of femur in 2010, 2012 and 2015. The results demonstrated consistent improvement in this area and the department performed better than the national average. However, despite the improvements they were still not fully compliant with national standards. For example, one of these standards was for 75% of patients to be given pain relief within 30 minutes of arrival but the results of the 2015 audit showed that this was achieved in 50% of cases. The department had set itself a target of meeting this standard in 2016 and there was an action plan in place to support this.
- Local audits were also undertaken. The department completed a general sepsis audit in November 2014 based on a sample of 104 patients. This audit showed that there was need for improvement as there was less than 50% compliance with this standard. A re-audit of this was completed in July 2015 which showed that compliance had increased to between 50% and 75%. An action plan for improvement was put in place and a further re-audit was completed in September 2015 which demonstrated further improvement in some areas, such as 70% compliance with the CEM standard of antibiotics being given within 1 hour.
- Audits were also completed in accordance with CEM guidelines for neutropenic sepsis (this is caused by a condition known as neutropenia, in which the number of white blood cells are low). This showed considerable improvement in performance over a period from October 2014 to September 2015. The overall compliance during this time had increased from 66% to 82%, an example being 94% compliance in giving antibiotics within the CEM target of 1 hour.

Competent staff

- We looked at appraisal records for nursing and medical staff which showed that 94% of nursing staff had their appraisals completed which was above the trust's target of 90%. However, only 70% of medical staff had completed their appraisals. We were told that it was the individual doctor's responsibility to arrange their appraisal.
- Staff told us that they could request training and development during their appraisal. We saw evidence of 'in house' development training days being available for staff and dates on which these had been completed. Examples included a minor injuries study day and consultant led teaching days covering topics such as allergic reactions, torso injuries and ear, nose and throat infections.
- We saw evidence that staff were being supported to progress their skills. At the time of the inspection, there were two emergency nurse practitioners working towards a degree and a prescribing course and there was an emergency nurse practitioner training to be an advanced nurse practitioner.
- There was a preceptorship plan in place for nursing staff. New members of staff were given an induction booklet to complete and were assigned a named mentor. Clinical induction lasted for four weeks where new staff could work as supernumerary and shadow a qualified member of staff without directly being responsible for patients. We were told that this period could be reduced to two weeks for a more experienced nurse.
- There was a scheme due to commence in 2016 where a band 6 or a band 7 nurse could train to be a confirmer of registration. This meant that they were able to confirm

whether members of staff had the requisite evidence in order to be revalidated with their professional bodies when required. We were told that at the time of inspection not many nurses were able to do this.
- The trust policy states that all staff had access to an annual appraisal and training opportunities and we were told by the trust that all clerical staff had been appraised, however a member of reception staff told us that they had not been included in this.

Multidisciplinary working

- The department worked with teams within and outside the hospital on a regular basis.
- The department worked alongside mental health practitioners for as part of the rapid assessment, interface and discharge (RAID) team. This team was based in the hospital and provided 24 hour cover for assessment of adults with mental health concerns.
- The department had good links with the ACST (access to community services) team which consisted of occupational therapists, physiotherapists and nurses. Their primary aim was to ensure that appropriate care was organised for patients to allow a safe discharge.
- Similarly, there were good links with the complex care team. This team became involved with patients with complex needs whose discharge would take longer than 48 hours. We saw evidence of joint working with staff in the department to identify patients who would require their services.
- The department were involved in child safeguarding meetings which took place weekly. We reviewed meeting minutes which showed that the department was appropriately represented.
- The department worked alongside external voluntary organisations and charities to support patients.

Seven-day services

- The main department was open 24 hours a day, every day. The children's department was only open between 7.30am and 1am. Outside of these times children had to be seen in the same area as adults. Staff did tell us that they tried to provide cubicles for children during these times when possible, although this did not always happen, especially when the department was busy. There was a paediatric bay in the main resus area which was accessible 24 hours a day.
- There was always consultant cover on the department between the hours of 8am and midnight and they were available on call outside of these hours.
- There was minimum of a senior doctor (ST4) available 24 hours a day.
- A 24 hour radiology service was available within the department which included the provision of x-ray facilities and emergency scanning equipment. CT (computerised tomography) and MRI (magnetic resonance imaging) scanning services were available 24 hours but were located in a different part of the hospital.

Access to information

- Staff throughout the department including receptionists, nursing and medical staff had readily available access to IT terminals throughout the department.
- The department had a system that was used and could be accessed throughout the department. This enabled access to patient records, assessments and treatment plans. The co-ordinator was also able to update the system to track where a patient was moving to. All areas in the department had access to this system apart from radiology . We were told by staff in radiology that patients sometimes waited longer than needed as they had to wait for nursing staff to bring a patient's notes before they could be seen.
- The system used provided support for safeguarding and patient assessment through pro-formas which were included as part of the system.
- There was both intranet and internet access for all medical staff, which we were told by staff of all grades that they used on a regular basis and they felt it was an efficient system.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- There was an up to date policy regarding consent, mental capacity and deprivation of liberty safeguards which was accessible to staff on the intranet. Staff were able to find this policy if it was needed.
- We reviewed 20 patients' notes. Out of these records, only two patients did not have capacity and were therefore in need of having a 'best interest' decision made for them. We found that there was no documentation to support this in either case. Best interest decisions are made where a patient who has either a pre-existing condition or an acute illness is

unable to make an informed decision about their own care and treatment. However, we did find that in both of these cases bed rail assessments had been completed appropriately.

- We were told that in order to improve staff awareness, there were e learning modules on the intranet and there was a specific module as part of the mandatory training providing education around dementia, mental capacity and deprivation of liberty. Only 56% of nursing staff had completed this at the time of inspection.
- Staff had access to training modules that involved high risk conflict resolution and clinically related challenging behaviour (MAYBO). We were told that this training involved the use of appropriate restraint if it was needed. This had been delivered to 56% of staff in the department.

Are urgent and emergency services caring?

Good

Care and treatment was delivered to patients in an individual, caring and compassionate way. Staff treated patients and each other with dignity and respect, and interactions were positive.

Staff had a visible person centred approach to delivering care and worked efficiently to ensure the needs of the patients were being met.

Staff actively involved patients and their relatives in the delivery of care and treatment, and tailored their help to the individual needs of the patient.

Patients had a named nurse on admission and we observed staff spending time with the patients to address their individual needs.

The outcomes of national satisfaction surveys were similar to, or, better than other trusts.

Compassionate care

- Patients were positive about their interactions with staff. They told us that the staff were 'lovely' and that they were happy with the care they had received.
- We observed staff being open, friendly and helpful to patients and each other.
- All patients we spoke to reported that the overall view of the quality of the service was good, and that they were happy with the quality of the service received.
- The NHS Friends and Family Test is a satisfaction survey that measures patients' satisfaction with the healthcare they have received. The test data between July 2014 and August 2015 showed the emergency department consistently scored above the England average, indicating that 96.8% of patients were positive about recommending the hospital to friends and family.
- In the 2014 CQC Accident and Emergency survey, patients gave the department a score of 8 out of 10, which was better than other trusts, when asked did the hospital staff tell you who to contact if you were worried about your condition or treatment after you left the Accident and Emergency department.

Understanding and involvement of patients and those close to them

- Patients said that they had been involved in their care and were aware of the discharge plans in place.
- Patients told us that they were supported to contact relatives if required, and they had received information about their care and treatment.
- In the 2014 CQC, Accident and Emergency survey, patients gave the department a score of 8.6 out of 10, which was about the same as other trusts, for how much information about your condition or treatment was given. In addition, patients gave a score of 7.6 out of 10, which was about the same as other trusts, when asked if family or those close to them had been given the opportunity to talk to a doctor.
- Patients that required extra support to make their needs known had a 'This is me' booklet in their notes. This was completed alongside the patient and those closest to them to ensure that it expressed their preferences. We observed the booklet being used on the ward to help meet the needs of patients.
- The service had a dementia champion. Dementia champions are specially trained to help support the care for patients' living with dementia. These champions acted as a point of contact for the staff on the ward.
- The department used a discreet symbol which was placed on the main door outside cubicles to alert staff that a patient had passed away.

- A named nurse for each patient was included on the white board above their beds so that family or those close to them were able to gain information from staff involved in the care of the patient.
- We observed a family member asking for information and the named nurse came in a timely manner to assist in providing advice.

Emotional support

- We observed staff providing reassurance and comfort to patients. Staff took time to understand the needs of the patients' to enable them to best address their concerns. We observed staff taking a detailed history from a patient to ensure they fully understood their circumstances.
- In the 2014 CQC Accident and Emergency survey, patients gave the department 6.7 out of 10 for if you were feeling distressed while in Accident and Emergency department, did a member of staff help to reassure you and 7.2 out of 10 for nurses and doctors discussing any fears and anxieties about your condition or treatment. These scores were about the same as other trusts.
- Patients had an allocated nurse who was able to help support them with any concerns or fears. The named nurse was clearly identified for each patient on the ward.
- The department worked alongside other organisations to provide help to patients. We observed a housing officer providing advice to a patient to ensure that their needs were met prior to being discharged.
- The ward had a bereavement pack for families that included toiletries and a room was available for relatives to have privacy during difficult times.

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

Good

The department had clear strategies in place to deal with differing levels of patient numbers, and there were pathways in place to relieve pressure on the department by referring patients to more appropriate areas or to other medical staff who could deal with them in a more timely fashion.

National targets patients to be seen, treated, discharged or admitted within 4 hours were generally met and performance was consistently better than the national average. The department had identified areas for improvement, such as meeting the national standard for triaging patients within 15 minutes and had put action plans in place to improve this.

There were good systems in place to support staff in meeting the needs of individual patients. There was evidence that improvement had been made in adult mental health services by the implementation of the rapid assessment, interface and discharge team (RAID) who were based on site and are accessible over a 24 hour period. We also saw evidence of an equality and diversity lead and a dementia lead.

Staff did raise concerns on numerous occasions around the poor accessibility of the child and adolescent mental health service (CAMHS). Staff felt that children waited much too long following referrals to CAMHS being completed and that at times they struggled managing the patients as a result of this. We were told that there were systems in place including admitting children if needed to help mitigate this risk.

The children's department was open between 7.30am and 1am the following day. Outside of these times, children had to attend the main adult department which may not be best suited to their needs.

Leaflets were available in the department. However, they were only available in English.

Service planning and delivery to meet the needs of local people

- The children's department was open between 7.30am and 1am the following day. During this time there was an area that was friendly for children which had toys available for them to use and the walls were decorated with murals. Outside of these times, children had to attend the main adult department which may not be best suited to their needs. However, staff did tell us that they would always try to make sure that children were placed in cubicles while waiting.

- Children's nurses were only available during the opening times for the children's department. However, general nurses had access to clinical staff on the children's ward (Rainbow Ward) which was in a separate part of the hospital and there was a paediatric consultant on call.
- A resilience plan had been developed to ensure that the hospital would be able to manage the pressures associated with winter. The plan involved partnership working with other agencies to ensure patients were quickly seen and safely discharged. The plan highlighted the actions and responsibilities of each partner agency.
- The department had links to the hospital at home service which was a service that supported patients at home to prevent hospital admissions. They were also able to offer intravenous (IV) antibiotics in a person's own home.
- We saw that a 'pit stop' triage bay being used in the main department and private triage rooms in the waiting area being used to triage patients.

Meeting people's individual needs

- There was a dementia lead in place for the care of patients living with dementia. The lead worked alongside two link nurses and other nurses who had general dementia training.
- There was a pro-forma available to act as a reminder for staff in the department to initiate an assessment by an appropriate nurse where required. A system was also in place where patients over 75 years of age should be routinely asked if there has been a history of memory problems in the last 12 months. This led to a dementia screening being completed by an appropriate nurse.
- There was a marker available to identify patients with dementia. The marker goes both on the cubicle and on the patient records. However, there were no reasonable adjustments in place apart from the use of side rooms.
- We observed two patients living with with dementia; both of these had been appropriately identified and managed.
- We were also shown 'twiddlemuffs'. These are double sided gloves which have been designed specifically for patients with dementia to be used as a distraction while they are waiting. We were told this strategy can be very effective.
- We observed the 'red tray' system being used effectively on two occasions. This is a system that was used to help staff identify patients who may need support eating. Staff told us that this was used throughout the department.
- There was a rapid assessment, interface and discharge team (RAID) being used at the hospital 24 hours a day. This initiative was developed as a result of mental health services being based of site which resulted in extended waiting times and problems in meeting the needs of patients. This was reflected in poor results from mental health audits that had been completed.
- Staff who specialise in dealing with patients with mental health concerns were based in the hospital 24 hours a day. We were told that patients were being seen in a more timely manner and patient's individual need was being met as a result of this.
- Staff told us that they questioned whether the needs of children with mental health concerns were met on a consistent basis. The child and adolescent mental health team (CAMHS) was not based on site which could lead to long delays. We were told that this was a problem mainly for adolescents as many of them were very reluctant to remain the department for a long period of time so they were difficult to manage. Staff told us that they did not feel that they had the training to deal with this effectively while waiting for a long period of time.
- There were translation services to use when required. There was a telephone based system in place to assist when patients initially presented in the department and there was access to interpreters when required.
- Leaflets were available in the department. However, they were only available in English. There were contact details listed on there if they were required in other languages.
- There was evidence that equality and diversity was taken into consideration. There was an equality and diversity champion in the department who supported staff with issues surrounding disability, cultural belief and sexual orientation.

Access and flow

- Between March 2015 and the time of inspection, the departments performance in meeting the Department of Health target for 95% of patients to be seen, treated,

discharged or admitted within 4 hours was mixed. The service met the target in six of the nine months. However, performance was consistently better than the national average in that time.

- The percentage of patients waiting between 4 to 12 hours for admission to the hospital from the time the initial decision to admit was taken was consistently better than the England average from July 2014 to July 2015.
- The department monitored patients who left without being seen on a monthly basis. Between November 2014 and October 2015 this was consistently better than the national target of 5%.
- From July 2014 to July 2015, the median time to initial assessment (triage) was lower (better) than the England average.
- The service continuously met the Department of Health 1 hour target which measured the median average time of arrival to the start of definitive treatment between August 2014 and June 2015.
- The ambulance time to treatment was similar to the England average and generally lower than the standard aside from an increase in performance in July 14.
- The department failed to meet national targets for ambulance turnaround times of 30 minutes. On around 40% of occasions in 2014, the patient handover took between 30 and 60 minutes. This rose to around 50% during 2015.
- Between October 2014 and August 2015, there were 664 instances where ambulance staff had to wait for more than an hour to hand over their patient.
- The department used an electronic dashboard (Accident and Emergency APP) that constantly monitored flow through the department. It used predictive information based upon seasonal variances and data from previous years to generate likely numbers of attendees to the department. The system also used live data of ambulances on route to the department. Where demand was strong at particular times of the day the department was able to flex staff from other areas to ensure response rates were maintained.
- Meetings were held several times a day to discuss flow through the hospital. This helped ensure there were enough beds available for patients being admitted and reduce the waiting time in department. We were shown the Accident and Emergency APP in operation and found that it gave real time data to hospital performance. The system was on the department wall so that everyone was able to monitor patient flow.
- Patient flow was consistently included on the trust's risk register. Overall bed capacity was listed as the main factor for delays in the department. A clear action plan had been put in place around this including the use of an escalation policy.
- The ambulatory unit was used to assist with demand and capacity with staff being able to triage patients directly to this area when appropriate. There were nursing staff, a doctor and a consultant available in the there at specific times of the day. They could sometimes review and discharge patients in a more timely fashion than if they waited in the main department to be seen.
- The service also had a clinical decisions unit (CDU) available. There was a specific policy in place regarding its use. Patients were not supposed to be in this department longer than 48 hours. However, we reviewed two patient's records who had been there longer at the time of the inspection.
- In 2014, the department introduced an initiative called ISAT (initial senior assessment and treatment), which was led by a senior doctor. The ISAT initiative was based around rapid assessment at triage so that a patient's care could be instigated quickly. This was available between the hours of 12pm to 8pm on a daily basis. The department carried out an audit in July 2015 to assess the effectiveness of the service. A sample of 100 patients was used and the audit showed that time to initial assessment, investigations and initial treatment were reduced and the overall time to discharge from the department was reduced by an average of 70 minutes.
- There was a general practitioner (GP) available in the department between 1pm and 8pm, Monday to Friday, and 11am to 7pm at weekends. Patients could be triaged directly to the GP where appropriate, which allowed patients to bypass the main department.
- There were three bed meetings per day to discuss and manage patient flow through the hospital.
- We observed a meeting which took place once a week called the 'communications cell' which allowed access and flow to be discussed by representatives of different departments within the hospital. We saw that this was

attended by representatives of the surgical team, the medical team, the discharge planning team and business intelligence as well as representatives of the emergency department.

Learning from complaints and concerns

- We reviewed a sample of formal complaints made between February 2015 and September 2015. Complaints that were made during these periods were mainly around staff attitude, general experience in the department and waiting times.
- We saw that complaints were dealt with in a positive way. There was a named person assigned to manage each individual case. An investigation was carried out and an action plan and outcome was also documented as a result.
- We saw evidence that the outcome of complaints was discussed in monthly clinical governance meetings.
- We were told by reception staff that they knew how to provide information to patients or relatives about how to make formal complaints. We also observed information about this in the main waiting area and leaflets were available.

Are urgent and emergency services well-led?

Good

The trust had a clear vison and strategy with a clear commitment to quality. The department was managed by an accessible management team that were visible and well known to the staff. Managers spent time in the department, providing support and encouragement.

There was a positive culture throughout the department. Staff were very positive about their managers and felt supported to carry out their roles. Staff felt confident in raising concerns, they felt they were able to suggest improvements and were proud to work for the trust. Many staff had been in post for many years.

There were a range of reward and recognition schemes to recognise the work that staff completed in ensuring quality of care and patient safety.

The department actively sought feedback from patients and visitors to help improve the quality of the service.

A risk register was in place and monitored regularly with actions and review dates. However, not all departmental risks assessments to mitigate the impact of risk were routinely updated in a timely way, or completed.

Vision and strategy for this service

- The trust had a clear vision and strategy with a clear commitment to quality. The trust's mission was to provide the best quality healthcare for patients. Their vison was to be in the top 10 percent for everything they do and to be safe, effective and caring; with patient safety as their highest priority. Staff had a good understanding of the vision and reported that patient care and quality came first.
- The department managers had a realistic strategy to improve care for patients, and had seen an improvement in results in department waiting times, staffing levels and results from national audits.
- In the 2014 national staff survey, 80% of staff agreed that "care of patients is my organisation's top priority" compared to 71% the previous year and a national average of 67%.

Governance, risk management and quality measurement

- The trust used a risk register to monitor risks; actions to mitigate risks were recorded with progress and review dates in place. Items on the register reflected those highlighted by the senior staff.
- Although a risk register was in place and monitored regularly, we found that departmental risks assessments may not be reviewed in a timely way or, in some instances, completed at all. For example we observed that the risk of not having a 24 hour children's emergency department (CED) was completed in 2012 but then only updated again in 2015. In addition, there were some concerns in the CED about the risk of children leaving unattended or unauthorised visitors entering through a gate with a slide lock but a risk assessment had not been completed and instead, the security of children in the department relied upon staff and parent vigilance.
- Monthly governance and quality meetings were in place in the directorate. There was a set agenda which included review of incidents, key risks, monitoring of performance, complaints, infection control, mortality and morbidity rates. From reviewing the minutes of these meetings we saw how performance shortfalls

were addressed and action plans formulated. Actions and key points from the governance meetings were cascaded to staff through team meetings, a communication book and via email to ensure that staff were kept informed.

- A divisional quality executive committee met monthly to discuss quality, risks and safety across the medicine division. Clinical incidents, medicine safety, divisional risk register, complaints and patient experience were discussed at each meeting, with action plans for service improvement, ensuring that quality and patient safety were priorities of the service.
- Information relating to performance against key quality and safety performance i.e. cleanliness and infection control audits were posted on the walls within the department so that patients, visitors and staff were kept informed. We observed the information to be up to date and displayed in a user friendly way.
- The service used a performance dashboard to measure key quality indicators in terms of meeting standards. Improvements in performance were ongoing and the managers of the department were clear in the work needed to improve performance.
- The trust recognised that an important element of achieving high quality care was to ensure that the staff had the capacity and capability to deliver improvement. From 2012 to March 2015, 259 staff across the trust had signed up to be quality champions. The aim was to involve staff to help improve services for patients. All quality champions who had completed the training programme and commenced an improvement project were awarded a bronze badge. Silver and gold badges were awarded to those champions who sustained their improvements and disseminated them to other organisations.

Leadership of service

- The emergency department was part of the medicine division and was led by the divisional medical director, the deputy director of operations, a clinical director, head of nursing and an unplanned care manager. The department had a matron to provide an interface between staff and senior managers.
- The senior team were visible and accessible and were well known to the staff group. We observed leaders to be on the ward supporting staff at busy times. Staff knew who their leaders were, and felt that managers were supportive and approachable.
- The matron for the department had many years' experience and had recently been awarded the Healthcare professional of the year award for 2015 for excellence in her role in the department.
- The managers encouraged continuous development, through personal development reviews and in house training. We reviewed 10 personal development records and found that staff had objectives set, and plans for personal development.
- The department had a practice development nurse who completed training logs to ensure staff were up to date with the personal development and training requirements. We reviewed records for staff and found that courses both internally and externally had been booked up until April 2016 to ensure continuous development.
- The ward had a programme of in-house training and study days, delivered by the medical team and by staff from the ward. The training included major incident training, sepsis, tissue viability, minor injuries and x-ray.
- The medical team had a teaching rota which was operated by consultants. The teaching rota for May 2015 through to November 2015 was evident on the ward and included teaching on torso injuries and allergic reactions. Staff we spoke to reported that the training was beneficial and helped them to provide quality care to their patients.

Culture within the service

- Staff felt respected and valued by the trust. Staff reported that the trust listened to their views, they took part in staff surveys and there were schemes in place to recognise the good work that staff had done.
- The NHS staff survey in 2014 showed that 78% of staff would recommend the organisation as a place to work, compared to 66% who felt this the previous year and a national average of 55%.
- There was an emphasis on staff wellbeing. The managers understood the impact of short staffing within the department. A recruitment drive had filled all nurse vacancies. A full establishment of nursing staff had been in place for three months.
- Staff reported that their wellbeing was supported by a range of services, including counselling and personal 1:1 if required. Debriefing sessions were held following

particular difficult times in the department. Staff we spoke to were aware of different support mechanisms, and felt if they had any issues they could speak to their managers.
- Staff reported that they were encouraged to highlight concerns, and felt that they could speak up and challenge managers.
- The trust had an online system where staff were able to put forward their views and gain feedback from the senior managers. Staff were positive about the access to the senior management and felt that they were being listened to.

Public and staff engagement

- The trust had a 'recognising excellence awards', and an employee of the month/ year award, to recognise the work and contribution that staff make to the delivery of the service.
- The department also ran its own employee of month scheme to recognise the hard work of the staff in the department. The staff felt this was good for morale in the department.
- The trust actively sought feedback and suggestions from its patients and visitors. We observed they used the friends and family test to gather the views of patient and family experiences. The trust had a twitter and Facebook account and a feedback form on the website so that people were able to share their views and experiences electronically. Comments posted on the Facebook page in November for the Accident and Emergency department were favourable and one patient wrote; "So impressed with this hospital, the staff are so pleasant, helpful and kind. In particular I would highly like to thank the kids Accident and Emergency nursing staff and the fracture clinic; we were treated with such care and compassion".
- The department had good links with the volunteer services and they were present on the department. Leaflets were displayed, and the organisations visited the department to offer their services. The department also ran a tour of the department for the community learning disability service to help alleviate the fears and anxieties of a hospital admission.
- Staff views were positive and they felt that they were included in the delivery of their service. Regular meetings took place, and information was disseminated in a variety of ways to keep them informed.
- The department ran a scheme known as the '12 days of Christmas'. This scheme was in partnership with the greater Manchester police. The scheme provided police officers on the department leading up to Christmas between the hours of 11pm to 7am alongside the 24 hour security team to ensure the safety of patients and staff.
- The department carried out surveys to gather the views of patients. In the 2014 survey, patients had asked for more privacy when booking in at reception. During the inspection the booking in area was being revamped to offer patients better privacy.

Innovation, improvement and sustainability

- The department used an electronic dashboard (Accident and Emergency APP) that constantly monitored flow through the department. It used predictive information based upon seasonal variances and data from previous years to generate likely numbers of attendees to the department. The system also used live data of ambulances on route to the department. Where demand was strong at particular times of the day the department was able to flex staff from other areas to ensure response rates were maintained.
- Meetings were held several times a day to discuss flow through the hospital. This helped ensure there were enough beds available for patients being admitted and reduce the waiting time in department. We were shown the Accident and Emergency APP in operation and found that it gave real time data to hospital performance. The system was on the department wall so that everyone was able to monitor patient flow.
- The department recognised the importance of service improvement and had a number of staff who had been given quality champion awards, and others that were about to start the quality champion programme. We observed that the department had two staff that had been given gold awards, one staff member had been given a silver award, and three staff given bronze award. Staff wore their awards and reported that they were proud of the achievement and recognition for the contribution they had made to service improvement.

Medical care (including older people's care)

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

Information about the service

Medical care services at the hospital provide care and treatment for a wide range of medical conditions, including general medicine, cardiology, respiratory and gastroenterology. The trust provides a stroke service which is part of the Greater Manchester regional thrombolysis service.

There are a total of 497 beds in total at the hospital. The hospital provides medical care services to a population of 320,000 people and between January 2014 and December 2014 there were around 31,818 admissions.

We visited the Royal Albert and Edward Infirmary as part of our announced inspection on 9 and 11 December 2015.

As part of this inspection we visited the Ince ward (cardiology), Winstanley ward (respiratory medicine), Lowton ward (general medicine), Shevington ward (geriatric medicine), Standish ward (geriatric medicine), cardio-respiratory unit, coronary care unit, acute stroke unit, ambulatory care, discharge lounge and the endoscopy unit.

We reviewed the environment and staffing levels and looked at 26 care records and 15 medication records. We spoke with five family members, 22 patients and 58 staff of different grades, including nurses, doctors, ward managers, matrons, ward clerks, chaplain, allied health professionals, such as physiotherapists and occupational therapists, and the senior managers who were responsible for medical services.

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

Medical care (including older people's care)

Summary of findings

We found that the Royal Albert and Edward Infirmary was delivering good medical services to patients but some areas of the service, particularly those relating to safety, required improvement.

All staff knew the trust vision and behavioural framework and said they felt supported and that morale was good. All staff were committed to delivering good, compassionate care and were motivated to work at the hospital.

The hospital had implemented a number of schemes to help meet people's individual needs, such as the forget-me-not sticker for people living with dementia or a cognitive impairment and a red label to indicate that a patient was frail or elderly. This helped alert staff to people's needs. However, we found on the discharge lounge patients' privacy and dignity was not always being maintained and this was due to the facilities available not being fully used.

People were supported to raise a concern or a complaint and lessons were learnt and improvements made. Medical services captured views of people who used the services with changes made following feedback. A survey showed that people would recommend the hospital to friends or a relative.

There were governance structures in place which included a risk register. Some actions on the register had no timeframes for completion and it was unclear if these were being managed in an effective way to lower the risk.

There were concerns in relation to nursing staffing on some of the wards during the day and at night, especially on Ince ward and Astley ward. Clinical staff had access to information they required, for example diagnostic tests and risk assessments. However, we found records were left unsecured on the wards we visited and whilst records did include a treatment plan for each patient, there were standards for record keeping that required improvement.

Clinical waste was not always being stored in the designated places and there were concerns over the design of the endoscopy unit leading to the use of the discharge lounge to recover patients. There were also concerns about the decontamination facilities on the unit.

Nursing staff were unclear about the procedures to follow when reaching decisions about using bed rails which are a form of restraint. This was due to the assessment paperwork not including the recording of consent or best interest decisions but staff knew about the key principles of the mental capacity act. Incidents were reported by staff through effective systems and lessons were learnt and improvements made from investigations where findings were fed back to staff. There were systems in place to keep people safe and staff were aware of how to ensure patients' were safeguarded from abuse. The hospital was clean and staff followed good hygiene practices.

There were a number of patients being cared for in non-speciality beds but there were clear protocols in place to help manage care for these patients. Best practice guidance in relation to care and treatment was usually followed and medical services participated in national and local audits. Action plans were in place if standards were not being met.

Medical care (including older people's care)

Are medical care services safe?

Requires improvement

There were some staff vacancies which were noted on the risk register and actions had been identified to mitigate this risk. However, there were occasions where the nurse staffing levels were not overall sufficient to meet the needs of patients, for example on Ince ward and Astley ward.

Equipment had up to date electrical safety certificates but clinical waste was being stored in an unlocked area on Ince ward. We found used sharps containers which had been left open in unlocked areas which were accessible by patients and the public and cleaning chemicals had been left out in an unlocked room on a number of wards. The design of the endoscopy unit did not accommodate mixed gender lists but alternative processes were in place to maintain patient dignity through recovery in an alternative area. There had also been incidents when the decontamination units had broken down but the trust were taking action to address this.

The records we looked at were documented accurately and medical decisions were documented clearly. However, records trolleys were left unlocked on some of the wards we visited and there were some standards for record keeping that required improvement.

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

Incidents were reported by staff through effective systems and lessons were learnt and improvements made from investigations There were systems in place to protect people from avoidable harm and staff were aware of how to ensure patients' were safeguarded from abuse. The hospital was visibly clean, staff followed good hygiene guidance and there was appropriate monitoring of infections.

Incidents

- There were systems in place for reporting actual and near miss incidents across medical services. Staff were familiar with and encouraged to use the trust's procedures for reporting incidents. There was evidence that staff understood their responsibilities to raise concerns and record safety incidents.
- There had been one never event reported in medical services in December 2014. Never events are serious, wholly preventable incidents that should not occur if the available preventative measures had been implemented. The incident had been fully investigated and changes made to practice. For example, a checklist had been implemented to visually check all equipment before and after procedures.
- From August 2014 to July 2015 medical services at the hospital reported 1,857 incidents, which included 11 serious incidents. These were mainly in relation to pressure ulcers, ward closures and infection control issues. All serious incidents were investigated and action had been taken to prevent re-occurrence. All other reported incidents were rated as low or moderate harm.
- There were examples of learning and changes to practice following an incident. For example, in response to a medication incident, it was reinforced with staff that medication rounds should be completed by two members of staff instead of one and the doors on the Winstanley ward were closed whilst medication was being given to patients this helped to reduce medication incidents.
- Learning from incidents was discussed during team meetings, shared via email and communicated by a five point weekly communication bulletin. Staff signed to say they had read the bulletin on the wards we visited. However, on the Ince ward there was no evidence the bulletin had been shared and read by staff since September 2015.
- Minutes of key governance meetings in medical services showed that incidents and learning were discussed and actions identified to improve care provided. For example, one action identified was to include additional categories on the incident reporting system for neurological observations.
- The trust's policy for duty of candour had been implemented. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that

person. Staff understood the principles of the duty of candour and could clearly outline when this would be applied. We saw evidence of the policy being applied appropriately.
- Multidisciplinary mortality and morbidity reviews took place on a quarterly basis and staff had identified key themes, for example, poor documentation and access to hospice care. The themes were discussed at key governance meetings to identify learning for each ward.

Safety thermometer

- The trust was required to submit data to the health and social care information centre as part of the NHS Safety Thermometer (a tool designed to be used by frontline healthcare professions to measure a snapshot of specific harms once a month). The measurements included pressure ulcers, falls and catheter acquired urinary tract infections.
- From August 2014 to October 2015 there were two pressure ulcers reported across medical services at the hospital. In the same period, there were five falls which resulted in harm and one catheter-acquired urinary tract infection.
- Results of the safety thermometer were displayed on every ward and area we visited. The results related to that individual ward or area. Ward managers had actions in place for improvement when there had been a reduction in performance against previous months.
- The trust had a falls team that undertook a rapid review of all falls that occurred. Learning from these reviews included the introduction of 14 safety matrons across the trust, a volunteer on the Standish ward to sit with patients with a cognitive impairment and a high risk of falls and volunteers and auxiliary nurses sitting with high risk patients at meal times.

Cleanliness, infection control and hygiene

- The wards we inspected were visibly clean and well maintained. All staff were aware of current infection prevention and control guidelines. This included the use of 'I am clean' stickers to inform colleagues at a glance that equipment or furniture had been cleaned and was ready for use.
- Between June 2014 and April 2015, the trust's overall performance with regard to infection rates was mixed. They had sometimes been better than the England average and sometimes worse. There had been one case of methicillin-resistant staphylococcus aureus (MRSA) reported, 22 cases of clostridium difficile and 11 incidents of methicillin-susceptible staphylococcus aureus (MSSA) at the trust.
- In medical services there had been two incidents of clostridium difficile and there had been no incidents of MRSA between April 2015 and July 2015.
- There were sufficient hand wash sinks and hand gels. Hand towel and soap dispensers were adequately stocked. All wards had antibacterial gel dispensers at the entrances and by people's bedside areas and appropriate signage, regarding hand washing for staff and visitors, was on display.
- Staff consistently followed hand hygiene practice and 'bare below the elbow' guidance. Personal protective equipment (PPE) such as aprons and gloves were readily available and in use in all areas.
- Side rooms were used as isolation rooms for patients identified as an increased infection risk (for example patients with MRSA). There was clear signage outside the rooms so staff were aware of the increased precautions they must take when entering and leaving the room. These rooms were also used to protect patients with low immunity.
- Cleaning schedules had been completed as required. The trust used the national colour coding scheme for hospital cleaning materials and equipment. This ensured that these items were not used in multiple areas, therefore reducing the risk of cross infection. Cleaning store rooms were generally clean and tidy.
- We observed that the disposal of sharps, such as needle sticks followed good practice guidance. Sharps containers were dated and signed upon assembling them and the temporary closure was used when sharps containers were not in use on the majority of the wards. However, on the Ince ward and the discharge lounge, we observed that there was a sharps container, containing used cannulas and needles, left open in an unlocked room which was accessible to patients and the public. We raised this with staff who immediately closed the container.
- Infection, prevention and control (IPC) audits and hand hygiene audits were carried out on a regular basis on each ward. These identified good practice and areas for improvement. Key actions were identified to be implemented by the staff team, for example, there were a reminder sent to staff to ensure that they had access to products and were familiar with the trust policy for

dealing with spillages such as blood and body fluids. Compliance levels of hand hygiene audits across the wards were mostly good. Only Ince and Lowton wards in medical services achieved less than 90%. Their scores were marginally below at 89%.

Environment and equipment

- The wards and areas we visited were well maintained.
- There were systems in place to maintain and service equipment. Portable appliance testing had been carried out on electrical equipment regularly and electrical safety certificates were in date. Hoists had been serviced appropriately.
- Resuscitation equipment was available on all the wards we visited. Resuscitation trollies were locked and tamper seals were in place. Emergency drugs were available and within the expiry date. Records indicated that checks of the equipment had been completed on a regular basis.
- There was no lock to the main door on the room used to store dirty linen and clinical waste on the Ince Ward. Department of Health guidance on the safe management of healthcare waste (HTM 07-01) states: "Storage areas at the point of production (that is, patients' rooms) should be secure and located away from public areas." This meant there was a risk that clinical waste could be accessed by patients and the public which presented a risk of harm to people's health. Senior staff assured us that this would be looked into. All the other wards we visited used locked cupboards in the main corridor designated for clinical waste and dirty linen.
- We observed commodes stored in dirty utility rooms on the Shevington and Ince wards that had 'I am clean stickers' in place.
- Due to the design of the endoscopy unit, there were occasions when the service had to use the discharge lounge as part of the recovery process. The trust told us that when this occurred a trained nurse was allocated to remain with the endoscopy patient at all times and they had had the appropriate training. However we observed this did not always happened and a patient was not in line of sight of the nurses in the discharge lounge due to the position of the bedded area. Staff on the endoscopy unit said that a member of the endoscopy services was not always present with patients recovering on the discharge lounge and there had been patients sent down who could potentially be unstable. This meant that patients may be exposed to a risk if their condition deteriorated. However, nurses in the discharge lounge did know who to contact in an emergency. Between January 2015 and December 2015, there were 155 patients recovered in the discharge lounge following an endoscopy.
- There were incidents when the machines used to decontaminate endoscopes had broken down. This was recorded on the risk register and a business case was currently being implemented. This included shared replacement decontamination equipment with surgical services. We were assured by senior staff that there was a priority system in place for patients requiring an endoscopy when one of the machines broke down.
- Cleaning chemicals were left in an unlocked area on the discharge lounge and on the Shevington ward. These should have been stored securely as the chemicals were potentially hazardous and presented a risk to people's health.
- Patient-Led Assessments of the Care Environment (PLACE) assessments for 2015 showed a score of 99% for facilities across the trust, which was better than the England average of 90%. The trust was in the top 10% nationally for PLACE scores performance as at 2015 ranking 2nd out of 139 trusts.

Medicines

- All wards had systems in place for the safe handling and disposal of medicines. Ward based staff reported a good service from the pharmacy team.
- There were suitable arrangements in place to store and administer controlled drugs. Stock balances of controlled drugs were correct and two nurses checked the doses and identified the patient before medicines were administered. Daily checks of controlled drugs balances were recorded as outlined in the trust procedures.
- Medicines requiring storage at temperatures below eight degrees centigrade were appropriately stored in fridges. Records indicated that fridge temperatures were checked daily on all of the wards we visited. On questioning, staff knew how to reset the thermometer to check the fridge temperature range.
- All medicines on the wards were found to be in date, indicating that there were good stock management systems in place.

- Suitable cupboards and cabinets were in place to store medicines. This included a designated room on each ward to store medicines.
- We looked at 15 sets of medication records which indicated that patients were given their medicines in a timely way, as prescribed, and records were completed appropriately.
- We saw that antibiotics, for patients who required them, had all been prescribed in line with guidance.
- We found that there was a lack of documented prescribing on Winstanley ward and Ince ward for patients who required oxygen. Staff said this would be rectified when electronic prescribing was implemented in March 2016.
- We reviewed incidents of medication errors on seven medical wards between August 2014 and July 2015. There had been 320 medication errors reported with over 90% resulting in no patient harm. All had been investigated and appropriate action taken.
- The medicines safety newsletter was available on the intranet for staff. This included learning points from medication errors to be shared with staff.

Records

- We looked at 26 patient records and saw they included a range of risk assessments and care plans that were completed on admission and reviewed throughout a patient's stay. Patients had an individualised care plan that was regularly reviewed and updated in the records we reviewed.
- In most areas, records were stored in unlocked trolleys on the wards. This increased the potential for patient confidentiality to be breached.
- In the records we looked at, documentation was accurate, legible, signed and dated. They were easy to follow and medical staff had detailed information for patient's care and treatment.
- The trust undertook regular record keeping audits twice a year. The last audit in May 2015 showed that errors were not always being crossed out correctly and were not signed. Also, times when entries were written were not always documented and the patient number and the role of clinician making the entry were poorly recorded. Recommendations had been identified which included ensuring that staff crossed out any error with a single line only and were signed and dated separately.

Safeguarding

- There was a system in place for raising safeguarding concerns. Staff were aware of the process and safeguarding advice was accessible 24 hours a day, seven days a week, for staff if they had concerns.
- Between April 2014 and March 2015 there had been 526 contacts with the trust safeguarding team regarding adult safeguarding referrals across the trust; 271 of these resulted in actual safeguarding referrals.
- Training statistics provided by the trust showed that the majority of the staff had completed safeguarding adult training. Compliance rate at the hospital was mostly above the overall trust target of 95%, except for medical staff whose compliance rate was 78% and estates and ancillary staff which was 92%. Safeguarding training includes basic awareness of mental capacity act principals.
- Safeguarding training was included in induction training for all temporary staff before commencing work on the wards.

Mandatory training

- Staff received mandatory training on a rolling annual programme and was in areas such as health and safety, fire, manual handling, safeguarding and infection control and prevention.
- Information provided by the trust at the time of our inspection showed that the compliance rates for nursing and midwifery staff was mostly above the trust target of 95%. However, it was only 84% for basic life support and mental capacity act training (MCA) was only 52%. This was because specific MCA e-learning graining had only been available since September 2015. Compliance rates for medical and dental staff was below the trust target for information governance at 76% and infection control training at 75%.
- From the information the trust provided the compliance rate for other staff groups, including allied health professions, such as physiotherapists and occupational therapists across the trust, was above the trust target of 95% except in mental capacity act training which was between 56% and 62%.

Assessing and responding to patient risk

- A modified early warning score system (MEWS) was used throughout the trust to alert staff if a patient's condition

was deteriorating. Early warning indicators were regularly checked and assessed. When the scores indicated that medical reviews were required staff had escalated their concerns.

- Medical services undertook an audit of the MEWS system in 2015. This identified areas of good practice and areas of improvement. An action plan was in place to improve standards. For example ward managers were to identify training gaps and arranging the necessary training for staff.
- Upon admission to medical wards staff carried out risk assessments to identify patients at risk of harm. Patients at high risk were placed on care pathways and care plans were put in place to ensure they received the right level of care. The risk assessments included falls, use of bed rails, pressure ulcer and nutrition (Malnutrition Universal Screening Tool or MUST).
- To continually assess patient risk, intentional observation rounds were completed on patients every two to four hours depending on need.
- Matrons did not undertake a regular formal assessment of ward areas to look at patient safety and risks, such as incidents, safeguarding and cleanliness to improve standards for patient care. We did see a checklist that had been developed but this had not been implemented. A matron told us that this was still under discussion. However, we did see a matron on a number of the wards we visited asking the ward manager if there were any issues that needed highlighting and incidents and safeguarding referrals were discussed at key governance meetings.

Nursing staffing

- Matrons met regularly to discuss nurse staffing levels and ensure staff and skills were appropriately deployed and shared across all wards.
- Managers knew where there were shortfalls and where there was surplus on other wards so that staff could be called on if needed.
- Each ward had a planned nurse staffing rota and managers reported on a daily basis if shifts had not been covered. The National Institute for Health and Care Excellence (NICE) guideline 'Safe staffing for nursing in adult inpatient ward in acute hospitals' was used by the trust to determine their staffing needs. Medical wards undertook an audit every three months.
- Medical wards displayed nurse staffing information on a board at the ward entrance. This included the staffing levels that should be on duty and the actual staffing levels. This meant that people who used the service were aware of the available staff and whether staffing levels were in line with the planned requirement.
- On the day we inspected medical services at the hospital the majority of shifts were filled as planned.
- We looked at staffing levels for eight medical wards between June 2015 and October 2015. The average percentage of nursing shifts filled as planned during the day was variable. There were concerns over Astley ward at 76%, coronary care unit at 83%, Ince ward at 86% and Pemberton ward at 80%. The remaining four wards were over 90%.
- For the same period, the average percentage of nursing shifts filled as planned during the night between June 2015 and August 2015 were over 90% except for the Astley ward at 70% and Ince ward at 68%. Staff said when there was a shortage of registered nurses extra nursing auxiliaries were brought in to provide extra support for patients. For example in August 2015 there were 167% of nursing auxiliary shifts filled at night on Astley ward and 118% filled at night on Ince ward. However, this meant there was a risk that there was not enough staff with the right skills on duty.
- The establishment for the majority of the medical wards was a ratio of 1 registered nurse to 14 patients at night. A matron told us they felt that this was insufficient and had raised this with senior staff but the establishment had stayed the same. We looked at the night rotas for October and November 2015 for Ince ward which was a 28 bedded ward. In October, there was only one registered nurse on duty on two occasions instead of two due to short term sickness. The trust told us that both shifts were covered by a nurse doing an additional shift. In November this occurred on six occasions. The trust told us that they had made arrangements for the shifts to be covered by nurses doing additional shifts on four occasions and on two occasions senior cover was provided by the night hospital co-ordinator. However, when we reviewed the night nurse staffing figures for Ince ward reported to the trust board, we found that the fill rate for October 2016 was only 68% and for November 2016 63%. This meant there was a risk that patients did not receive the care they needed on these occasions.
- Senior staff said they tried to use the same bank and agency staff to ensure that they had the required skills to work on the ward. The number of agency and bank

staff used in medical services varied. However, from the information provided by the trust there had been an increase in the number of agency staff used on some of the wards in March 2015. For example the percentage of agency staff used on Standish ward was 20% and on Shevington ward it was 19% of shifts filled by agency staff. Agency staff were given an induction before commencing work on the wards.

- The number of nurse vacancies in medical services at the hospital was generally low. For example the highest vacancy rate at the times of the inspection was 10.68% for Ince ward. The turnover rate of nursing staff was variable, for example Ince ward was 9.88% and Shevington ward was 17.95% for the last 12 months. Nurse staffing was on the trust risk register and on the medical care divisional risk register. Actions had been identified to mitigate the risk. These included a review of the recruitment processes, daily reviews of staffing levels and a recruitment programme.
- We saw effective handover meetings between nursing staff and assistant practitioners which highlighted key risks. There was a checklist to help ensure all relevant information was shared with staff. This included deteriorating patients, falls, incidents and staffing.

Medical staffing

- Rotas were completed for all medical staff which included out of hours cover for all medical admissions and all medical inpatients across the wards. The information we reviewed showed that medical staffing was appropriate at the time of the inspection.
- Patients reported that they did not always see a doctor at the weekends, although there was sufficient cover outside normal working hours and at weekends should patients need to see a doctor. Consultant cover was available on site from 8am to 9pm daily and on call outside of these hours. There was an acute medical consultant who could get to the hospital within 30 minutes in an emergency.
- The percentage of consultants working at the trust was 45% which was higher (better) than the England average of 34%. The percentage of registrars was 34% which was lower (worse) than the England average of 39%. The percentage of junior doctors was 13% which was lower (worse) than the England average of 22%. Middle grade levels were 9% which were higher (better) than the England average of 6%.
- The turnover rate of medical staff was variable, for example the in the cardiology department it was 0%, endoscopy unit was 10% and general medicine department was 18% for the last 12 months..
- At the time of the inspection the vacancy rate for medical staff at the hospital was 19.63% in endoscopy services and the junior doctor rate was 12.9%. However, in the cardiology department and the general medicine department the vacancy rate was 0%.
- Vacancies in medical staffing was on the risk register with clear actions to lower the risk. These included a national and international recruitment plan.
- The use of locum medical staff across the trust during April 2014 to March 2015 was variable. However, in medical services it was mostly low. For example in general medicine at the hospital it was low at 0.2% and in cardiology, 7.4% of shifts were filled by locum staff.

Major incident awareness and training

- There were documented major incident plans within medical areas and these listed key risks that could affect the provision of care and treatment. There were clear instructions for staff to follow in the event of a fire or other major incident.
- Staff were aware of what they would need to do in a major incident and knew how to find the trust policy and access key documents and guidance.
- Staff in medical services had been involved in major incident exercises.

Are medical care services effective?

Good

Care and treatment was provided in line with national and best practice guidelines. Medical services participated in the majority of clinical audits where they were eligible to take part. For example the heart failure audit. Recent national audits indicated that there had been progress made to improve care for people who had chronic obstructive pulmonary disease and for patients who had a stroke and action plans were in place to improve this further. Services had undertaken a successful project in reducing aspiration pneumonia and reduced the mortality rate. Nutrition and fluid intake were recorded correctly and support was provided for patients

that needed assistance with eating and drinking. There was a focus on discharge planning from the moment of admission and there was good multidisciplinary working to support this.

There was evidence that services were provided seven days a week. Most staff said they were supported effectively but the number of staff who had received their annual appraisal was below the trust target. The endoscopy service had not achieved accreditation but plans were in place to improve this and gain accreditation.

We found that staff members' understanding and awareness of assessing people's capacity to make decisions about their care and treatment was largely good, however they did not recognise the principles in relation to the use of bedrails and trust documentation was not clear about recording the use of bedrails in relation to the Mental Capacity Act. The number of staff who had completed mental capacity act training was below the trust target.

Evidence-based care and treatment

- Medical services used evidence-based national and best practice guidelines to care for and treat patients. The trust monitored compliance with National Institute of Health and Care Excellence (NICE) guidance and were taking steps to improve where further actions had been identified.
- The service participated in all of the clinical audits they were eligible for through the advancing quality programme. In March 2015, audits demonstrated the trust was not meeting the appropriate care score for chronic obstructive pulmonary disease and heart failure. The service had actions plans in place to improve performance.
- There were examples of recent local audits that had been completed on the wards. These included documentation and clinical care indicators such as nutrition and pain management. Staff said they received the results of the audits and any identified learning was shared with them via email.
- Medical services participated in the joint advisory group on gastro-intestinal (JAG) endoscopy but hadn't achieved JAG accreditation at the time of the inspection. The JAG accreditation scheme ensures the quality and safety of patient care by defining and maintaining the standards by which endoscopy is practiced. The unit had an action plan in place to improve the quality of the patient experience. This included new decontamination facilities.
- Medical services had undertaken a pilot project looking at reducing aspiration pneumonia. This had resulted in a pathway and guidance for staff and had successfully reduced the mortality rate for patients. This was being evaluated to inform future plans.

Pain relief

- Pain relief was managed on an individual basis and was regularly monitored for efficacy. Patients told us that they were consistently asked about their pain and supported to manage it.
- We saw completed pain assessments in patient's records.
- The trust used the abbey pain tool to assess pain for those patients who had a cognitive impairment such as dementia or a learning disability.

Nutrition and hydration

- A coloured tray and jug system was in place to highlight patients that needed assistance with eating and drinking.
- Fluid balance charts were regularly completed and records showed that patients had an assessment of their nutritional needs using the malnutrition universal screening tool (MUST). Patients were referred to a dietician where necessary.
- The majority of patients we spoke with said they were happy with the standard and choice of food available. If patients missed a meal as they were not on the ward at the time, staff were able to order a snack for them. Finger food from the hospital canteen was also available for patients if they preferred this to the meal they had chosen.
- We saw there was a comprehensive selection of meals available from a menu which was available for patients. The menu was displayed on wards for patients and relatives to view.
- We observed drinks were available and in reach for all patients.

Patient outcomes

- The myocardial ischaemia national audit project (MINAP) is a national clinical audit of the management of heart attacks. The MINAP audit 2013/14 showed that

patients with a particular type of heart attack (non-ST segment elevation myocardial infarction (N-STEMI)) were generally managed appropriately. For example, 99.7% of patients diagnosed with an N-STEMI were seen by a cardiologist prior to discharge, which was better than the national average of 94%. In addition, 86% of patients with an N-STEMI were admitted to a cardiology ward, which was better than the national average of 55%. However, the percentage of patients who were referred or had an angiograph (an investigation that looks into the blood vessels of the heart) was 54% which was worse than the national average of 78%.

- The sentinel stroke national audit programme (SSNAP) is a programme of work that aims to improve the quality of stroke care by auditing stroke services against evidence-based standards. The latest audit results for July 2015 – September 2015 rated the hospital overall as a grade 'C' which highlighted that the service still needed to make improvements to the care and treatment of patients who had suffered a stroke. The trust had an action plan in place to improve performance against the standards.
- The 2013/2014 heart failure audit showed the hospital performed better than the England average in all four clinical (in hospital) indicators and in eight of the nine clinical (discharge) indicators.
- In the national diabetes inpatient audit 2013, the trust was better than the England average in 14 of the 21 indicators. The trust performed worse than the England average in patients receiving a foot assessment within 24 hours.
- Medical services had implemented an acute kidney injury specialist service which had seen the development of an education programme and ward champions. This had been successful in reducing the average length of stay for patients from eight days to three days.
- Between January 2014 to December 2014, HES data showed the readmission rates for the hospital were better than the England average in haematology but worse than the England average in gastroenterology and non-elective admissions to general medicine, cardiology and respiratory medicine.
- The Summary Hospital-level Mortality Indicator (SHMI) is an indicator which reports on mortality at trust level across the NHS in England using a standard and transparent methodology. Between April 2014 and March 2015 the SHMI score for Wrightington, Wigan and Leigh NHS Foundation Trust was 113. The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated at the hospital. Risk is the ratio between the actual and expected number of adverse outcomes. A score of 100 would mean that the number of adverse outcomes is as expected compared to the England average. A score of more than 100 means more adverse (worse) outcomes than expected. The trust was working with the Salford University to analyse the data behind the SHMI score.

Competent staff

- Staff told us they received an annual appraisal. According to trust figures, at the end of September 2015, all medical staff had received their annual appraisal. However, 79% of nursing staff and 84% of allied health professionals had received their annual appraisal against a trust target of 90%.
- Consultants said that the trust had fully embraced the appraisal system and it was a supportive and constructive process.
- Staff told us there was no formal system in place for clinical supervision. However, nurses told us that they did have regular meetings with their manager and they were able to speak to their manager at any time. The purpose of clinical supervision is to provide a safe and confidential environment for staff to reflect on and discuss their work and their personal and professional responses to their work. The focus is on supporting staff in their personal and professional development and in reflecting on their practice to encourage improvement.
- There was a preceptorship programme which supported junior nursing staff. Their competency in undertaking care procedures was assessed by qualified staff.
- Staff said that there were developmental opportunities which were emailed to them on a regular basis and they were supported to access these.
- The trust participated in the pre-employment programme with the skills for health academy which gave local unemployed people the opportunity for work experience and to undertake training at the hospital to increase skills and experience. This had resulted in a number of people becoming permanently employed in medical services.

- Staff in bands one to four were offered opportunities to undertake appropriate vocational qualifications.
- Medical services ensured that auxiliary nurses completed the care certificate. The care certificate is knowledge and competency based, and sets out the learning outcomes and standards of behaviours that must be expected of staff giving support to clinical roles such as healthcare assistants. Between April 2015 and May 2015, 11 auxiliary nurses across the trust had been supported to complete the care certificate.
- Staff confirmed they had an adequate induction. Newly appointed staff said their inductions had been planned and delivered well.

Multidisciplinary working

- Multidisciplinary team (MDT) working was well established on the medical wards. MDT meetings took place weekly and were attended by the ward manager, nursing staff and therapy staff such as physiotherapists and occupational therapists.
- Meetings on bed availability were held up to four times a day to determine priorities, capacity and demand for all specialities. These were attended by both senior management staff and senior clinical staff.
- We observed handovers, which included nurses and medical staff. There was effective communication and they were well structured.
- Daily ward meetings, called board rounds, were held on most of the wards we visited. They reviewed discharge planning and confirmed actions for those people who had complex factors affecting their discharge. We observed a board round and saw that it was well attended by a range of professionals.
- Ward teams had access to the full range of allied health professionals. Team members described good, collaborative working practices. There was a joined-up and thorough approach to assessing the range of people's needs and a consistent approach to ensuring assessments were regularly reviewed by all team members and kept up to date.

Seven-day services

- Staff and patients told us diagnostic services were available 24 hours a day, seven days a week.
- Consultant cover was available on site from 8am to 9pm, seven days a week.
- There was a designated matron on duty out of hours seven days a week. The hours they worked were 4pm to 8.30pm Monday to Friday and 9am to 5 pm at the weekends. This was in addition to the normal working hours of the matrons during the week and ensured support for staff seven days a week.
- The bed management team worked 24 hours a day, seven days a week, who supported staff in ensuring that patients were placed on the most appropriate ward to meet their needs.
- The enhanced discharge team and therapy services were set up to work seven days a week and were supported by a medical consultant. The team visited all medical wards to review patients and facilitate weekend discharges. The discharge lounge was open seven days a week.
- The ambulatory assessment area was available seven days a week which enabled GP's to refer patients for medical assessment every day of the week.

Access to information

- All staff had access to the information they needed to deliver effective care and treatment to patients in a timely manner including test results, risk assessments, and medical and nursing records.
- There were computers available on the wards we visited which gave staff access to patient and trust information. Policies and protocols were kept on the hospital's intranet which meant all staff had access to them when required.
- On the majority of wards there were files containing minutes of meetings, ward protocols and learning from incidents and audits which were available to staff.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The majority of staff knew about the key principles of the Mental Capacity Act 2005 (MCA) and how these applied to patient care.
- Information provided by the trust showed that compliance rates for MCA training was below the trust target of 95%. Only 21% of medical staff and 52% of nursing staff had completed the training at the time of the inspection. This was because specific MCA e-learning training had only been available since September 2015.
- Staff were not always following the key principles when using bed rails for patients. Staff we spoke to on the wards did not know that the use of bed rails can be seen as a form of restraint as outlined in the Royal College of

Nursing (RCN) rights, risk and responsibilities guidance. The bed rails assessment did not include the recording of consent or best interest decisions for the use of bed rails, though there was a trust policy that did outline the principles and the processes for the use of bed rails.

- Staff knew the principles of consent and we saw written records that indicated consent had been obtained from patients prior to procedures.
- Staff had knowledge and understanding of procedures relating to the Deprivation of Liberty Safeguards (DoLS). The Deprivation of Liberty Safeguards (DoLs) are part of the Mental Capacity Act 2005. They aim to make sure that people in hospital are looked after in a way that does not inappropriately restrict their freedom and are only done when it is in the best interest of the person and there is no other way to look after them. We saw examples of completed DoLS paperwork which were in line with guidance and best practice.
- Medical services worked in partnership with a neighbouring mental health trust to undertake formal capacity assessments for patients.

Are medical care services caring?

Good

Patients told us staff were caring, kind and respected their wishes. We saw staff interactions with people were person-centred. People we spoke with during the inspection were complimentary about the staff that cared for them. Patients received compassionate care and their privacy and dignity were largely maintained.

Patients were involved in their care, and were provided with appropriate emotional support

Compassionate care

- Medical services were delivered by caring and compassionate staff. We observed staff treating patients with dignity and respect.
- All the patients we spoke with were positive about their care and treatment. Comments included: 'care and treatment has been phenomenal' and 'staff acknowledged my religious beliefs when providing care'. Patients said that staff always introduced themselves.
- The NHS Friends and Family test (FFT) asks patients how likely they are to recommend a hospital after treatment. Between July 2015 and October 2015 eight medical wards scored above 92%; The Astley ward scored 100% on three occasions and Pemberton ward scored 100% on four occasions which indicated that patients were positive about their experience. The average response rate during this time was 40% which was better than the England average of 36%
- In the cancer patient experience survey for inpatient stay 2013/2014, the trust performed in the top 20% of all trusts in 16 of the 34 areas. These included 'nurses did not talk in front of patient as if they were not there' and 'patients given enough privacy when discussing their condition or treatment. They performed in the bottom of the 20% of all trusts in two of the areas which included 'patients given a choice of different types of treatment' and the same as other trusts in the remaining areas.
- The trust was performing better than the England average in all four parts of the patient-led assessments of the care environment (PLACE). These were cleanliness, food, privacy, dignity and wellbeing and facilities.
- The trust performed about the same as similar trusts in all areas of the 2014 CQC inpatient survey.
- We observed that patient's privacy and dignity was maintained on the wards we visited. However, the discharge lounge was available for both men and women and there were separate seating areas but there was no screen in place to separate them, although there were curtain rails available. We observed a female patient in her nightclothes in sight of male patients. This meant that there was a risk that their privacy and dignity may not have been maintained.

Understanding and involvement of patients and those close to them

- Patients had a named nurse and consultant. Patients were aware of this and they were displayed on a board above the bed.
- Patients and those close to them told us that clinical staff were approachable and they were available to talk to them they needed to.
- Patients said that they had been involved in their care and were aware of the discharge plans in place. Most patients could explain their care plan.
- Patients told us they felt safe on the ward and had received orientation to the ward area on admission.

Medical care (including older people's care)

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

Emotional support

- Staff said they had sufficient time to spend with patients when they needed support. Visiting times met the needs of the patients with whom we spoke. Open visiting times were available if patients needed support from their relatives.
- Chaplaincy services were available for patients 24 hours a day, seven days a week. The Chaplain told us how they helped ensure patient's emotional needs were being met. For example they arranged for a local vicar to provide flowers for a patient's relatives grave as they would not be able to attend and this was upsetting them.
- There was a multi-faith prayer room at the hospital.

Are medical care services responsive?

Good

Medical services consistently met the national 18 week referral to treatment time targets in all specialities from April 2013 to May 2015. WWL is in the top 10% nationally for RTT performance as at October 2015, ranking 5th out of 139 Acute Trusts.

The hospital had implemented a number of schemes to help meet people's individual needs, such as the forget-me-not sticker for people living with dementia or a cognitive impairment and a red label above the bed to indicate that a patient was at risk of falls. There were specialist nurses who provided support and advice to staff and the service was mostly meeting individual needs for patient who had dementia or a learning disability.

Services took into account the needs of the local people. There were ambulatory care services and the trust was part of the healthier together programme. There was access to translation services and leaflets available for patients about the services and the care they were receiving.

People were supported to raise a concern or a complaint. Complaints were investigated and lessons learnt were communicated to staff and improvements made.

There were good systems in place for the management of patients when there were shortages of beds on medical wards. Patients were seen regularly by a member of the medical team when they were placed on other wards in the hospital. However, there were a number of patients who were moved ward during the night and half of the patients experienced one or more moves during their stay. There was a clear focus on discharge planning with ward discharge co-ordinators although there were times when patients experienced delayed discharges and high occupancy levels on the wards.

Service planning and delivery to meet the needs of local people

- Medical services had a designated ambulatory assessment area. This unit provided assessment and treatment for patients on an outpatient basis who were referred from various sources, such as GP's, emergency care centres and the medical assessment unit. The unit was open 9am to 10pm Monday to Friday and 11am to 7pm at weekends.
- The hospital was part of the Greater Manchester health and social care devolution programme to provide a partnership approach to care and the healthier together programme. This was to reconfigure services across Greater Manchester into a small number of specialist centres to help meet the needs of patients
- The facilities and premises were appropriate for the services that were planned and delivered. However, there was no designated ward for dementia patients or reminiscence rooms on the wards. However improvements had been made to signage on the wards.

Access and flow

- Medical services met the national 18 week referral to treatment time targets in all specialities from April 2013 to May 2015.
- Between January 2014 to December 2014, hospital episode statistics (HES) showed that the average length of stay for elective medicine at the hospital was 7.3 days, which was longer (worse) than the England average of 4.5 days. For non-elective medicine it was 5.4 days, which was shorter (better) than the England average of 6.8 days.

Medical care (including older people's care)

- Between April 2014 and March 2015, the occupancy rate at the hospital was between 81% and 89%. It is generally accepted that, when occupancy rates rise above 85%, it can start to affect the quality of care provided to patients and the orderly running of the hospital.
- Information provided by the trust showed there were a large number of patients being cared for in non-speciality beds which may not be best suited to meet their needs (also known as outliers). Between February 2015 and August 2015, data showed there had been 138 outliers at the hospital.
- At the time of our inspection, senior staff said there were 15 medical outliers. Patients who were outliers were reviewed on a daily basis by a member of the medical team. We reviewed the records for four medical patients who were outlying on the emergency surgical trauma unit, and found they had been seen daily by a member of the medical team. Wards that had outlying patients had contact arrangements for the relevant speciality teams in and out of hours. There was a standard operating procedure for outlying patients which was being followed.
- In the period September 2014 to August 2015, 50% of patients experienced multiple ward moves during their stay. This was slightly more than the previous year.
- Information provided by the trust showed that between March 2015 and August 2015, a number of patients on medical wards were transferred to another ward after 10pm at night. For example, 147 patients had been transferred from the Ince ward during the night, 75 had been transferred from the Standish ward and 136 had been transferred from the Winstanley ward.
- The hospital held bed management meetings regularly throughout the day during the week to review and plan bed capacity and respond to acute bed availability pressures. Ward discharge assistants supported these meetings by providing up to date information on ward capacity.
- There was a clear focus on effective discharge planning for patients and wards. Staff discussed discharges at the daily board round and at the bed management meeting. Discharge letters were sent to GPs' and patients were given a copy.
- There was a discharge team who supported patient discharges that were complex or required rapid discharge. There were discharge managers allocated to medical wards to support the process.
- Data provided by the trust showed that discharges were often delayed due to waiting for care packages (3.2% which was better than the England average of 12%) or for equipment that was needed in the home (4.8% which was worse than the England average of 2.7%) They were working with partner organisations to ensure that patients were discharged as soon as possible.
- To support this, the trust had access to community beds in care homes which were used for patients who were fit for discharge but were waiting for care packages or equipment to be put in place. A hospital discharge co-ordinator supported the patient and their family whilst in the community bed.
- The discharge team met daily and this included, senior management staff, discharge co-ordinators, social services representatives and a member of the local clinical commission group. At the time of the inspection on 11 December 2015, staff said there were 26 delayed discharges across medical services. This meant that there were 26 people in hospital that didn't need to be. These were discussed at the discharge meeting and actions put in place by the multidisciplinary team. We observed an effective discharge meeting.
- The trust had a discharge lounge which operated between the hours of 8.30am and 9.30pm seven days a week. The lounge was managed by two nurses. They were unable to accept patients of different gender who required a bed as there was only one bedded area which impacted on flow of patients on the wards. There was set criteria for which patients were not suitable for the discharge lounge; this included those who were confused or receiving palliative care (end of life). There had been around 1,829 medical patients who had used the discharge lounge between January 2015 and November 2015.

Meeting people's individual needs

- The trust used a discreet red label above beds to indicate that a patient was frail or elderly and was at risk of falls. This alerted staff to look at the risk assessment and care plan to ensure that any reasonable adjustments were made.
- The hospital had implemented the 'forget-me-not' scheme which involved the use of a discreet flower symbol to act as a visual reminder to staff that patients were living with dementia or were confused. This was to ensure that patients received appropriate care, reducing the stress for the patient and increasing safety.

- There was a clinical lead for dementia that provided support for staff and acted as a central point of contact for queries. The service had a dementia strategy and there were core groups looking at what was required for the implementation of the strategy, for example improving the patient journey and caring for carers.
- Staff compliance with dementia training at the hospital was above the trust target of 95% except for medical and dental staff, where the compliance rate was 75%. There were dementia champions on all of the wards we visited. The role of the dementia champion was to act as a resource for staff, patients and their carers.
- Memory boxes were used at the hospital but not on all the wards we visited that had patients who were living with dementia.
- The trust used the 'this is me' documentation for carers to record information about patients living with dementia or a learning disability. This ensured that staff knew the patients' likes and dislikes and ensured their needs were met. .
- People living with a learning disability were supported when having an endoscopy. Staff told us how they made reasonable adjustments such as a quiet room or specific supported appointments. Medical services had access to psychiatric services to see and assess appropriate patients with a cognitive impairment.
- There was a range of specialist nurses, for example for dementia, and diabetes, who offered specialist advice to staff caring for people with these conditions. Staff told us they knew how to contact these specialists and felt supported by them. Staff also knew how to access the learning disability team from the local mental health trust for advice and support.
- Leaflets were available for patients about services and the care they were receiving. These were on the trust intranet for staff to print off for patients. There was only a limited amount available on the wards we visited for patients and relatives to pick up without asking a member of staff. Staff knew how to access copies in other languages for patients whose first language wasn't English. However, there were limited trust leaflets available in an accessible format for people living with dementia and learning disabilities
- Patients who had suffered a stroke and been admitted to another hospital for specialist care, as outlined on the stroke pathway, were transferred back to the hospital as soon as possible. The hospital was achieving the target of 80% of patients spending more than 10% of their stay at the Royal Albert and Edward Infirmary before discharge.
- We saw that the majority of people had access to call bells and staff responded promptly.

Learning from complaints and concerns

- Staff understood the process for receiving and handling complaints and were able to give examples of how they would deal with a complaint effectively.
- Patients told us they knew how to make a complaint. Posters were displayed around the hospital detailing how to make a complaint. Leaflets detailing how to make a complaint were readily available in all areas. Notice boards within the clinical areas included information about the number of complaints and any comments for improvement.
- The trust recorded complaints electronically on the trust-wide system. The local ward managers and matrons were responsible for investigating complaints in their areas. Ward managers told us how they were working to achieve 'on the spot' resolutions of concerns where possible.
- Data showed there had been 70 complaints raised across medical wards at the hospital between September 2014 and August 2015. The highest proportion of complaints related to communication with staff members. However, all patients we spoke with told us they had no concerns regarding communication from staff.
- An example of learning from a complaint was to confirm with the patient the name of their GP when completing patient details on admission so that correct information is sent to the GP.
- Complaints were discussed at governance meetings which also outlined key lessons learnt to be shared with staff. Staff told us managers discussed information about complaints during staff meetings to facilitate learning

Medical care (including older people's care)

Are medical care services well-led?

Good

Medical care services were well-led, with evidence of effective communication within staff teams. The visibility of senior management was good and there was a clear strategy and actions for implementation. Staff knew how their ward performance was monitored.

Medical services captured views of people who used the services with learning highlighted to make changes to the care provided. People would recommend the hospital to friends or a relative. There was good staff engagement with staff being involved in making improvements for services. All staff were committed to delivering good, compassionate care and were motivated to work at the hospital Staff felt supported and able to speak up if they had concerns although the number of staff who felt valued was lower than the England average.

Risk registers were in place and had actions identified. However, there was no target date for completion of the actions although the risks were reviewed regularly. The risk register was monitored at main meetings across all medical services.

Vision and strategy for this service

- The trust's vision was to provide the best quality healthcare for all patients, be in the top 10% for everything they do and to be safe, effective and caring. The vision was underpinned by the values of compassion, respect and dignity, patients first, teamwork, accountability and forward thinking. Staff at all levels within medical services at the hospital referred to the vision and values.
- The rust's strategic objectives were based on the vision and these objectives were cascaded down to individual objectives for staff.
- Medical services had a quality strategy in place which identified challenges and objectives. For example reducing medication incidents and achieving the expected date of discharge for all patients. The plans also identified actions to meet the objectives.

Governance, risk management and quality measurement

- The risk register highlighted risks across all medical services at the trust and actions were in place to address concerns, for example lack of staff on the medical assessment unit and slips, trips and falls by patients and visitors. Information provided by the trust showed each risk had a review date but there was no target date for completion of the action. This meant it was not clear whether all risks were being managed as effectively as possible.
- Staff at all levels knew that there was a risk register and senior managers were able to tell us what the key risks were for their area of responsibility.
- There was a clear governance reporting structure in medical services. The divisional quality executive meeting for medical services was held on a monthly basis. As part of the meeting, there was a review of items to celebrate good practice and items of concern. There was also feedback from other key meetings, for example senior nurses meetings and an update from the governance and risk panel.
- It was clear from the minutes we reviewed that the risks, incidents and complaints were reviewed and discussed. It was also clear that learning had taken place to be shared with staff. Actions from the meeting were identified in the minutes along with the person responsible but there was no target date for the actions to be completed. It was therefore difficult to track what progress had been made against agreed actions.
- Senior staff were able to tell us how their ward's performance was monitored, and how performance reports were used to display current information about the staffing levels and risk factors for the ward.
- The trust had a quality champion project in place and staff were awarded either a bronze, silver or gold award for undertaking projects which improved the quality of care provided for patients. Examples of projects included reducing the number of pressure ulcers and preventing respiratory admissions. There were a number of staff in medical services who were quality champions. For example, the divisional medical director.

Leadership of service

- Staff reported there was clear visibility of the trust's board throughout the service. Staff could explain the leadership structure within the trust and within medical services. The executive team were accessible to staff.

Medical care (including older people's care)

- All nursing staff spoke highly of the ward managers as leaders and told us they received good support. We observed good working relationships within all teams.
- Doctors told us that senior medical staff were accessible and responsive and they received good leadership and support.

Culture within the service

- Staff said they felt supported and able to speak up if they had concerns. They said that morale was good.
- In the 2014 staff survey, 96% of staff at the trust said they were enthusiastic about their job and 92% looked forward to going to work.
- Staff said there was a positive culture around challenging decisions by other staff. For example, if a doctor stated that a patient was ready for discharge and a nurse did not feel it was appropriate, they said they would feel comfortable discussing this further with the doctor to ensure the patient received the correct care.

Public engagement

- The medical divisional quality executive meeting highlighted patients' experiences of using the hospital's services. These were shared with staff to help improve services.
- The trust had comment cards in place for patients and relatives to complete. In May 2015, medical services had received 96% positive comments and only 4% negative comments.
- The trust carried out their own patient survey and in May 2015, medical services achieved the trust target except for two questions which were, being involved in decisions about their discharge and knowing which consultant was currently treating them. However, all the patients we spoke to knew about their discharge and the name of their doctor
- This hospital participated in the NHS friends and family test giving people who used services the opportunity to provide feedback about care and treatment. At the time of the inspection, 97% of patients would recommend the wards at the hospital to friends or a relative.

Staff engagement

- The trust celebrated the achievements of staff at an annual event. At the last event, medical services had a number of staff who were nominated for their work at the trust.
- Staff participated in the 2014 staff survey. This included how staff felt about the organisation and their personal development. Seventy three percent of staff in the trust felt the training and development they had undertaken had helped them to deliver a better patient experience and 74% felt it had helped them to do the job more effectively. However, only 52% felt that they were valued by the organisation which was worse (lower) than the national average of 62%.

Innovation, improvement and sustainability

- Dementia leads were undertaking a project looking at implementing an electronic menu with live pictures of the meals available for patients. Patient experience was then going to be captured to inform the future of the project.
- An analysis of the 2014 staff survey results showed 74% of staff in the trust, who responded, felt they were able to make suggestions to improve the work of their team/department. This was the same as the national average of 74%. In addition, 71% of staff said they had frequent opportunities to show initiative in their role and 58% said they were involved in deciding on changes to improve services for patients.

Surgery

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

Information about the service

Surgical Services are provided at the Royal Albert Edward Infirmary (RAEI) for elective, emergency and day case surgery as part of Wrightington, Wigan and Leigh NHS Foundation trust. The hospital has 513 beds and is close to Wigan town centre

In 2014, there were 35,277 surgical spells trust wide serving a population of around 320,000 people in the Wigan and Leigh area. At RAEI 50% of surgical stays were emergencies, 31% were day cases and 19% were elective.

We inspected the trust between 8-11 December 2015 and visited theatres 1-6, Aspull, Shevington, Langtree and Orrel wards, surgical assessment lounge and surgical assessment unit. During this time we spoke to 29 staff including nurses, doctors and other clinical staff, six patients and reviewed 15 patient records.

Summary of findings

Overall, we found that the Royal Albert Edward Infirmary delivered 'Good' surgical services.

Staff were committed and proud of the services they provided. Staffing levels were sufficient and a safer nursing care staffing tool was utilised to ensure staffing levels were adequate. Medical staff rotas were in place and locum agency staff filled any gaps when the service was short staffed. Staff morale was good and staff felt well supported.

Incidents were reported and lessons learnt shared amongst staff. Staff knew how to access the incident reporting system and could tell us about incidents they had reported. There were low incidents of pressure ulcers and infections. Risk assessments were completed and staff implemented measures to reduce risks.

The environment was clean and tidy and staff had access to the equipment they required to do their jobs. Medicines were managed safely and stored securely.

Referral and discharges worked well and staff shared relevant information. Services worked in coordination and patients were appropriately referred to specialist services. Staff treated patients with respect and dignity, offered support and included them in care planning. Patients received a caring service and staff discussed treatment plans with patients to ensure a person-centred approach.

Surgery

The trust 18 week referral to treatment times were similar to or above the national average of 90% for all surgical specialities except general and oral surgery. WWL is in the top 10% nationally for RTT performance as at October 2015, ranking 5th out of 139 Acute Trusts.

Risk registers were in place and discussed at team meetings. Staff were aware of the trust's values and vison. Staff felt well-supported by managers and colleagues.

Are surgery services safe?

Good

We rated the surgical services as 'Good' for being safe.

Staff knew how to report incidents and could give us examples of incidents such as pressure ulcers and falls. Staff were aware of 'Duty of Candour' (the regulation introduced for all NHS bodies in November 2014, meaning they should act in an open and transparent way in relation to care and treatment provided was in practice) and felt confident to practice this.

Staff had infection control training and were aware of trust polices. Audits were completed and we observed appropriate hand washing and use of personal protective equipment (PPE).

The environment was clean and tidy. Equipment was available and routinely serviced. Medicines storage was secure and logs maintained.

There was sufficient staffing levels and staff felt confident to raise issues with management. Mandatory training was provided annually, face to face and via e-learning.

Incidents

- Staff were aware of the electronic incident reporting system and could access it.
- Staff could tell us types of incidents reported and these included pressure ulcers, staffing issues and falls.
- Two never events were reported at Royal Albert Edward Infirmary between August 2014 and July 2015 classed as surgical invasive procedures. Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented
- Rapid reviews of the never events were completed and actions identified. The investigation and analysis of never events which had occurred were robust and scrutinised through the Serious Incidents Requiring Investigation Panel. Action plans were reviewed at the panel and Quality and Safety Committee until they were satisfied.

Surgery

- There were six reported incidents classed as serious between August 2014 and July 2015 across the division requiring investigation.
- Staff understood the term 'Duty of Candour'. Duty of candour was evident in the rapid reviews seen.
- The trust commissioned it's solicitors to deliver Duty of Candour training in 2014, and they were due to provide this training again. An e-learning training module for Duty of Candour was under development.
- The incident reporting system prompted staff to indicate if Duty of Candour had taken place when reported harms were classed as moderate or above.
- Mortality and morbidity were audited weekly trust wide and a report was produced and distributed to over 1000 staff. The trust aimed to audit 400 deaths per year. The division also conducted mortality and morbidity meetings.

Safety thermometer

- NHS Safety Thermometer data between July 2014 and July 2015 showed three falls that resulted in harm were reported, one in July 2014 and two in May 2015. Results were displayed on each ward and theatre area. The NHS Safety Thermometer is a national improvement tool for measuring, monitoring and analysing avoidable harm to patients and 'harm free' care
- Records reviewed confirmed that patients received an assessment of venous thromboembolism (VTE) risk on admission; however it was not always clear if this was reviewed within 24 hours of admission.

Cleanliness, infection control and hygiene

- All areas we inspected were visibly clean and tidy. Hand gel and personal protective equipment was accessible on each ward and was utilised by staff and visitors. We observed that staff washed their hands effectively during and between interventions and tasks. Cleaning logs were completed efficiently within theatre areas.
- Staff reported being aware of the current infection control procedures and guidelines. Arrangements were in place for the safe handling, storage and disposal of clinical waste and sharps.
- Sharps bins were signed and dated, and partially closed when not in use.
- Staff completed effective hand decontamination in the operating theatre, and utilised personal protective equipment appropriately.
- Hand hygiene audits were completed and results showed good compliance of between 88.88% and 100% in December 2015.
- All patients had pre-operative screening for Methicillin-resistant Staphylococcus aureus (MRSA).

Environment and equipment

- Wards and theatres were clean and tidy and staff had access to the equipment they required.
- A trust wide equipment service stored, serviced and loaned equipment as required. Staff reported that this was a good and responsive service.
- Equipment was routinely maintained and serviced. Some displayed green 'I am clean' stickers, however this was not consistent.
- Wards had diluted Sochlor solution utilised for cleaning sinks in unlocked dirty utility rooms. This could pose a risk to patients. Aspull ward had three containers full of solution with no lids. We alerted staff and this was immediately rectified.
- Daily checks of resuscitation trolleys and logs were completed and up to date. Equipment was serviced and in date.
- Domestics were mopping floors and wet floor signs were utilised to alert patients, staff and visitors.
- Association of Anaesthetists of Great Britain and Ireland (AAGBI) guidelines were utilised to check anaesthetic equipment.
- We alerted staff to one blood pressure machine due for servicing in October 2015, staff actioned this immediately.

Medicines

- Controlled drugs were stored in a locked cupboard and checked daily. Pharmacy staff also reviewed stock levels.
- Recording of daily drug fridge temperatures showed they were within the optimum range of between two and eight degrees.

- Drug trolleys observed were secured to the wall when not in use. We checked three random drugs in each trolley in use and all drugs were in date.
- Prescription charts were completed and signed. Omissions had reasons for omission recorded.
- Prescribed antibiotics had number of days documented however not all had a stop date indicted.
- There was recording of allergies on prescription and nursing assessment documents.
- Medicine charts were in booklet form and included nil by mouth guidance and a prescribing chart for patients with a Parkinson's disease diagnosis.
- Wards had hypoglycaemia boxes available for the treatment of patients with a low blood sugar level.
- Staff had access to medicine management training.

Records

- The trust utilised electronic and paper based records. These were in the form of nursing records and medical case notes . The record trolleys that were inspected were unlocked which meant they were potentially accessible to the general public.
- Records were legible, signed and dated, however name and designation was not always clear or printed.
- Nursing notes were kept at the bedside and medical notes kept in record trolleys.
- Records showed evidence of input from the multi-disciplinary team.
- We reviewed 15 sets of records and found they were of a good standard and all risk assessments were fully completed.

Safeguarding

- The trust had safeguarding policies and procedures in place and had allocated leads for safeguarding adults and safeguarding children.
- Online training was available for safeguarding training level one and two.
- Staff knew how to refer to the safeguarding policy and how to raise an alert. Staff showed us how they accessed the policy.
- Trust data showed that between 96-98% of clinical staff had completed mandatory safeguarding training.

Mandatory training

- Staff confirmed they had a trust induction on commencing work and this included temporary staff.
- Annual mandatory training included training in areas such as infection control, fire safety, health and safety and safeguarding.
- Staff told us they received reminders to attend training and were given the time to complete necessary training. The trust completion target was 95% and in December 2015 completion rates were above the target except for basic life support at 85.6% and information governance at 94%.

Assessing and responding to patient risk

- Staff told us how they escalated risks to patient safety to mangers and matrons, these included staffing issues and bed capacity issues.
- A Venous thromboembolism (VTE) assessment was completed on each admission. There was appropriate prescribing of medication and days of administration noted. VTE is an international patient safety issue and a clinical priority for the NHS in England. Risk assessments completed for each patient included falls assessment, bed rail assessment, moving and handling, Malnutrition Universal Screening ToolMUST) and Waterlow (t
- Early warning scores were completed and documented, however this was not always in line with trust guidance of a minimum of eight hourly.
- We observed electronic World Health Organisation (WHO) checklist completion in theatre. The WHO checklist is an international tool developed to help prevent the risk of avoidable harm and errors during and after surgery. These were fully completed.
- The trust undertook audits for the completion of WHO checklists and highlighted any areas for improvement. Audits for RAEI showed that 10 out of 37 checklists audited had areas for improvement between January 2015 and August 2015.

Nursing staffing

- The trust reported 21 surgical staff vacancies at the hospital.

Surgery

- Wards displayed their expected and actual staffing levels at the entrance to wards. These numbers were correct at the time of the inspection.
- Trust data showed sickness levels of between 4-9% across the surgical services at Royal Albert Edward Infirmary. The lowest sickness level reported was on Swinley ward and the highest on Aspull ward.
- Use of bank staff was 9.7% in August 2015.
- The trust utilised a safer staffing acuity tool every three months to assess requirements for each ward and clinical area. Daily staffing levels were reported to Matrons and displayed on boards at ward entrances.

Surgical staffing

- Medical staff skill mix showed the proportion of consultants was 38%, which was lower than the England average of 41%. Junior level grade doctors were higher at 23% against the England average of 12%.
- Medical staff felt supported and could access consultants when necessary.
- The General Medical Council (GMC) national training scheme survey 2015 showed the trust performed within expectations.

Major incident awareness and training

- Staff told us that they could access the major incident policy via the intranet. Those asked were not aware if a copy was available on the ward. We did not see a copy on ward visits. Mandatory training included major incident planning.

Are surgery services effective?

Good

We rated the surgical services as 'Good' for being Effective.

Staff followed national and local guidelines and policies. The division participated in local and national audits, such as the hip fracture audit. Action plans were formulated and shared.

Patients were assessed for pain relief and pain link nurses were available on the wards. Staff had appraisals and access to training and development. Patient's nutrition and hydration needs were assessed.

Multi-disciplinary team worked well across theatres and wards, working collaboratively to plan and provide care. Staff obtained consent to treatment and discussed care planning. Trust policies for mental capacity and deprivation of liberty safeguards were in place.

Evidence-based care and treatment

- Staff utilised national guidelines by National Institute for health and Care Excellence (NICE). These included prevention of pressure ulcers and prevention of surgical site infection.
- Staff could access local policies and procedures via the intranet.
- Association of Anaesthetists of Great Britain and Ireland (AAGBI) guidelines were utilised in theatre for checking anaesthetic equipment (2012).

Pain relief

- Staff assessed pain for patients living with dementia utilising the Abbey pain score (this tool is used for measurement of pain in people with dementia who cannot verbalise
- Patients had their pain scores recorded and staff asked if they required pain relief.
- Wards had allocated pain link nurses to support and train staff on the wards.

Nutrition and hydration

- Staff were observed assisting patients with food and drink where required.
- Menus were displayed on the wards and patients reported plenty of choice at each meal.
- Fluid balance charts inspected were up to date and fully completed.

Patient outcomes

- The risk of readmission to Royal Albert Edward Infirmary was worse than the England average for all elective surgery and generally better than the England average for all non-elective surgery.

Surgery

- Data from the Bowel Cancer Audit (2014) showed that the trust was performing well on two indicators and better than the England average for three indicators.
- The Royal Albert Edward Infirmary scored better than the England average for five indicators in the Hip Fracture audit.
- There was a mixed performance in the National Emergency Laparotomy audit
- Data from the Lung Cancer Audit (2014) showed the trust were performing better than the England average for the percentage of cases discussed at multi-disciplinary team (MDT) meetings and the percentage of patients receiving computed tomography (CT) before bronchoscopy.
- The trust's patient reported outcomes' following surgery were the same as national results.

Competent staff

- Staff reported having annual appraisals and data supplied by the trust showed completion figures of 79% for nurses within the surgical division, 100% for medical and dental staff and 89% for other clinical staff.
- Staff reported having access to development within their roles and were given time to access courses.

Multidisciplinary working

- Staff worked well as a multi-disciplinary team to promote early mobilisation and enhance recovery post-operatively.
- Patient records showed joint documentation from nurses, medical staff and allied health professional.
- Bed meetings are held three days a day, determined capacity across the trust sites and any identified issues were escalated appropriately.

Seven-day services

- Services were available seven days per week, including access to physiotherapy.
- Patients were reviewed at weekends and discharges planned where appropriate.

Access to information

- Information boards were visible in staff areas and these displayed audit information, link nurse details and trust wide correspondence.
- White boards utilised for handovers also included updated trust wide information as well as any issues raised. This included new policies, any new incidents and trust updates.
- Staff had access to the trust intranet and access policies and procedures when required.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Mental Capacity Act assessments were completed by staff and doctors.
- Pre-operative assessment included completion of consent form. Recommendations from a consent audit in September 2015 included ensuring that a consent review was undertaken prior to theatre.
- The trust had a safeguarding lead in post and a policy was in place. Staff knew how to access the policy.
- Staff knew how to make a safeguarding referral and felt confident to do so.
- Flow charts were displayed in staff areas and resource folders were kept accessible to staff for Mental Capacity Act and Deprivation of Liberty Safeguards information.

Are surgery services caring?

Good

We rated the surgical services as 'Good' for being Caring.

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

Staff engaged with patients and offered kind and considerate care to patients and those close to them. We saw that privacy and dignity was maintained and their needs were met.

Compassionate care

- The NHS Friends and Family Test (FFT) overall response rate for this trust was lower than the England average of 36.4% between June 2014 and July 2015. The Royal

Albert Edward Infirmary (RAEI) response rate was 25.8%. Between April and June 2015 90-100% staff would recommend the hospital. Post boxes were available on wards to allow submission of FFT forms.

- Wards displayed FFT information on boards at the ward entrance.
- We observed staff providing care in a compassionate and responsive way.

Understanding and involvement of patients and those close to them

- Patients spoken with during our inspection reported good communication with staff and that they were involved in care planning.
- We observed interactions between staff, patients and their relatives which were thorough and opportunities were given to ask questions.
- Staff gave verbal advice to patients post-operatively and contact numbers were given prior to discharge if the patient needed any advice.

Emotional support

- Wards have bereavement link nurses to support team members, patients and relatives.
- Macmillan nurses supported staff with end of life care and were available to support patients and those close to them.
- We observed staff offering emotional support and listening to patients' concerns.

Are surgery services responsive?

Good

We rated the surgical services as 'Good' for being Responsive.

Emergency, elective and day case surgery was undertaken at the Royal Albert Edward Infirmary (RAEI). Nursing and therapy staff worked together to improve patient rehabilitation. Service planning and delivery was undertaken to meet the needs of the local population.

Referral to treatment times in October 2015 were 92% which exceeded the national average of 90%.

Individuals had their needs assessed and adjustments made accordingly. Wards had identified dementia champions and utilised the 'forget me not' symbols.

Service planning and delivery to meet the needs of local people

- The facilities and premises in surgical services were appropriate for the services that were planned and delivered.
- Bed meetings were held every day to review capacity.
- Engagement with other trusts in the area assisted with planning services for the population and supporting neighbouring trusts.

Access and flow

- Between April 2015 and September 2015, the trust exceeded the 90% standard for the proportion of patients waiting 18 weeks or less from referral to treatment. The latest figures for October 2015 showed the trust's performance was at 92%, with the exception of general and oral surgery.
- General surgery and trauma/orthopaedic wards had medical outliers (medical patients that were not nursed on a medical ward due to bedding shortages) each month between January 2015 and August 2015. The number of patient outliers for June 2015 was 141.
- There were 18 cancelled operations in March 2015 and two of those were not re-booked within 28 days.
- The latest data between April and June 2015 shows that out of the 129 cancelled operations in this trust, 15 did not receive treatment within 28 days. Senior managers confirmed this and that they discussed action plans to prevent further issues.

Meeting people's individual needs

- Positive feedback was received on meeting the needs of patients with learning difficulties. Staff endeavoured to meet the patient and carer's needs.
- Wards had designated 'forget me not champions' for dementia to advise staff and also refer to the dementia lead where appropriate. The trust reported having nearly 200 champions at the time of the inspection and 150 of those had completed or were completing an national vocational qualification in dementia care.

- Symbols on white boards behind patient's beds indicated those at risks of falls, patients living with dementia, or if assistance is required with eating.
- The trust utilised interpretation and translation services, which could be face to face, via telephone, written or sign language.
- The trust provided a medical photography service which was available for end of life patients to take memory photographs, usually of interlinked hands.
- The trust had a chaplaincy and spiritual care department. The services run seven days a week. The service is accessible at any time and also completes routine weekly visits to all wards.

Learning from complaints and concerns

- Patient advisory and liaison service (PALS) details and leaflets were available on wards and leaflets made available.
- Monthly performance reports included the response and timeliness of responses and details of complaints partially upheld or upheld by the Parliamentary Health Service Ombudsman (PHSO).
- Staff aimed to resolve complaints locally. The patient relations team (PALS) triaged all formal complaints.

Are surgery services well-led?

Good

We rated the surgical services as 'Good' for being Well-led.

Staff at all levels were enthusiastic and felt well supported. They were aware of the trust vales and were proud of the services they provided. Governance and quality meetings were held and incidents and risks discussed.

Staff felt involved in forward planning and service development. The NHS Friends and family test was utilised and results displayed. The trust held an annual awards event to celebrate success and achievements.

Compliments and complaints received were shared with staff. Lessons learnt were shared and discussed in team and divisional meetings.

Vision and strategy for this service

- Staff could access the trust intranet and show us the trust values.
- Staff were aware of the trust values and the aim to be in in the top 10% of trusts nationally.
- Noticed boards displayed the five point communication board to highlight local and trust wide information.

Governance, risk management and quality measurement

- Senior staff discussed current clinical risks and how they worked collaboratively with staff to address them.
- Meeting minutes reviewed showed discussion of governance issues and shared action plans.
- Staff discussed risks that had been reported and escalated including staffing and equipment issues. The divisional risk register recorded all risks reported and the associated mitigating actions taken.
- There were regular team meetings and huddles to discuss issues and wards displayed information on notice boards.

Leadership of service

- Staff stated that the executive team and board members were accessible and responsive.
- Appraisals were conducted with staff and one to one meetings could be requested when required.
- Staff felt well supported by their line managers and senior management. Staff felt confident to raise issues with line managers and had access to the trust whistle blowing policy.

Culture within the service

- Staff were positive and enthusiastic and felt valued by the organisation. They felt they worked well with colleagues and supported each other where required.
- Staff felt encouraged to raise issues and concerns and felt confident to do so. They stated that the executive team and board members were accessible and responsive.

Public and staff engagement

Surgery

- The in-patient survey also had similar results to all questions asked as the national average. An example being 'Do you feel you got enough emotional support from hospital staff during your stay?' The trust scored 7.3 against the national average of 7.1.
- Surgical services participated in the NHS Friends and Family tests enabling people to feedback about their care and treatment.
- Staff received regular email communication from the trust providing updates on changes and improvements.
- There were regular staff engagement meetings and all staff invited to attend.

Innovation, improvement and sustainability

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- Staff reported being encouraged to improve and to forward ideas for improvements and cost efficiencies. This included updated handover sheets for staff. They felt their views were listened too.
- There was a planned upgrade of theatres three and four planned for March 2016.

Critical care

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

Information about the service

The critical care services were based at the Royal Albert Edward Infirmary. The intensive care unit provides care for up to seven level 3 (intensive care) patients and four level 2 (high dependency) patients. The service also provides a 24-hour outreach service to the hospital by a team of trained nurses and support outreach staff.

The services are consultant-led and provided specialist and secondary care and treatment to adult patients with a range of serious life-threatening illnesses in the Wigan, Wrightington and Leigh areas as well as the wider Greater Manchester area. Patients could be admitted to the critical care services via the emergency department or from within the wards and departments across the trust. Patients transferred from other hospitals are accepted onto the unit as part of the critical care network. There were 221 admissions to critical care and 171 discharges between April 2014 and March 2015.

We visited the Royal Albert Edward Infirmary as part of our announced inspection during 8 to 11 December 2015. As part of the visit, we inspected the intensive care unit (ICU).

We spoke with three patients and the relatives of three patients. We observed care and treatment and looked at three care records. We also spoke with a range of staff at different grades including nurses, doctors, consultants, the pharmacy technician, the pharmacist, the practice educator, support workers, outreach specialist nurse, the matron for critical care and the consultant lead for intensive care. We received comments from our listening event and from people who contacted us to tell us about their experiences. We reviewed performance information about the trust.

Critical care

Summary of findings

We rated the critical care services at the hospital as good. This was because patient safety was monitored and incidents were investigated to assist learning and improve care. Patients received care in safe, clean and suitably maintained premises. The staffing levels and skill mix was sufficient to meet patients' needs. Patients were supported with the right equipment. Patients received care and treatment by trained multidisciplinary staff that worked well as a team.

Medicines were stored and administered appropriately. However, fridge temperatures were not always maintained below 8ºC. Staff minimised the risk to patients by taking additional steps such as reducing the expiry date of medicines stored in the fridges.

The services provided care and treatment that followed national clinical guidelines and staff used care pathways effectively. The services performed in line with expected levels for all performance measures in the Intensive Care National Audit and Research Centre (ICNARC) 2013/14 audit. This meant the majority of patients had a positive outcome following their care and treatment.

There was sufficient capacity to ensure patients could be admitted promptly and receive the right level of care. Bed occupancy levels were consistently lower than the England average. The number of out-of-hours discharges, delayed discharges and patients transferred out for non-clinical reasons were within expected levels when compared to other critical care units nationally.

The relatives of patients spoke positively about the care and treatment provided. Patients were treated with dignity, empathy and compassion. Staff involved patients or their relatives in their care and supported them with their emotional and spiritual needs.

There were systems in place to support vulnerable patients. Complaints about the service were shared with staff to aid learning. There was effective teamwork and clearly visible leadership within the department. Staff were positive about the culture within the critical care services and the level of support they received from their managers.

Are critical care services safe?

Good

Patient safety was monitored and incidents were investigated to assist learning and improve care. Patients received care in safe, clean and suitably maintained premises. The staffing levels and skill mix was sufficient to meet patients' needs. Patients were supported with the right equipment. Patient records were completed appropriately. The majority of staff (98%) had received mandatory training in order to provide safe and effective care.

Medicines were stored and administered appropriately. However, medication fridges were located in a treatment room where the temperatures fluctuated. This meant the fridge temperatures were not always maintained below 8ºC. However, staff minimised the risk to patients by taking additional steps such as reducing the expiry date of medicines stored in the fridges.

Incidents

- The strategic executive information system data showed there were no serious patient safety incidents reported by the critical care services between May 2014 and April 2015.
- Staff were aware of the process for reporting any identified risks to staff, patients and visitors. All incidents, accidents and near misses were logged on the trust-wide electronic incident reporting system.
- Staff told us they were encouraged to report incidents and received direct feedback from the matron for critical care. Incidents logged on the system were reviewed and investigated by the matron to identify learning and prevent reoccurrence.
- Staff told us incidents and complaints were discussed during monthly staff meetings so shared learning could take place. Learning from incidents was also shared through monthly newsletters.
- The incident reporting system provided prompts for staff to apply duty of candour (being open and honest with patients when things go wrong) for incidents that had led to serious or moderate harm.
- Patient deaths were reviewed by individual consultants. These were also presented and reviewed at bi-monthly audit meetings.

Critical care

Safety thermometer

- The NHS Safety Thermometer assessment tool measures a snapshot of harms once a month (risks such as falls, pressure ulcers, blood clots, catheter and urinary infections).
- The critical care services had low levels of falls with harm, infections and pressure ulcers. Safety Thermometer information showed there were no falls with harm or catheter urinary tract infections and one pressure ulcer reported by the hospital relating to critical care services between June 2014 and October 2015.
- Information relating to the safety thermometer outcomes was clearly displayed on notice boards within the critical care unit.

Cleanliness, infection control and hygiene

- Information supplied by the trust showed there were no cases of Methicillin-resistant Staphylococcus aureus (MRSA) or Clostridium Difficile (C.diff) infections reported over the last 12 months across the critical care services. The overall infection rates were within expected levels for the size of the trust.
- Intensive Care National Audit and Research Centre (ICNARC) data also showed that unit acquired MRSA infection rates were within expected levels compared to the England average.
- All patients admitted to the critical care services underwent MRSA screening procedures. Patients identified as at risk were also screened for C.diff.
- There had been one incident of ventilator-associated pneumonia (VAP) that was identified in November 2015.
- The patient had received safe and appropriate treatment through the use of a recognised ventilator care pathway, which included placing the head of the bed at 30-45 degrees angle, daily oral care with Chlorhexidine and the daily sedative interruption and daily assessment of readiness to extubate (removal of tubing from a patients airways). A root cause analysis investigation involving nursing and medical staff had commenced so that learning could take place following the incident.
- The critical care unit was clean, tidy and maintained to a good standard. However, we found the staff kitchen was not cleaned to a good standard. The matron was made aware of this and this area was suitably cleaned during the inspection.
- Staff demonstrated adherence and good awareness of current infection prevention and control guidelines. There were clearly defined roles and responsibilities for cleaning the environment and decontaminating equipment.
- There were arrangements in place for the handling, storage and disposal of clinical waste, including sharps. There was a sufficient number of hand wash sinks and hand gels available throughout the critical care unit. Staff wore personal protective equipment, such as gloves and aprons, while delivering care.
- We observed staff following hand hygiene and bare below the elbow guidance. Hand hygiene audits were carried out on a monthly basis to monitor staff adherence to trust policies. Hand hygiene audit results showed compliance by critical care staff was 100% between April 2015 and July 2015.
- The critical care unit had three single rooms that could be used to isolate patients identified with an infection. We saw that appropriate signage was used to protect staff and visitors.

Environment and equipment

- The environment and equipment in critical care unit was visibly clean and well maintained. The clinical areas were tidy and free from clutter. Each patient bed area had an equipment trolley containing all the equipment required to treat the patient.
- The equipment we saw within the critical care unit included labels showing they had been serviced and when they were next due for servicing.
- Equipment was serviced by the hospitals maintenance team under a planned preventive maintenance schedule. Staff told us that all items of equipment were readily available and any faulty equipment was either repaired or replaced on the same day.
- Staff told us that all items of equipment were readily available and bed spaces were equipped with the right equipment needed to treat patients, such as ventilators and intubation equipment (for placement of tube in patients airways).
- Emergency resuscitation equipment was available and checked on a daily basis by staff.

Medicines

- Medicines, including controlled medicines, were securely stored. Staff carried out daily checks on controlled medicines and medication stocks to ensure that medicines were reconciled correctly.
- We found that medicines were ordered, stored and discarded safely and appropriately. A pharmacy technician was responsible for maintaining minimum stock levels and checking medication expiry dates.
- We saw that medicines that required storage at temperatures below 8C were stored in medicine fridges. Fridge temperatures were monitored daily to check medicines were stored at the correct temperatures.
- The medicine fridges were kept in a treatment room where the temperatures fluctuated. This meant the fridge temperatures were not always maintained below 8C. For example, the daily logs showed a number of occasions where temperatures were recorded above 8C.
- The pharmacy technician and the matron told us this issue also affected other wards in the hospital and we saw this issue was logged as a risk on the divisional risk register.
- The pharmacy technician told us additional controls had been put in place to ensure medicines were appropriately stored. This included discarding medicines, limiting the number of medicines in the fridges and reducing the expiry date of medicines stored in the fridges to maintain the efficacy of the medicines and minimise the risk to patients.
- The critical care unit had a dedicated pharmacist based on the unit during weekdays. The pharmacist reviewed all medical prescriptions, including antimicrobial prescriptions, to identify and minimise the incidence of prescribing errors.
- We looked at the medication records for five patients and found these to be complete, up to date and reviewed on a regular basis.

Records

- Staff used an electronic patient records system. We looked at the records for three patients. These were complete and up to date.
- The three patient records included risk assessments, such as for venous thromboembolism (VTE), pressure care or nutrition and these were completed correctly.
- The three patient records showed that nursing and medical assessments were carried out in a timely manner and documented correctly.
- Observations were well recorded and the observation times were dependent on the level of care needed by the patient.

Safeguarding

- Staff received mandatory training in the safeguarding of vulnerable adults and children. Records showed 100% of critical care staff had completed safeguarding adults training, 96.9% of staff had completed safeguarding children training and 100% of staff had completed advanced (level 3) safeguarding children training.
- Staff were aware of how to identify abuse and report safeguarding concerns. Information on how to report adult and children's safeguarding concerns was clearly displayed in the critical care unit. The unit also had safeguarding link nurse in place. Staff could also obtain support and guidance from the trust-wide safeguarding team.
- Safeguarding incidents were reviewed by the matron and also by the hospitals safeguarding committee, which held meetings every three months to review safeguarding incidents and look for trends.

Mandatory training

- Staff received mandatory training, which included key topics such as infection control, information governance, equality and diversity, fire safety, emergency planning, inclusion and diversity, safeguarding children and vulnerable adults, manual handling and conflict resolution.
- Mandatory training was delivered on a rolling programme and monitored on a monthly basis.
- The overall mandatory training completion rate for all staff across the critical care services was 98%. This showed the majority of staff had completed their mandatory training and the trusts internal target of 95% compliance had been achieved.

Assessing and responding to patient risk

- Critical care staff carried out routine monitoring based on the patients individual needs to ensure any changes to their medical condition could be promptly identified.
- Patient records showed that staff escalated concerns correctly, and repeat observations were taken within necessary time frames to support patient safety.

Critical care

- Ward staff across the hospital used early warning scores. If a patients health deteriorated, staff were supported with medical input and could access the critical care outreach team.
- The critical care outreach team was available 24 hours per day and provided support and training for ward staff in the management of acutely ill and deteriorating patients across the Royal Albert Edward Infirmary.
- Records for September 2015 to November 2015 showed the critical care outreach team had carried out a total of 771 patient assessments across the hospital. This included 331 new patient referrals and 440 follow up assessments.
- The outreach team also followed up all patients that had been discharged from the critical care services within 24 to 48 hours of discharge from the unit.

Nursing staffing

- Nurse staffing levels were reviewed every six months against minimum compliance standards, based on national NHS safe staffing guidelines. The expected and actual staffing levels were displayed on a notice board in the unit and these were updated on a daily basis.
- Nursing staff handovers occurred three times a day and included discussions around patient needs and any staffing or capacity issues.
- During our inspection the critical care services had a sufficient number of qualified nursing and support staff with an appropriate skill mix on each shift to ensure that patients received the right level of care.
- The unit provided care for up to seven level 3 (intensive care) patients and four level 2 (high dependency) patients. All intensive care (level 3) patients were nursed 1:1 and all high dependency (level 2) patients were nursed 1:2 in accordance with Intensive Care Society (ICS) guidelines.
- The staffing establishment was for nine trained nurses and two nursing assistants during the morning and evening shifts and nine trained nurses during the night.
- There was also a lead nurse (band 7) on each shift. However, the lead nurse was not always supernumerary (i.e. additional to the staffing establishment) as recommended by ICS guidelines. The matron for critical care told us the low bed occupancy levels in the unit meant the lead nurse was able to carry out their additional duties with minimal impact to patient safety.
- The matron and business manager were in the process of submitting a business case to have a supernumerary lead nurse on each shift but there was no clear timeline for when this would be in place.
- There were vacancies for one band 5 nurse and one band 6 nurse in the unit. Recruitment to fill these posts was due to commence in January 2016.
- The matron for critical care told us they did not routinely use external agency. The majority of cover for staff leave or sickness was provided by the existing nursing team.
- External agency staff use in the unit was less than 1% and so was within levels recommended by ICS guidelines (less than 20% agency staff on any one shift).
- The critical care outreach team included five nurses, with at least one nurse on site over a 24 hour period.

Medical staffing

- During our inspection we found the critical care services had a sufficient number of medical staff with an appropriate skill mix to ensure that patients received the right level of care.
- There was a designated lead consultant for intensive care as set out in the ICS standards.
- There were eight critical care consultants committed to the unit with a rota divided into two sections; one covering Monday to Thursday and the second covering Friday to Monday. During weekdays, at least two consultants were based on the unit between 8am and 6pm. During out of hours there was at least one on-call consultant.
- Consultant cover on the weekends was mainly provided by at least one on-call consultant between 08:00am Saturday until 08:00am Monday (48 hours cover). A consultant was present on the unit for up to four hours during out of hours and on the weekends so that patients could be assessed when required and to maintain daily ward rounds on the weekends.
- There was at least one junior or middle grade doctor resident on the unit at all times.
- The consultant to patient ratio did not exceed 1:8 during weekdays and 1:15 during out-of-hours service in line with ICS standards.
- There was one whole time equivalent consultant vacancy. Locum doctors were used to cover existing vacancies and for staff during leave. Where locum doctors were used, they underwent recruitment checks and induction training to ensure they understood the hospitals policies and procedures.

Critical care

- We saw that daily medical handovers took place during shift changes and these included discussions about specific patient needs. Medical staff across the different grades participated in the medical handovers.

Major incident awareness and training

- There was a documented major incident plan within the critical care services and this listed key risks that could affect the provision of care and treatment.
- There were clear instructions in place for staff to follow in the event of a fire or other major incident.
- Records showed the majority of staff (95%) had completed basic adult life support training.

Are critical care services effective?

Good

The service provided care and treatment that followed national clinical guidelines and staff used care pathways effectively. The service performed in line with expected levels for all performance measures in the Intensive Care National Audit and Research Centre (ICNARC) 2013/14 audit. This meant the majority of patients had a positive outcome following their care and treatment.

Patients received care and treatment by multidisciplinary staff that worked well as a team. Staff understood the legal requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

Evidence-based care and treatment

- Staff followed policies and procedures based on national guidelines, such as the Intensive Care Society (ICS), National Institute for Health and Care Excellence (NICE), National Confidential Enquiries into Patient Outcome and Death (NCEPOD) recommendations as well as guidance published by the relevant medical bodies such as the Royal Colleges and British Medical Association.
- Staff carried out an assessment of delirium (acute confusion) in patients using the Delirium, Alcohol withdrawal, and Suicide /Harm to others (DASH) guidelines.
- The critical care services participated in quality audits as part of risk over network (RICON) project in collaboration with the Greater Manchester Critical Care Network. The service participated in six quality audits, including medicine safety, communication, patient access, lung protective ventilation and airway safety.
- Findings from clinical audits were reviewed for any changes to guidance and the impact that it would have on practice was discussed during departmental audit meetings that took place every two months. Audit findings were also shared with the care network to look for improvements to the service.

Pain relief

- The critical care staff had guidance available about the medicines used for analgesia. Medical staff confirmed that analgesia was a routine part of sedation management. Pain was assessed as part of the overall patient assessment and was accompanied by sedation scoring where relevant.
- There was a dedicated pain team within the hospital and staff knew how to contact them for advice and treatment when required.
- Patient records showed that patients that required pain relief were treated in a way that met their needs and reduced discomfort.

Nutrition and hydration

- Patient records included an assessment of patients nutritional requirements. Where patients were identified as at risk, there were fluid and food charts in place and these were reviewed and updated by the staff.
- Where patients had a poor uptake of food, this was addressed by the medical staff to ensure patient safety. A dietician provided routine input during weekdays and was available to participate in daily ward rounds if needed. There were protocols for initiating appropriate nutritional support out of hours.

Patient outcomes

- ICNARC 2013/2014 data showed the critical care services at the hospital performed within expected levels for unit acquired MRSA, hospital mortality, delayed discharges, out-of-hours discharges, non-clinical transfers out and for unplanned readmissions within 48 hours.
- ICNARC data supplied by the trust up to the period of April to June 2015 showed that the mean length of stay for ventilated admissions, patients with severe sepsis and elective surgical admissions was either similar or better (shorter) than other comparable units nationally.

- The data also showed the readmission rates for both early (within 48 hours of discharge from the unit) and late (over 48 hours) were better than comparable units.

Competent staff

- The critical care service had a practice educator that oversaw training processes and carried out competency assessments based on national critical care competency guidelines.
- Newly appointed staff had an induction and their competency was assessed over a period of eight weeks before working unsupervised. During the induction period, the new starters were supernumerary (i.e. in addition to the staffing establishment). This was followed by further training during the first year after which they were placed on a post graduate critical care course.
- Staff told us they routinely received supervision and annual appraisals. Records showed the annual appraisal completion rate was 86% for nursing staff and 80% for support staff. This meant the majority of staff had completed their annual appraisals although the trust target for 95% appraisal completion had not been achieved for these staff groups. The records also showed 100% of all medical staff in critical care had completed their appraisals.
- Records showed that as of November 2015, 77% of nursing staff had completed the post registration award in critical care nursing, which exceeded the ICS standard for at least 50% of staff to have completed the training. The matron for critical care told us training for additional staff was ongoing and they expected 89% of staff to have completed the post registration training by January 2016.
- Records showed 100% of all eligible medical staff in the critical care services that had reached their revalidation date had been revalidated with the General Medical Council.
- The nursing and medical staff were positive about on-the-job learning and development opportunities and told us they were supported well by their line management.

Multidisciplinary working

- There was effective daily communication between multidisciplinary teams within the critical care services. Staff handover meetings took place during shift changes and safety huddles were carried out on a daily basis to ensure all staff had up-to-date information about risks and concerns.
- There was a daily ward round which had input from nursing, microbiology, pharmacy and physiotherapy. The nursing staff told us they had a good relationship with consultants and ward-based doctors.
- There were routine team meetings that involved staff from the different specialties. Patient records showed that there was routine input from nursing and medical staff and allied health professionals.
- Staff told us they received good support from the pharmacy team, dieticians and physiotherapists as well as diagnostic support such as for x-rays and scans.
- The critical care outreach team was available 24 hours per day and provided support and training for ward staff in the management of acutely ill and deteriorating patients.
- From January 2016, the critical care services planned to deliver a rehabilitation service and follow up clinic for patients that had a long term stay in critical care. The proposed plans outlined running the follow up service with the outreach team and a critical care consultant, pending the approval of a business case to support the plans.

Seven-day services

- Staff rotas showed that nursing staff levels were appropriately maintained outside normal working hours and at weekends to meet patients needs.
- We found that sufficient out-of-hours medical cover was provided to patients by junior and middle grade doctors as well as on-site and on-call consultant cover. Patients admitted to critical care were seen daily by a consultant.
- Microbiology, imaging (e.g. x-rays), physiotherapy and pharmacy support was available on-call outside of normal working hours and at weekends. Physiotherapy and pharmacy support was available on the unit during the day on Saturdays and Sundays.
- Staff told us they received good support outside normal working hours and at weekends.

Access to information

- Staff used an electronic patient records system. The patient records we looked at were complete and up to date. They contained detailed patient information from

arrival to the critical care unit through to discharge or admission to the wards. This meant that staff could access all the information needed about the patient at any time.

- Staff told us the information about patients they cared for was easily accessible. The lead consultant told us they experienced difficulties producing specific reports from the electronic system which meant this information had to be manually obtained by accessing multiple patient records. There was ongoing consultation with the software provider in order to address this.
- Notice boards were used to highlight where patients were located within the unit and to identify high risk patients at risk such as patients with an infection or those identified as being at risk of falls.
- We saw that information such as audit results, performance information and internal correspondence was displayed in all the areas we inspected. Staff could access information such as policies and procedures from the trusts intranet.

Consent and Mental Capacity Act

- Staff understood how to seek consent from patients and understood the legal requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Records showed 93% of critical care staff had completed mental capacity act training.
- If patients lacked the capacity to make their own decisions, staff told us they sought consent from an appropriate person (advocate, carer or relative) that could legally make decisions on the patients behalf. When this was not possible, staff made decisions about care and treatment in the best interests of the patient and involved the patients representatives and other healthcare professionals. For example, we saw during our inspection that staff were supported by a psychiatrist on the unit during the assessment of a patient with mental health needs.
- There was a trust-wide safeguarding team that provided support and guidance for staff for mental capacity assessments, best interest meetings and Deprivation of Liberty Safeguards applications.

Are critical care services caring?

Good

The relatives of patients spoke positively about the care and treatment provided. They told us patients were treated with dignity, empathy and compassion. Staff ensured patients or their relatives were involved in their care and supported them with their emotional and spiritual needs.

Compassionate care

- During the inspection, we saw that patients were treated with dignity, compassion and empathy. The patients we saw were well positioned and their dignity was maintained.
- We observed staff providing care in a respectful manner. We saw that patients bed curtains were drawn and staff spoke with patients in private to maintain confidentiality.
- We spoke with the relatives of five patients. They told us the staff were kind and caring and gave us positive feedback about ways in which staff showed them respect and ensured that patient dignity was maintained. The comments received included cannot fault the staff and the doctors and nurses are very caring.
- Patients and relatives we spoke with gave a mixed response about staff attitude. They told us some staff were very friendly and helpful while others were quite passive and did their job and went.

Understanding and involvement of patients and those close to them

- When necessary, relatives could arrange face to face meetings with a consultant. Patient relatives spoke positively about the communication and support received from staff. They told us they had been kept fully updated and were given opportunities to have all their questions answered.
- Due to the nature of the care provided in a critical care unit, patients could not always be directly involved in their care. Where possible the views and preferences of patients were taken into account and this was documented in their records. Relatives of patients told us staff had asked them about patient preferences and likes and dislikes.

Emotional support

Critical care

- Patients had an allocated nurse who was able to support their understanding of care and treatment and ensure that the patient or their relatives were able to voice any concerns or anxieties.
- Staff could seek support from the palliative care team if a patient required end of life care. There were no facilities for overnight accommodation for the relatives of patients. However, the matron for critical care told us they provided additional support such as transferring patients to side rooms for privacy and allowing flexible visiting times for relatives if needed.
- Information leaflets were available to provide patients and their relatives with information about bereavement, chaplaincy services and counselling services. Nursing and medical staff were included in debriefing sessions after traumatic events.
- The matron for critical care told us they were in the process of developing patient diaries that would be useful to inform patients about their care and stay in critical care at times when they may have memory gaps as a consequence of sedation or their medical condition.

Are critical care services responsive?

Good

There was sufficient capacity to ensure patients could be admitted promptly and receive the right level of care. NHS England data showed bed occupancy levels between January 2015 and October 2015 were consistently lower than the England average and ranged between approximately 40% and 70%.

ICNARC data showed the number of out-of-hours discharges, delayed discharges and patients transferred out for non-clinical reasons was within expected levels when compared to other critical care units nationally.

There were systems in place to support vulnerable patients. Complaints about the service were shared with staff to aid learning. There had only been one complaint relating to critical care services between September 2014 and August 2015.

Service planning and delivery to meet the needs of local people

- The critical care unit had allocated seven intensive care beds and four high dependency care beds. As part of the escalation plan, an additional three beds in the theatre recovery area could be used for the treatment of critically ill patients in the event of high demand.
- There were 221 admissions to critical care and 171 discharges between April 2014 and March 2015.
- The unit provided critical care services for adults over the age of 16 years. If a child was admitted to the service they were assessed, stabilised and then transferred to neighbouring hospitals for treatment.
- Staff were aware of how to escalate key risks that could affect patient safety, such as staffing and bed capacity issues. There was daily involvement by the matron to address and manage these risks.
- There were daily meetings with the bed management team to ensure patient flow was maintained and to identify and resolve any issues relating to the admission or discharge of patients.

Meeting people's individual needs

- Information leaflets about the services were readily available. We did not see written information readily available in different languages or other formats, such as braille. However, staff told us these could be provided upon request.
- Staff could access a language interpreter if needed.
- Staff received mandatory training in dementia care. The unit also had dementia link nurses and dementia champions in place that had received additional training and could provide advice and support for staff on the unit. Staff could also contact the trust-wide safeguarding team for advice and support around caring for patients living with dementia or a learning disability.
- Staff involved carers and others involved in the patients care and specific care plans were put into place. The matron for critical care told us they planned to introduce patient diaries to assist the recovery of confused or unconscious patients during their stay.
- There were defined visiting hours for relatives. However, relatives could arrange to visit patients at any time during the day depending on the patients condition.
- Staff could access appropriate equipment to support the moving and handling of bariatric patients (patients with obesity) admitted to the critical care unit.

Access and flow

Critical care

- NHS England data showed bed occupancy levels between January 2015 and October 2015 were consistently lower than the England average of 80%. The percentage of occupied beds in the unit ranged between approximately 40% and 70% during this period. During the inspection, we saw that a number of beds in the unit were unoccupied.
- Patients from other hospitals within the Greater Manchester Critical Care Network were admitted to the unit when these hospitals had capacity constraints.
- The critical care unit operated a closed admission policy with all admissions needing to be discussed between the referring team and the critical care consultant. Admission to the critical care unit occurred within four hours of making the decision to admit and most patients admitted to the unit were assessed by a consultant within 12 hours in accordance with ICS guidelines.
- ICNARC data showed the number of patients transferred out for non-clinical reasons was within expected levels. The number of out-of-hours discharges to the ward was similar to comparable critical care units nationally. There had been eight instances where patients were discharged during out-of-hours between January 2015 and July 2015. The matron for critical care told us patients were seen by a consultant and only discharged if it was clinically safe to do so.
- The number of delayed discharges was also within expected levels when compared to other units nationally. Records between January 2015 and July 2015 showed there were 52 instances of delayed discharges greater than four hours. The main reason for delayed discharges was due to a lack of available beds on the wards.
- NHS England data between April 2015 and November 2015 showed there were no urgent surgery cancellations due to a lack of clinical care beds at the hospital.

Learning from complaints and concerns

- Information on how to raise complaints was displayed within the critical care unit and included contact details for the Patient Advice and Liaison Service (PALS). The patients relatives we spoke with were aware of how to raise complaints.
- The matron for critical care was responsible for reviewing and investigating complaints. Information about complaints was discussed during monthly team meetings to raise staff awareness and aid future learning.
- The matron told us any minor issues or concerns raised by patients or their relatives were addressed immediately by staff.
- The hospitals complaint policy stated that formal complaints would be acknowledged within three working days and investigated and responded to within 25 working days for routine complaints and up to 60 days for complex complaints that required detailed investigation or root cause analysis.
- Records showed there was only one formal complaint relating to critical care services between September 2014 and August 2015 and this complaint was appropriately investigated but the complaint was not responded to and closed within 60 days.

Are critical care services well-led?

Good

The risk register identified key risks relating to the services and these risks were monitored through monthly divisional quality and executive committee meetings. There was effective teamwork and clearly visible leadership within the department. Staff were positive about the culture within the critical care services and the level of support they received from their managers. The management team understood the key risks and challenges to the service and how to resolve these.

Vision and strategy for this service

- The trust mission statement was To provide the best quality healthcare for our patients and the trust vision was To be in the top 10 per cent for everything we do. The trust strategy was To be safe, effective and caring. Patient safety always remains our highest priority of all.
- This was underpinned by a set of values and behaviours that were based on patients first, teamwork, compassion, respect and dignity, forward thinking and accountability.
- The trust vision, values and objectives had been cascaded to staff across the critical care unit and staff had a clear understanding of what these involved.

Critical care

- There was no strategy document specifically for the critical care services. However, the strategy for the critical care services had been incorporated into the surgical divisional quality strategy 2014-17, which included specific performance targets and actions relating to patient safety, clinical effectiveness and patient experience.

Governance, risk management and quality measurement

- There were monthly divisional quality and executive committee meetings and monthly staff meetings. There was a set agenda for these meetings with standing items, including the review of incidents, key risks and monitoring of performance. Identified performance shortfalls were addressed by action planning and regular review.
- Within the critical care unit, there were routine staff meetings to discuss day-to-day issues and to share information on complaints, incidents and audit results.
- Risks were documented and escalated by the service appropriately. Risks relating to the critical care service were incorporated into a local departmental risk register and the divisional risk register. These were reviewed and updated during monthly divisional quality and executive committee meetings.
- We saw that routine audit and monitoring of key processes took place to monitor performance against objectives. Information relating to performance against key quality, safety and performance objectives was monitored and cascaded to staff through performance dashboards and newsletters.
- The critical care services were routinely peer reviewed through the Greater Manchester Critical Care Network to assess compliance against national standards. The next peer review was scheduled for April 2016.

Leadership of service

- The critical care services were incorporated into the surgery division at the hospital. There were clearly defined and visible leadership roles within the critical care services. There was a designated lead consultant for intensive care that oversaw the critical care services. The nursing staff were managed by a lead nurse on each shift, who reported to the matron for critical care.
- The staff we spoke with told us they understood the reporting structures clearly and that they received good management support.

Culture within the service

- Staff were highly motivated and positive about their work. They described the senior nursing and medical staff as approachable, visible and provided them with good support.
- Staff told us there was a friendly and open culture. Trainee medical and nursing staff told us that they felt supported.
- Records showed sickness levels for all staff across the critical services were 5.99% between December 2014 and November 2015. The sickness levels were higher than the national average during this period. The matron for critical care told us this was mainly due to staff on maternity leave or on long term sickness. Cover for sickness or unplanned leave was provided by the staff within the existing team.

Public engagement

- Staff told us they routinely engaged with patients and their relatives to gain feedback from them. There had been ad hoc patient engagement through patient and carer forums and tea party events, where patients that had previously stayed on the unit and their relatives were invited to attend and share their experiences.
- The critical care services did not participate in the NHS Friends and Family test, which asks patients how likely they are to recommend a hospital after treatment.
- Staff sought feedback from patients and their relatives by asking them to complete a feedback survey. The survey covered key areas such as respect and compassion, staff skills and competency, pain management, emotional support and communication. The information was used to look for improvements to the services.
- The most recent survey was in progress at the time of our inspection and the results had not been compiled. The previous survey from March 2015 was based on 14 responses and the feedback received was mostly positive.
- The survey results showed that 100% of relatives thought that respect to patients was very good to excellent, pain control was excellent (85%), breathlessness control was excellent (80%) and agitation control as positive (75%).

Critical care

- The survey also showed that 91% of relatives thought they had emotional support, 85% considered the skills and competency of staff as very good to excellent and 71% of relatives thought communication was very good to excellent.
- A review of the data from the CQCs adult inpatient survey 2014 showed that the trust performed within expectations in comparison to other trusts for all 10 sections.

Staff engagement

- Staff told us they received good support and regular communication from their line managers. Staff routinely participated in team meetings. Staff from different grades (e.g. band 6 and band 7 nurses) were encouraged to attend leadership meetings and participate in regional critical care network meetings and activities
- The trust also engaged with staff via team briefs, newsletters and through other general information and correspondence that was displayed on notice boards and in staff rooms.
- The matron for critical care confirmed the findings from the NHS staff survey of 2014 were discussed with the critical care staff and they discussed staff concerns during routine team meetings.

Innovation, improvement and sustainability

- The critical care services carried out collaborative work with the Greater Manchester Critical Care Network. There was participation in quality audits, such as the ventilator care bundle audits. This information was shared with the care network to look for improvements to the service.
- The matron for critical care was confident about the ability of the service to meet patient needs in the future. The key risks to the critical care services were identified as delayed discharges, medicine safety and pressure ulcers.
- The lead consultant and matron for critical care were confident about the future sustainability of the critical care services. They felt the devolution of Manchester proposals could have an impact on services in the future but were working collaboratively with other trusts such as Salford Royal NHS Foundation Trust to improve their clinical and financial viability.

Maternity and gynaecology

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

Information about the service

Maternity and gynaecology services are provided at Royal Albert Edward Infirmary (RAEI) in Wigan, Leigh Infirmary and community clinics. Maternity in patient services are delivered at RAEI only.

RAEI maternity includes a delivery suite and a maternity ward. The delivery suite includes nine delivery rooms, one of which has a birthing pool. All rooms are en-suite with tea and coffee making facilities. The maternity ward includes both antenatal and postnatal women in separated areas. There are twenty eight beds on the maternity ward, which includes bays and three side rooms. There is also an antenatal day assessment unit and a triage area.

The maternity unit has a dedicated operating theatre, on the delivery suite, for maternity operations. General theatres are used to support planned maternity operations. The neonatal unit is next to the maternity department.

Antenatal clinics are held at Leigh Infirmary as well as at a number of locations within the community including Thomas Linacre Centre (TLC), Longshoot Health Centre, Hindley and Chandler House (Poolstock).

There is an early pregnancy assessment unit service (EPAU) located next to Swinley ward, at RAEI 24 hours per day and next to ward 2, at Leigh Infirmary, on weekday mornings.

The gynaecology clinic is situated in the dedicated women's centre in the Hanover unit at Leigh.

There is no dedicated ward for gynaecology patients. Patients, at RAEI, are nursed on Swinley ward or ward 2 at Leigh. Both wards are female surgical wards. Leigh provides elective day case surgery on weekdays only, whereas; there are 24 hour services, for both maternity and gynaecology, seven days a week at RAEI.

As part of the inspection, we visited each in patient area at RAEI and Leigh, including the EPAU areas. We also visited the women's centre and antenatal clinic areas at Leigh Infirmary.

At RAEI, we spoke to 50 members of staff of all grades including consultants and other medical staff, heads of services, quality lead, matrons, midwives, nurses and student nurses. We spoke with 18 patients and 5 family members, observed care and reviewed records for 12 patients.

We received comments following our listening event and from people who contacted us to share their experiences, as well as reviewing information received about the service.

Maternity and gynaecology

Summary of findings

The maternity and gynaecology services at Royal Albert Edward Infirmary (RAEI) required improvement in the safe and well–led domains. However we rated them as good in terms of being caring, effective and responsive.

Staff knew how to report incidents. Lessons were shared and learned using techniques such as role play scenarios that included both midwifery and medical staff, however; the Trust-wide learning system was not disseminating learning to all staff effectively. All areas were visibly clean and tidy and staff followed hygiene procedures.

Safeguarding processes were in place and under review. However, we found that door entry systems to both the postnatal ward and the delivery suite did not adequately protect patients. We observed some visitors let other people gain access to the unit who had not used the intercom system to identify themselves to staff members.

Medicines were stored in secure cupboards and daily checks completed, however out of date items were identified and on the delivery suite, the controlled drug cupboard was on the open corridor behind the nurse's station.

There was a lack of assurance about the recording and maintenance of equipment including that used in an emergency. There were on-going maintenance issues related to sewage coming up through the drains on the maternity unit which had been reported and investigated several times but not resolved. Staff reported that this happened on a monthly basis requiring patients in the area to be re-located.

In the maternity unit, we found care records and prescription charts to be legible and completed appropriately. However on Swinley ward, we found records showed that patient care had not been carried out within expected timescales for a patient whose condition was deteriorating. The processes on that ward to obtain consent for surgical procedures did not always follow best practice guidance.

Midwifery and nursing staff had completed the majority of mandatory training to the trust's target of 95% with the exceptions of basic life support at 84%. Medical staffing numbers were adequate for the patient needs. Any shortfall in staffing levels was supported by bank nurses; however the monitoring of locums was not robust.

Trust guidelines were in place; however these were not always clear or adhered to. Guideline reviews were not robust in that they did not always identify required changes and updates. The trust participated in a number of local and national audits. The national neonatal audit (NNAP) showed that the trust performed below the NNAP standard for four out of five indicators.

Women were assessed for pain relief and supported individually whether in labour or post operatively. There was a choice of meals available and patient's breast feeding was supported in the wards and in the community. Midwives were annually assessed by their supervisors and other staff had been appraised to be competent. Midwives did not routinely rotate between the various areas which meant there was no formal process to keep all their skills up to date. Services were available seven days a week on the wards; however no routine antenatal or gynaecology clinics were available at RAEI.

Patients and their families were positive about their care from the nurses, midwives and doctors. They felt involved, were given good explanations and felt that staff were helpful and kind. We observed staff actively engaging with patients and families in a kind and compassionate way. Patients were accommodated sensitively, where possible, if a side room was appropriate. Emotional support was available if needed.

The service had been planned across the geographical location. Each maternity patient was allocated a named midwife, both in the community and as an inpatient. The busiest of the antenatal clinics was Thomas Linacre Centre (TLC) that was close to RAEI.

There were specialist midwives including public health, safeguarding and a mental health nurse. In addition,

Maternity and gynaecology

diversity and dementia champions were available. Any patient identified with a learning disability or mental health need were supported on an individual basis as required.

Midwives were not clear about the trust vision and strategy. There were regular senior meetings that were cascaded to staff but staff felt that meetings with them needed to be more formal. Staff felt that they were supported by their managers, however hospital midwives felt there were fewer opportunities for them to develop than midwifes in the community.

A trust 'pioneering staff engagement' programme was in place across a multi-disciplinary team with a number of innovating programmes in progress. The service has received several awards over the past two years.

Are maternity and gynaecology services safe?

Requires improvement

We rated maternity and gynaecology services as requiring improvement for providing safe care.

Systems were in place to investigate and learn from incidents. This included one to one and group sessions including using real life scenarios for learning and development. However incidents which occurred in the wider trust, and may have a common theme, were not shared in maternity services. Infection prevention and control measures were in place. Hand hygiene and cleanliness audits showed the maternity services were better than the trust's average. Medicines were securely stored and accurate records were kept.

There was sufficient equipment available; however not all of the required checks were recorded, on the maternity ward, in order for staff to be assured it was in good working order, including emergency equipment. Staff had completed mandatory training in line with the trust's target with the exception of adult life support which was below the target. Staff had completed training in safeguarding adults; however there was no information provided about safeguarding children training. The ward entry systems did not safeguard patients from unwanted visitors and the systems for the protection of stored infant milk were not secure.

Records were up to date and reviewed, including patient observation records, risk assessments and medical notes. However, a divisional audit of the World Health Organisation (WHO) surgery checklist carried out in January 2015 showed that, of 30 sets of patient's notes reviewed, only 73% included a WHO checklist form. Actions were agreed and records for safer surgery were stored electronically.

The procedure to identify a deteriorating patient was not clear about when to seek medical assistance or the frequency of observations. There were systems in place to assess the fluctuating staffing requirements on the maternity service. Although the use of bank and agency

was high sickness and recruitment had improved and the majority of shifts were filled. There was adequate medical staff cover including consultant and dedicated anaesthetist.

Incidents

- Staff in the maternity unit, demonstrated a good understanding of the electronic incident reporting system.
- A total of 255 incidents were reported for maternity services between May 2015 and August 2015. For the same time period, there were 28 incidents reported for gynaecology across the trust. Most incidents were reported as no harm. No common themes were identified.
- Lessons learned from incidents were shared across the multidisciplinary teams of medical, nursing and midwifery staff in a newsletter. All the incident investigations and action plans were reviewed at monthly multi-disciplinary team (MDT) meetings.
- The use of skills and drills training had was part of feedback from incidents. Notes from real incidents were used to identify how to deliver the session. However this had been introduced in the past few weeks and there was no protocol for who was involved or how the learnings included those who did not attend. These sessions were not yet documented as learning opportunities.
- A one to one debrief session took place with those staff who had been involved in specific incidents as part of their learning.
- Community midwives maintained a file of incidents, complaints and changes as a result of learning in their respective clinic bases following monthly emails.
- Staff in maternity services did not learn from incidents which occurred in other services within the trust. There was no system in place for learning from incidents with a potential common theme such as medication errors.
- Senior staff understood their responsibilities with 'Duty of Candour' (the regulation for all NHS services, introduced in November 2014 that means they should be transparent and open following any incident).

Safety thermometer

- There was a harm free care board displayed on the maternity ward. This had been adapted to include some measures for maternity; however it did not contain all the information to reflect the established NHS maternity safety thermometer.
- The compliments and complaints were displayed and in October 2015 there had been 92 positive comments and one complaint.

Cleanliness, infection control and hygiene

- All areas were visibly clean and tidy. There were completed cleaning schedules in the delivery suite.
- Monthly audits were undertaken to assess standards of cleaning, nursing care and facility provision. From September 2014 to September 2015, scores ranged between 96.6% for the delivery suite and 96.6% and 98.8% for the maternity ward. This was higher than the trust average.
- All bed curtains included stickers to indicate when they were last changed and we saw these had been done within the required time period.
- Staff were observed following hand hygiene procedures appropriately at the point of care. Hand hygiene audits from April 2015 to August 2015 showed that maternity, Swinley ward and theatre anaesthetics scored 100%. Theatres scored 100% except for June 2015 with a score of 88.9%. Theatre recovery scored 100% in April and July 2015, with 94% in August 2015.
- Appropriate infection control protocols and personal protective equipment procedures were adhered to in theatre areas.

Environment and equipment

- Wards and theatre areas were well maintained and equipment was safely stored.
- On entering the hospital through the main entrance there was a lack of signage to the maternity unit.
- The delivery suite had nine delivery rooms. This included one room with a birthing pool and a bereavement suite.
- The maternity ward had capacity for 28 beds that included three single side rooms and a two bedded day assessment unit. The four bedded bays were used flexibly to accommodate either post or antenatal patients and the ward could be separated using double doors in the corridor.

Maternity and gynaecology

- Maternity operating theatres were adjacent to the maternity wards which meant patients could be quickly transferred in an emergency.
- The neonatal unit was easily accessible from the delivery suite which resulted in timely transfer of babies when required.
- There was a bereavement room away from the main delivery suite area. This had homely furnishings and decoration with facilities for food and drink preparation.
- Patients with a still born baby had to have their delivery in the same area as other patients despite the bereavement room being available. Staff reported they could not use the bereavement room for deliveries because it did not meet with infection control guidance. Infection control staff advised us that furniture had been treated and all fixtures and fittings met with infection control guidance to ensure patients could use the room during delivery. However maternity staff preferred the height of beds in the delivery suite which meant that women delivered there and were transferred, with their families, to the bereavement suite.
- There was a birthing pool room that included equipment such as a thermometer (to check water temperature), non-slip mats and two safety nets (in case of need for emergency evacuation).
- In the delivery suite, the adult resuscitation trolley was stored behind a door locked with a key pad. This meant that, in an emergency situation, it could delay access to equipment. This was addressed onsite with the ward manager and it was relocated out onto the ward during the inspection.
- In the delivery suite, daily checks had been completed for the resuscitation trolley and defibrillator for November 2015 and December 2015 and all items in the post-partum haemorrhage (PPH) and emergency trollies were in date.
- One item on the emergency trolley was out of date on the maternity ward despite the daily check having been signed for that day. This meant these items had not been checked thoroughly and records were inaccurate.
- On the maternity ward, there were gaps noted in the recording of daily checks of the defibrillator. For the month of November 2015, there was twelve signatures to indicate the daily check had been completed. For the week commencing 30 November 2015, were no checking signatures at the weekend. There were no signatures for the week of the inspection, commencing 7 December 2015. This meant there was no assurance this emergency equipment was in full working order.
- On the delivery suite the daily checks on the resuscitaires we reviewed had been completed for the past three months.
- The portable appliance sticker (PAT) was unreadable for one resuscitaire. Ward managers could not provide records that this equipment met with the maintenance requirements. The process in place involved contact with the estates department therefore on a daily basis staff using the equipment could not assure themselves it was fit for purpose.
- Staff told us they had sufficient equipment, including Cardiotocography (CTG) and sonicaids (monitoring equipment) particularly as there had been recent purchases; however there was a lack of storage space which resulted in rooms being used for storage of equipment as well as office space.
- On the maternity ward, some areas were hot and patients had complained. Staff told us that the temperature was difficult to control as it was linked to four other wards. There were electric fans available if needed.
- There were ongoing maintenance issues related to sewage coming up through the drains on the maternity ward. This had been reported and investigated several times but not resolved. Staff reported that a requirement for patients in the area to be relocated.
- There was a room for storage of infant milk on the maternity ward. There were two fridges; one for expressed breast milk and the other for prepared formula milks. One of the fridges had been 'condemned' and was removed during the inspection and temporary arrangements were in place to store expressed breast milk on the neonatal unit. This room was unlocked. The ward manager explained the process for storing milk safely in the fridge included the use of labelled, sealable bags. This system did not provide assurance milk stored had not been tampered with and we saw open bags meaning it did not work in practice.
- Gynaecology patients were admitted to Swinley ward if a surgical procedure was necessary. This was a female surgical ward with a capacity of 26 in-patient beds. Orrell ward included a surgical assessment unit and admitted gynaecology patients requiring a short stay or elective surgery.

- Community midwives had a lack of space in clinics. They were currently using GP surgeries with limited space and poor computer links.

Medicines

- Medicines, including controlled drugs, were securely stored and administration records were accurate.
- Daily checks of controlled medication had been carried out on the delivery suite and the maternity ward. This included a record of two signatures and dates for all medication stored. Those we checked were accurately recorded.
- Piped medical gases were available by the patient's bedside. Others were securely stored.
- Medicines training was delivered to all newly qualified midwives via an e-learning package. This included time spent in pharmacy. Qualified midwives who were recruited to the trust did not have this training. There was no assessment of staff competence to safely administer medicines throughout their employment in the trust.

Records

- Records for maternity patients included their 'hand-held green notes' as well as paper inpatient records. Gynaecology patient's records were paper-based and followed the general surgery pathway.
- Records of observation charts and medication sheets were kept at the end of patient's beds so that staff could access information easily
- Patient's medical records were not safely stored on all areas. On the maternity ward, the notes trolley was stored outside of the ward office. We were told it was kept locked, although we observed it was open.
- In the maternity unit, we reviewed care records for seven patients and prescription charts for five patients. We found them to be legible and completed appropriately.
- On Swinley ward we reviewed five sets of notes for the gynaecology patients and we found the doctor's signatures were difficult to read and there was no General Medical Council (GMC) signature stamp included. An audit of record keeping for gynaecology patients had been completed in September 2015. This showed that operation notes did not contain the printed name (74%) or designation of the consultant who completed the record (36%).
- There was a sticker on the post-operative notes to show that individual patients had been reviewed. This provided a visual indicator for staff to identify patients who required a medical review.

Safeguarding

- Information provided by the trust showed 98% of nursing and midwifery staff had completed safeguarding adults training. In December 2015, 96.7% of staff had completed safeguarding children training, however; the level of the training was not specified."
- Entry and exit systems on the maternity unit did not protect patients or babies. Entrance to both the delivery suite and the maternity ward was via a call bell and video system for entry through locked doors. Staff could view security screens at the ward reception area and in the ward office; however staff were not always present in these areas. Staff told us visitors were required to ring to gain access in or out; however we saw that the public sometimes let other people into the unit who had not used the intercom. The abduction and lockdown policies did not clearly describe procedures related to unit accessibility.
- There was no baby tagging system in use on the unit. Babies were issued with two labels which were barcoded with the mother's details and a handwritten label for the baby.
- There was a nominated safeguarding lead midwife who worked full time. They provided advice and support to staff including information about referral to other agencies.
- Staff were able to describe the safeguarding referral process with a recording system in the patient's notes or electronically.
- Staff training was provided about female genital mutilation (FGM) by the safeguarding team. Midwives told us that they would report any FGM they suspected and there was a question in the green hand held notes. There was good support network available for patients.
- There was concern from the community midwives that not all patients with complex needs had the support they required. There were specialist public health midwives for patients with specific needs such as drug and alcohol problems. Community midwives said they had concerns that these midwives could take only 75 patients which were the 2% most at risk they had to

manage the rest within their usual caseload. Some of these patients' needs meant they required one to one support and they could not provide this within their work pattern.

Mandatory training

- Midwifery and nursing staff had completed the majority of mandatory training to the trust's target of 95% with the exceptions of basic life support at 84%. These were trust wide figures and not specific to maternity and gynaecology staff.
- Midwives received mandatory training in adult basic life support, internal neonatal life support, safeguarding children level three and e-learning modules including mental capacity act (MCA) and Deprivation of Liberty Safeguards (DoLS), dementia training, inclusion and diversity and moving and handling. Mandatory training was delivered using face to face training and e-learning. Moving and handling training was delivered by e-learning only rather than face to face.
- Thirty five midwives, across the trust, had completed neonatal life support training (NLS) which was accredited by the resuscitation council UK, in the last four years. This was in addition to in-house NLS training which had been completed within the last 12 months. There were seven midwives that had completed NLS (RC (UK) in 2011. All other midwives had received in–house NLS training within the last 12 months.
- The trust had recently updated their 'skills and drills' maternity mandatory training to include scenario based training using 'sim man' simulation equipment to replicate real life events.
- The role of the practice development midwife identified and co-ordinated education delivery and training needs within maternity services.

Assessing and responding to patient risk

- Records for patients on the delivery suite and maternity unit included assessments of risk and records of care needed in an emergency. The majority of those we reviewed had been completed and were up to date; however for one patient who had required an emergency caesarean section their notes was incomplete.
- We reviewed five patients' records on Swinley ward and saw for one patient when their early warning score observations (EWS) indicated a deterioration in their condition no medical review took place. Senior staff on the ward agreed there was a lack of clear guidance on the observations chart of the when to request a medical review.
- In the records we reviewed there was a lack of consistency of frequency of observation of a patient's condition. There was no guidance on the charts as to the frequency required dependent on the score.
- The early warning scoring system policy was currently under review by the critical care outreach team.
- On the delivery suite, we observed 'fresh eyes' in practice, indicating that a second midwife had reviewed the cardiotocography (CTG) every two hours with stickers completed as per the trusts 'Antenatal and Intrapartum Fetal Heart Monitoring' policy. (CTG is used in pregnancy to monitor both the foetal heart rate as well as the contractions of the uterus. Its purpose is to monitor foetal well-being & allow early detection of foetal distress.)
- The maternity ward had a policy of open curtains in each bed space, in order to observe patient safety.
- The division undertook an audit of the World Health Organisation (WHO) surgery checklist which was carried out in January 2015. Results showed that, of the 30 sets of patient's notes reviewed, only 73% included a WHO checklist form. Actions were agreed. Records of world health organisation (WHO) checklists for safer surgery were stored electronically. We were provided with examples, on request, that had been completed appropriately.

Nursing and Midwifery staffing

- Between October 2013 and May 2015, the ratio of all midwifery staff to births was in the range 1:21 to 1:23, which was better than the England average. The England average had reduced from 1:30 to 1:27 over the same period. The latest data showed the ratio had decreased to 1:28 in October 2015 which was in line with the England average.
- Expected and actual staffing levels were displayed and updated on a daily basis on notice boards in all areas we inspected. The full establishment of staff, on delivery suite, was seven midwives for all shifts, however; the actual was six midwives. There was also a health care assistant who supported each shift. Staff told us the current number was sufficient. Patients received 1:1 care during labour.

Maternity and gynaecology

- There was four hourly monitoring of midwifery staffing on the unit against the activity to ensure safe staffing numbers were maintained. A monthly safe staffing report was provided to the trust board and the National Patient Safety Agency (NPSA) labour ward acuity tool was undertaken to monitor staffing levels and patient dependency. The trust followed the birth rate plus recommendation of 1:30 and was compliant with 'safer childbirth' guidance to support staffing levels.
- Current long-term sickness and interim staffing requirements, during recruitment processes, were covered by bank staff. The target for bank nurses was less than 5%, however 14% were employed in November 2015 and 8.9% in December 2015.
- Although the use of bank nurses may be more than the trusts' target in maternity services the majority of shifts were filled. In December 2015 the average fill rate for nurses and midwives on day shifts was 91.76% and on night shifts 92.7%.
- The sickness rate had improved to fewer than 4%. This had been achieved by improvements in staff engagement and better support mechanisms which included a link with human resources. There was one full time vacancy on the delivery suite and maternity ward and one vacant health care assistant post. There was no long term sick leave in the community and three long-term sickness posts in the inpatient maternity services.
- Supervisors of Midwives supported staff on an on call system. Community midwives may be requested if bank were not available, and if they had capacity.
- The Labour Ward lead midwife working supernumerary on the Labour Ward two days per week (this was part of the two managerial days that were allocated to her per week). There were reporting arrangements in place to monitor midwives working in a supernumerary capacity. There had been two recent midwife appointments at the time of the inspection. As is usual Trust procedure, they were working supernumerary whilst completing their induction period.
- Handovers were held, in the delivery suite office to maintain confidentiality using the board to allocate staff. Shift leaders then attended a multidisciplinary handover at 09:00.
- In the event of a caesarean section, staff from the delivery suite supported theatre staff. This meant that three members of staff including two midwives and a health care assistant were needed to scrub for theatre and assist. Midwives told us that if they felt that this was compromising safety, they would raise an incident.
- A pilot scheme had recently commenced, utilising the general theatres for elective caesarean sections. If this theatre was used, a midwife was required to care for the baby. On the maternity ward, all the planned and actual staffing requirements were fulfilled.
- There was a written handover produced for each shift as well as daily 'huddles' at 08:00.
- On the second day of the inspection, we observed that there were no patients in the delivery suite. Staff did not rotate to the maternity ward except for a band six midwife assisting in triage late in the afternoon.
- Newly qualified midwives and midwives new to the trust had an induction programme that included rotation to all areas. Core midwives, across the trust, were allocated to areas that included the delivery suite, maternity ward, antenatal clinics and community midwives. Staff were able to request changes to increase their skills if required.
- For gynaecology, on Swinley ward, there were 4.09 vacancies (11.09%) with a sickness rate of 3.8% in the last financial year. The use of temporary staff on this ward between April 2014 and March 2015 was on average 6.5% per month. This was higher than the trusts' target of less than 5%.

Medical staffing

- Between January 2014 and June 2015, there was an average of 71 hours of consultant cover on the delivery suite per week which was sufficient to meet guidance for the number of births.
- A consultant covered the delivery suite from 09:00 to 17:00 every weekday with a non-resident consultant on call outside of these hours. There is also a non-resident. A registrar and a GP trainee or foundation year two (FY2) doctor was available on-site for the delivery suite 24 hours per day, seven days a week.
- Gynaecology patients, on Swinley ward were supported 09:00 to 17:00 every weekday by maternity medical staff including a GP trainee or FY2 doctor, extending to 21:00 on 2 of the days, with senior support from a registrar or a consultant if needed. Trust wide obstetrics and gynaecology medical staff included: 10 obstetric consultants, one long term locum, five specialist

trainees in obstetrics and gynaecology, one speciality hospital doctor, one GP innovative post, one full time and one part-time speciality trainee (ST2) in obstetrics and gynaecology, three GP trainees and four foundation year (FY2) doctors.
- The maternity anaesthetist was a dedicated obstetric doctor. If required, the anaesthetist attended patients in other parts of the hospital out of hours as a first responder in an emergency situation only.
- The anaesthetist was supported by an operating department assistant (ODA) in theatre.
- Daily medical handovers took place that included discussions about patient needs and any other issues.

Major incident awareness and training

- Midwifery staff were not clear about their roles and responsibilities in the event of a major incident, although; mandatory training requirements included a module 'emergency planning".
- Staff in the maternity services had not completed any training major incident awareness.

Are maternity and gynaecology services effective?

Requires improvement

We rated maternity and gynaecology services as requiring improvement for being effective.

The annual appraisal rates in maternity services did not meet the trusts' target. There was no competency assessment for midwives to work in theatres; this was agreed on a peer- assessment basis. Midwives did not rotate around the various units to keep up their skills.

Staff had a good understanding of the requirement to work within the mental capacity act however, the consent procedures meant the consent given by a patient may not be up to date.

Audits of practices and procedures took place and actions for change were implemented as a result when necessary. However the system to review patient pathways and guidelines did not result in up to date guidance which reflected national policies for all areas of practice.

The outcomes for patients were monitored on a monthly basis and recorded on a maternity dashboard which included targets. These were monitored at the governance meetings and any concerns identified were discussed. Most outcomes were in line with the national average or the trusts' target; however post-partum haemorrhages and inductions of labour had both risen in the past few months. The trust was aware of this and had monitoring mechanisms in place.

Patients were given a choice of pain relief and received it in a timely manner. The service had been awarded UNICEF UK Baby Friendly status to level three and a high number of patients were breastfeeding their babies on leaving the unit. There was good multi-disciplinary working and some services were available seven days per week. There was good support for midwives to complete external additional courses.

Evidence-based care and treatment

- The trust had an audit plan in place that included a wide range of obstetrics and gynaecology subject areas.
- The trust modified early obstetric warning score (MEOWS) audit, of recording of patient observations, carried out in October 2015, included review of 27 notes. There were concerns about recording of respirations. A subsequent action plan had been developed which included amendment guidelines, charts and inclusion in mandatory training.
- One of the recommendations in the local supervising authority (LSA) annual audit report (2015) was that the clinical risk management strategy (2014), needed to be reviewed as it was out of date.
- Guideline reviews were not robust and did not always include reviewing the references on the documents. An example of this was the guidelines for patients with high body mass index (BMI) which we found were not clear or consistent. We were told that all women in this category would be seen by an anaesthetist but the guideline did not reflect this. This guideline also referred to a specialist weight management team who should be faxed, but we were told this team no longer existed. The last review date was 18 November 2015 when the weight management team had already ceased.
- The trust guideline for a low risk woman requesting a home birth was ratified by the clinical cabinet by a virtual meeting on 18 June 2014. There were no terms of reference for a virtual meeting. It was confirmed that a

teleconference had taken place. Mental health guidance referred to accessing a 'public health midwife', but the flow chart in appendix one didn't include 'public health midwife'.

- The female genital mutilation (FGM) guideline was written by one individual and not a multidisciplinary approach. Referencing did not include current guidance such as a reference to the Nursing and Midwifery Council (NMC) 2002 version of the code of conduct. There were no details about what or how to report a suspected incident.
- Following recommended referral processes for growth scans, patients at risk of having a small for gestational age baby were identified and a training programme had been put in place since April 2014, on the customised fetal growth charts for all midwives.
- The trust enrolled in the 'AFFIRM' (Does Promoting **A**wareness of **F**etal movements and **F**ocusing **I**nterventions **R**educe Fetal **M**ortality?) study, in August 2014 where patients presenting with reduced fetal movements were scanned and followed with a departmental growth scan the next working day.
- The maternity service was part of the project saving babies in the north of England project (SaBiNE) which had been led by NHS England and the perinatal institute since June 2015. This aimed to reduce the number of stillbirths and neonatal deaths, using a package of care and training which monitored patients antenatally. Areas that were focused on included antenatal surveillance of growth and outcomes (gestation related optimal weight (GROW)), smoking cessation, reduced fetal movement pathways and training for staff relating to fetal heart rate monitoring.

Pain relief

- In the delivery suite, we observed pain relief being given including a discussion of the available options and the possible effects of different medication.
- On the surgical Swinley ward, strong pain relief (i.e. morphine) was prescribed, in patients records, if required post operatively.
- A middle grade anaesthetist reported that if an epidural (pain relief given as an injection into the space around the spinal cord) was needed, this was usually administered promptly.
- An audit of epidural anaesthesia, carried out in 2014, reported that 97.1% of 409 women were satisfied and would have another epidural.

Nutrition and hydration

- There was a good choice of food displayed, in the corridor, on the maternity ward, with protected mealtimes in place for the patients. There was a snack trolley that included drinks, fruit and biscuits for patients if required.
- Between July 2014 and June 2015, the percentage of women breast feeding post-delivery was between 52% and 54%, then increased to between 89% and 92% at time of discharge home. The percentage of women breastfeeding on discharge from maternity care fell to between 74% and 78%.
- There was a dedicated breast feeding room, on the maternity ward that included comfortable chairs and breast pumps; however the room had also been utilised for private staff meetings.
- There was an infant feeding team that covers the whole of the maternity service to promote and support breast feeding.
- There were three midwife lactation consultants that have undertaken external accredited training.
- The trust had baby friendly level three status. The UNICEF UK Baby Friendly Initiative provides a framework for the implementation of best practice with the aim of ensuring that all parents make informed decisions about feeding their babies and are supported in their chosen feeding method.
- It was initially awarded in 2012 and reassessed in 2015. Midwives who were participating in the preceptorship programme were now required to spend a week with the infant feeding team.
- The maternity ward also supported patients who were bottle feeding their babies. There was information included in a folder with leaflets and advice and there was plans to develop a training and information video for parents.

Patient outcomes

- From 1 January 2015 to 30 November 2015, there were 2,651 deliveries, which was similar to the number of births in 2014. The percentage of mothers aged 20-34 was 79% which was higher than the England average of 76%. The percentage of deliveries with a gestation period between 37-42 weeks was 92% which was slightly higher than the England average of 91%.

Maternity and gynaecology

- Between April 2014 and March 2015, there were 14 stillbirths, and an early neonatal death reported. This was a reduction from the number of still births reported in 2013/14, of which there were 18.
- From April 2014 to March 2015, there were 318 unexpected admissions to the neonatal unit, of which 132 were full term babies. This was higher than 2013/14 which reported 286 unexpected admissions of which 112 were full term babies. There were monitoring arrangements in place and no themes had been identified regarding maternal or neonatal readmission rates.
- The national neonatal audit (NNAP) showed that the trust performed below the NNAP standard for four out of five indicators. They met the standard for 98-100% of babies having their temperature taken within an hour of birth.
- The Intelligent Monitoring report from May 2015 found no maternity outliers in the trust. Of the total deliveries for 2014 (2,686), 54.9% were classified as normal (non-assisted deliveries), compared to the England average of 60.4%.
- The percentage of elective caesarean section deliveries was 10.9%, which was the same as the England average. There were 19.1% emergency caesarean section deliveries compared to an England average of 15.1%. The remaining deliveries were breech, forceps or venteuse (vacuum) deliveries.
- The trust was part of the North West normality group; however there was no current consultant lead. Midwives described the consultants as supportive of midwifery led care and gave an example of a consultant encouraging a lady to walk to theatre which started her labour naturally and another where a lady wanting a home birth who needed an induction which failed and was given a "gentle section". There was an enhanced recovery programme for elective caesarean sections
- Delays in patients requiring an elective caesarean section were being monitored weekly; the pilot scheme was now in operation that resulted in elective sections being carried out during weekdays in the general theatre suite.
- The induction of labour system was managed so that patients were given prostin (medication to assist the onset of labour) in the antenatal area of the maternity ward. Once labour was well established, the patient was transferred to the delivery suite for the birth. The timing of the booked inductions was managed so as to aim to deliver the babies during the day and not at night as per NICE guidance. On the latest dashboard, the inductions for November 2015 were 34.29%. The trust goal was below 27%
- There had been an increase in post-partum haemorrhage (PPH) with 12 in July and nine in August 2015. The trusts' target was less than four. This had been recognised by the consultants and was attributed to the change in medicines recommended in the NICE guidelines. An audit of this was underway. The information provided up to November 2015 did not contain the number of post-partum haemorrhages therefore it was not possible to understand if this trend had decreased.
- Between April 2014 and March 2015, a total of 40 medical terminations of pregnancy (TOP) were carried out and four surgical TOP's, for the same period, at RAEI. The last audit of the TOP service was in 2013 when it was concluded that there were "Minimal adverse outcomes between Home Vs Hospital MTOP" and "Service provided high level of patient satisfaction." Referral to Treatment (RTT) times were requested for the TOP service, however; the trust reported that this data was unavailable. Doctors were pro-active with contraceptive implants following TOP and worked with the family nurse partnership to reduce further pregnancies.
- The ablation service was last audited in 2012 and was planned for re-audit in February 2016. The colposcopy accreditation report was last completed in 2011 and all action plans had been closed.

Competent staff

- Newly qualified midwives completed an 18 month preceptorship programme that included experience in all obstetric departments.
- For regular midwives, there was no mandatory requirement to rotate between departments, unless a request was made: therefore skills may not have been up-to-date in all areas. In the last 12 months, a total of 37 midwives, across the departments had not delivered a baby. This included 13 midwives on the maternity ward, three managerial midwives and three midwives in the community teams.
- Staff attended training and were signed off as competent in both general theatres and obstetric theatres prior to initially assisting in caesarean section delivery. Theatre competencies were not checked again.

It was an individual choice if they felt competent to take on the role. Staff undertook a self-assessment that was discussed at the annual performance development review (PDR).The trust confirmed that there were 40 midwives deemed as competent on the delivery suite, 10 midwifes on the maternity ward, one in triage as well as other midwives following completion of their preceptorships. There was a package of training for staff to be competent to use equipment which included a 'checklist' type assessment.

- Not all staff were up-to-date with appraisals and supervision. The appraisal compliance rates, at RAEI, were 71.4% for rotational midwives, 90.9% for delivery suite, 82.9% for the maternity ward, 50% for antenatal, 100% for the infant feeding team and 71.9% for community midwives. The compliance rate for medical staff, between April 2015 and September 2015 was 100%. The trust target, annually, was 90%.
- The supervisors of midwives were allocated 15 hours per month for their supervisory responsibilities which they said were adequate. Midwives reported a concern regarding revalidation and felt that the role of the supervisor of midwives was not being acknowledged in this process. They had linked with the revalidation head of professional practice for the nurses in the trust who confirmed that the band seven staff would be the confirmers and not the supervisors of midwives.
- Midwives said they were supported, possibly with time or finances, and encouraged to attend external courses if this was identified as a development need during supervision. For example, a midwife enrolled in a critical care module with 50% of the time agreed.
- There was an external development programme available for maternity support workers.
- Records provided by the trust showed there were 22 midwives who were trained in undertaking examination of the newborn across the trust. These staff had received an update within the last 12 to 18 months as well as the completion of the national screening committee e-learning module.
- Three midwives in triage performed third trimester scans for single pregnancies. One midwife sonographer was able to carry out scans for dating the pregnancy, first trimester screening, and anomaly and growth scans. There were 7.9 whole time equivalent sonographers and a trainee sonographer, who carried out gynaecology, early pregnancy scans, cervical length, dating, anomaly and third trimester pregnancy scans. All consultants performed basic obstetric scans with one who performed more detailed obstetric scans. The speciality trainees (ST2 – 7) carried out basic third trimester pregnancy scans.
- There was personality disorder training undertaken by two midwives in order to understand the specific needs of a patient during the birthing experience.

Multidisciplinary working

- Midwives and doctors reported good multi-disciplinary team working; although there was no current resident physiotherapist or dietician. Sonographers were involved in antenatal care.
- An anaesthetist said there was good communication with midwives and obstetricians and they were kept informed off anything which may need their input.
- Some patients chose to be supported across trusts, for example, community antenatal and postnatal care at Wigan, whereas delivery was booked at another hospital. There were agreements in place, between trusts, when a transfer to a specialist hospital was needed. The neonatal outreach team was available if needed.
- The community midwives received discharge referrals, from the maternity ward, daily by telephone.
- There was a good process in place in respect of communicating an abnormal result as GPs had full access to the hand held records as well as access to the pathology system.

Seven-day services

- On the maternity ward, the triage area was available between 08:00 and 20:00, every day. Overnight, the triage service was based and staffed in the delivery suite assessment room
- The gynaecology and early pregnancy assessment unit (EPAU) based next to Swinley ward, was available every day and night. The dedicated staff were available until 02:00 with ward staff supporting overnight. Referrals were via their own GP, accident and emergency or by self-referral.
- There were no midwife sonographers in the EPAU which meant they could not access a scan out of hours and would be given an appointment to return during opening hours. Weekend sonography was only available for emergencies.
- There were no routine antenatal or gynaecology clinics based at RAEI.

Maternity and gynaecology

Access to information

- There were concerns about the lack of available computers in community services. In some clinics there was one computer for 10 midwives and an administrator booking in patients. A lot of information was shared via email and due to the high volume access was not always easily accessible for community midwives based in surgeries.
- There were monthly multi-disciplinary governance meetings and labour ward forums, a quarterly supervisory newsletter and safeguarding newsletter.
- Staff accessed the trust-wide intranet system for policies and guidelines.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- A NHSLA (Litigation Authority) audit of consent documentation, across obstetrics and gynaecology was carried out in 2014. The results showed 'significant assurance', apart from in response to the question "all / some of the actual risks that were discussed are stated"; the score for gynaecology was 47%.
- We reviewed two patient's 'notes on Swinley ward for gynaecology operations. Consent documentation was fully completed; however for one patient it was dated 17/11/15 and was not re-signed with no indication the patient still consented to the operation prior to surgery on 8/12/15. We discussed this with managers who explained the consent may be signed during a pre-operative assessment which can take place several weeks prior to surgery. Following this the consent to treatment is not always revisited with the patient. This does not meet best practice guidance.
- Staff understood the need to hold best interests meetings for patient who may have impaired mental capacity. The safeguarding lead supported best interest meetings if required.
- Security guards were available, although only called upon if unavoidable harm as a result of an individual's behaviour put themselves or others at risk.
- Staff training included an e-learning module for mental capacity act (MCA) and deprivation of liberty safeguards (DOL's).
- A mental health research nurse had recently been appointed in the trust and the rapid assessment interface and discharge (RAID) team was accessible if needed.
- An example was given of a patient with mental health issues who had their link midwife present at the birth of their baby.
- Two midwives had completed personality disorder training to help staff understand the specific needs of one patient and help them to have a positive birth experience.

Are maternity and gynaecology services caring?

Good

Maternity services at The Royal Albert Edward Infirmary (RAEI) were good in terms of being caring.

Patients and their families were positive about their care from the nurses, midwives and doctors. They felt involved, were given good explanations and felt that staff were helpful and kind. We observed staff actively engaging with patients and families in a kind and compassionate way. Patients were accommodated sensitively, where possible, if a side room was appropriate. Emotional support was available if needed.

When in ward bays, with curtains around the beds, conversations were overheard during examinations.

Compassionate care

- Patients were positive about the care they received and said staff communicated well with them. Patients and visitors were treated with kindness and compassion. Patient's privacy was observed when partners were asked to leave during protected meal time. Each woman had their 'named midwife' displayed above the beds.
- We observed 'good regard' in theatre with clear explanations and communication with a patient prior to surgery.
- We were told about how the maternity ward had transferred a woman to a side room in order that a visiting child with a disability could be accommodated.
- The NHS friends & family test (FFT) (a survey which asks patients whether they would recommend the NHS service they have received to friends and family) results showed that the percentage of patients who would recommend the antenatal services was 96% compared to the England average of 95%. The percentage of patients who would recommend the maternity ward

was 98% compared to the England average of 93%. The percentage of patients who would recommend the birth services was 98% compared to the national average of 97%.

The percentage of patients who would recommend the postnatal community provision services was higher than the England average of 97%. The trusts performance for August 2015 and September 2015 for those who would recommend the service was100%.

- Midwives said they always offered 'skin to skin' contact at delivery if possible. The trusts' target for achieving this of over 75% was met once in the past eight months with an average of 66.77% achievement.
- The trust performed similar to other trust's for 16 of 17 questions in the CQC Survey of women's experiences of maternity services (2013). The question that scored better than other trust's was: "Thinking about your stay in hospital, how clean were the toilets and bathrooms you used?"
- Privacy and dignity was not always respected during the ward rounds. We observed a doctor, who was examining a woman, in a multiple bedded bay ward area, with the curtains closed. The discussion was overheard by women and their partners in the same bay. At that time, a side room was available that would have maintained privacy for the woman. On the delivery suite, a midwife opened the door to an assessment room that had no signs displayed without knocking. The room was occupied with a patient; although the curtains were pulled around the bed.

Understanding and involvement of patients and those close to them

- On the delivery suite, there were tea and coffee making facilities in every room for women and partners to help themselves.
- We observed good involvement of a patient and her family during labour. The midwife and a student introduced themselves, to the women and her partner, and explained what would be happening next. Options were discussed and there was clear communication and understanding. The partner was involved by asking him to prepare the clothes, for after the birth, by warming them on the resuscitaire. He assisted with changes in position to be as comfortable as possible. The woman and the family said that the staff were "great" and "very helpful and caring". They said that everything had been explained; they felt included and felt they had been able to ask questions throughout.
- On Swinley ward, where gynaecology patients were admitted, a patient needing privacy was accommodated, where possible, in a side room. They had recently converted an unused bathroom to the 'Bradley suite'. This could include two recliner chairs for patients who, for example, required rapid hydration for hyperemesis (excessive sickness in pregnancy) or a bed for a patient diagnosed with an ectopic pregnancy (not implanted in the uterus).
- Patients could be transferred to Orrell ward, if a side room was available, otherwise patients were resident in a bay with other female surgical patients. We were told that the bed manager was supportive in accommodating gynaecology patients sensitively.
- There was a patient in a single room in the delivery suite, following a termination of pregnancy for fetal abnormalities as there were no single rooms available on Swinley ward. We were told, by the matron, that women were usually given the option of where to stay in clinic.
- The Picker institute report (a survey), dated October 2015, included 90 patients. This was a response rate of 31%. The average response rate for the 64 trusts that ran the maternity survey 2015 was 41%.Results included that, 80% of patients said that the midwives listened to them during their antenatal check-ups, 94% felt that their partner was involved in their care during labour and birth and82% of respondents had confidence and trust in the midwifes they saw after going home.

Emotional support

- Individual named midwives presented handover of patients. We overheard a caring phone call discussion between a patient and a midwife. The midwife listened carefully and confirmed understanding of support and advice offered.
- We observed sensitive care, during a staff handover with regards to patients with particular issues highlighted, such as, support for a woman with a mental health diagnosis. A mental health research nurse had recently been appointed in the trust and the rapid assessment interface and discharge (RAID) team was accessible if needed.

- There were specialist midwives available, such as the public health midwives, who managed caseloads of women with drug and alcohol issues and a specialist screening midwife.
- There was a chaplain and multi-faith prayer room available.
- Intentional rounding (checking patients) was in place, in the maternity ward, however; records were not complete

Are maternity and gynaecology services responsive?

Good

Maternity services at the Royal Albert Edward Infirmary (RAEI) were good in terms of being responsive.

The service had been planned across the geographical location. There were maternity and gynaecology inpatient services, however no routine antenatal or gynaecology clinics onsite. Each maternity patient was allocated a named midwife, both in the community and as an inpatient. The busiest of the antenatal clinics was Thomas Linacre Centre (TLC) that was close to RAEI.

There were specialist midwives including public health, safeguarding and a mental health nurse. In addition, diversity and dementia champions were available. Any patient identified with a learning disability or mental health issue were supported on an individual basis as needed.

Service planning and delivery to meet the needs of local people

- Each GP surgery was allocated a named midwife with responsibilities for a woman's antenatal and postnatal care within a multidisciplinary team, The contact details of the named midwife were included in the woman's 'handheld notes'. The trust aimed for each woman to be seen by their named midwife at each appointment, whenever possible.
- The maternity and gynaecology services were provided at both hospital sites and community locations. There was no antenatal outpatient service at RAEI, except for the day unit. There were three consultant clinics weekly at TLC, close to RAEI, two for high risk patients and one for patients with pre-existing medical conditions. There were two consultant antenatal clinics at Leigh for patients in that local area.
- There were women who chose to combine the community and inpatient care with other trusts. There was also a recently developed 'tongue tie' clinic service available.
- Midwifery led clinics, for low risk women were available at TLC, although the capacity at this location was limited as the consulting rooms were shared with the main outpatient clinics.

Access and flow

- There was an early pregnancy assessment unit (EPAU) at Leigh where patients could attend up to 12 weeks pregnant and the unit on Swinley ward was for up to 18 weeks pregnant. The service on Swinley was available 24 hours a day, whereas Leigh was not available overnight.
- The overall maternity bed occupancy, in the trust, had increased overtime. The rate taken for March 2014/15 shows a 69% occupancy rate with 28 available beds. For June 2015/16 the occupancy rate is at 79% with 28 beds available and for September 2015/16 the trust's occupancy rate is at its highest with 83% and 28 beds available.
- Between April 2015 and November 2015, a total of 25040 women were seen across all trust sites antenatally, of which 4374 attended at RAEI.
- Between January 2014 and June 2015, the maternity unit, did not close, except for a temporary divert of four hours that took place in August 2015. One patient was diverted to a neighbouring unit. The maternity unit took high risk patients from other trusts. There had been delays in patients requiring an elective caesarean section, in the delivery suite due to emergency caesarean sections taking priority. As a pilot scheme, the general theatres were being accessed for elective caesarean sections during weekdays that could be two to four per day.

Meeting people's individual needs

- On the delivery suite, there were tea and coffee making facilities in every room for women and partners to help themselves.
- There were specialist midwives including practice development midwives, screening co-ordinator, quality

and safety, safeguarding and public health midwives. The public health midwives held a collective caseload of 75 patients providing individual support to patients with specific requirements such as drug and alcohol support or domestic abuse. There was no teenage pregnancy midwife specialist. This service was covered by the teenage pregnancy midwifery support team who provided care for the teenage pregnancy caseload across all areas, and worked closely with the family nurse partnership. There was a normality group, family nurse partnership and family planning services available.

- Some midwives were diversity champions which meant they helped support patients with a visual or hearing impairment. There was a dementia champion who was able to support visitors and other staff.
- An antenatal patient expecting a pre-term baby was able to tour the neonatal unit and meet the staff either in the delivery suite or unit. Following a visit to the unit, with the safeguarding lead, a patient with a learning disability could be accommodated in a single room, along with the partner during the length of stay.
- There was a mental health pathway and the Whooley questions (screening for depression) were used during an assessment in accordance with National Institute for Clinical Excellence (NICE) guidance (There was no obstetric consultant with a specialist interest in mental health or formal referral system. A mental health research nurse was recently appointed at the trust.
- There was a room, on the delivery suite, which had been decorated with a double bed and matching wardrobe and bedside cabinets suitable for parents who may have suffered a loss.
- There was a trustwide interpreter and translation service available if needed and 'cordless' phone handsets that could be accessed in delivery rooms.
- On the maternity ward, both parents of twin babies were able to be resident overnight prior to discharge.
- Until earlier this year, a dietician, psychologist and physiotherapist helped to support patients with a body mass index (BMI) of 35 and above. The midwife did an information pack before they left the service with information and guidance. Midwives we spoke with were unaware they could still refer patients to a weight management service although the trust informed us this remained available.

Learning from complaints and concerns

- There were posters displayed in the corridors and the lifts indicating how to access the complaints system. The complaint reporting system indicated that a total of 22 complaints had been received, for maternity and gynaecology, between September 2014 and July 2015. The majority were closed within a timely manner including apologies to complainants. There were four complaints recorded as open.

Are maternity and gynaecology services well-led?

Requires improvement

There had been changes to the management team. As a result the management at a ward level was being reviewed and recent changes were not embedded.

Midwives were not clear about the trust vision and strategy. There were regular senior meetings that were cascaded to staff but staff felt that meetings with them needed to be more formal. Staff felt that they were supported by their managers; however hospital midwives felt there were fewer opportunities for them to develop than in the community.

There was no current representation on the labour ward forum, however; there was service user representation on the clinical cabinet and maternity services liaison committee. In addition there was a book in the pool room on the delivery suite, for patients to share their experiences that contained only two entries.

A trust 'pioneering staff engagement' programme was in place across a multi-disciplinary team with a number of innovating programmes in progress. The service has received several awards over the past two years.

Vision and strategy for this service

- From 'the maternity services clinical risk management strategy' the directorate's clinical governance mission statement states: "To improve our services for both patients and staff, by promoting and encouraging the growth of a culture where high quality safe care and services flourish positively through teamwork and shared values".
- Midwives were not clear about the trust or division's mission statements, future vision and strategy and were concerned the unit was not sustainable.

Maternity and gynaecology

Governance, risk management and quality measurement

- The "corporate and divisional risk register" included three identified risks for maternity services (two were last reviewed 1/09/2014 and one 1/09/2013) and an additional two included neonatal services. There was no evidence of audits in the risk register including that the WHO checklist had last been audited in February 2015. The audit tracker showed that the date of the next audit was to be confirmed.
- The system to review guidelines and accompanying clinical pathways did not identify out of date information or ensure current best practice guidance was referenced. Monthly –multidisciplinary team meetings were held in order to review current guidelines and practices as necessary that included a variety of grades of doctors and midwives; however, managers agreed the review of guidelines and production of updates was not as effective as it should be.
- Senior doctors (registrars) were required to update guidelines following the discussions and then cascade to the team for agreement. Staff were able to offer feedback, via email, with regards to updating guidelines, as a quicker way of moving forward. This meant the opportunity for discussion was not present when this method was used. Further opportunities for discussions took place during the monthly meetings and the governance meetings between all grades of staff.
- Clinical cabinet meetings were held monthly where any clinical issues were discussed. This group included a lay representative.
- Following the Kirkup report (enquiry into maternity services), an action plan was developed that was presented at the matron's meeting, and then cascaded to the ward areas. The recommendations included mandatory training and communication workshops; however there was a lack of consistency between the manager's report of the actions taking place and the midwives view.
- There were 'quality champions' in the service that included a 'tongue tie' clinic and 'the triage system' in the unit.
- There was a monthly newsletter for the maternity ward and delivery suite, a quarterly supervisory newsletter and a safeguarding newsletter.
- The community band seven midwives were able to attend the monthly meetings which were formal and minuted and there were monthly labour ward forums on the delivery suite available for all staff.

Leadership of service

- Several of the management team, including the matron, had been in interim roles for up to twelve months. Staff had been recruited to permanent posts in the past two months. This resulted in the management systems in the maternity services being reviewed with many not yet embedded.
- The head of midwifery was approachable, visible, and could be contacted. She had a dual role across children and maternity services. The board were approachable and midwives viewed a monthly video presented by the trust chief executive officer. The trust board participated in 'walk arounds' in the unit, but no formal meetings.
- The community midwives said they felt supported by the matron to participate in development opportunities promoting a sense of pride and there were opportunities for all staff to develop. It reportedly worked well for the community although hospital midwives felt that there were fewer opportunities to develop.
- Some supervisors of midwives had planned to meet with the Director of Nursing, as part of the LSA action plan .Despite an invitation having been offered no date had been arranged. They saw this as indicative of the lack of involvement of maternity services in the wider trust.
- There was a leadership programme available for band six and seven midwives if this had been identified as part of their supervision, or discussions between line managers and matrons, which included sharing good practice in other areas.
- The appointment of the current matrons, some of which had been in post for a short time had resulted in greater visibility of senior managers.
- Each area of the maternity services was working in isolation of the other particularly the delivery suite and the maternity ward. There was a lack of consistency of management of these two areas; however there were plans for greater integration with the recent changes in managers.

Culture within the service

Maternity and gynaecology

- Midwives described a culture of openness where they could discuss issues and concerns. This had improved over the past 12 months.
- Not all midwives felt their voice was heard and their opinions were included and valued. This varied throughout the service and especially between the inpatient and community setting.
- Following the reorganisation of maternity services, the maternity unit was now more integrated within the service and other areas within the trust, particularly over the past two years. Despite this there were examples of information not being shared from the rest of the trust.
- Staff said they were proud of the services and liked working for the trust. They provided good care for patients with good team work and long serving employees.
- Doctors reported excellent clinical support that included teaching sessions on Friday afternoons. Staff were described as approachable and helpful with senior staff available if required for support.
- The senior midwives told us about the implementation of communication workshops, for midwives, however junior band midwives were unaware of the workshops.

Public engagement

- There were systems in place for patients to participate in the development of the maternity services. This included patient representation at meetings.
- There had been an active maternity services liaison committee, but since the management of this had transferred to the Clinical Commissioning Group it had ended with no staff in the trust taking ownership for the development of any formal liaison with patients.
- There was no current representation on the labour ward forum, however; there was service user representation on the clinical cabinet and maternity services liaison committee.
- There was a book in the pool room on the delivery suite, for patients to share their experiences that had two entries only.

Staff engagement

- There were royal college of midwives (RCM) meetings, but there were no steward's onsite.
- There were no opportunities for all the community midwives to get together and they had not been part of any workshops in the trust.
- The head of midwifery visited the clinics. These were informal visits and were not recorded. Midwives told us they discussed issues and actions were agreed; however they did not see these taking place and no feedback was received. ,
- There was a 'pioneering teams' programme set up to learn about how different things in the hospital work and share practice. The maternity service programme was in place between February 2015 and September 2015 focusing on staff engagement. The report at the end of the project promoted positive changes.

Innovation, improvement and sustainability

- Current innovations have included a four stage antenatal programme with input from a neighbouring trust, breastfeeding peer support, midwives and health visitors. The four sessions included "nurturing the needs of your bump and baby", "labour and birth", " breastfeeding workshop" and " getting it right for you and your baby"
- Twelve midwives received training in hypnobirthing to provide holistic care during the antenatal and intra-partum periods. Inclusion of contemporary therapies began in October 2015 with plans to include acupuncture later this year.
- The maternity service had been part of the saving babies in the north of England project (SABiNE) which has being led by NHS England and the perinatal institute since June 2015. This aimed to reduce the numbers of stillbirths and neonatal deaths, using a package of care and training monitoring patients antenatally. Areas that were focused on included antenatal surveillance of growth and outcomes (gestation related optimal weight – GROW), smoking cessation, reduced fetal movement pathways and training for staff relating to fetal heart rate monitoring.
- The development of the 'sim man' as part of the 'skills and drills' mandatory training was part of the poster presentation at a conference last year.

Services for children and young people

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

Information about the service

Wrightington, Wigan and Leigh NHS Foundation Trust provides a range of paediatric services. It offers the majority of these services at the Royal Albert Edward Infirmary (RAEI) in Wigan, including critical care, high dependency care and special care for new born babies in the neonatal unit and high dependency care, medical care and paediatric surgery for children and young people aged 0-16 years on Rainbow ward. The trust provides emergency care in the Paediatric Emergency Care Centre (PECC) within the A&E department. Outpatient services for children with ongoing medical needs are provided at the Thomas Linacre Centre.

The neonatal unit and Rainbow ward are situated on the third and fourth floors of the RAEI respectively and the Thomas Linacre Centre is situated on a separate site in Wigan town centre.

Hospital episode statistics data (HES) show the trust saw 2,247 children and young people between January 2014 and December 2014. At The Royal Albert Edward Infirmary 91% of cases were emergency admissions, 6% were elective admissions and 2% of admissions were day cases.

We visited RAEI between the 9 and 11 of December 2015 and performed an unannounced visit on the evening of 21 of December 2015. We inspected a range of paediatric services including Rainbow ward, the neonatal unit, surgical theatres and the Thomas Linacre Centre.

During the inspection we observed patient care and treatment and reviewed 15 prescription records and 12 patient records. We also spoke with 11 patients with their carers and 35 staff including nurses, junior doctors, consultants, ward managers, play specialists, domestic assistants, healthcare assistants, administration staff and senior managers. Prior to our inspection we reviewed the trust's performance data as well as comments from people who had contacted us about their experiences.

Services for children and young people

Summary of findings

Patient safety was a significant concern as nurse staffing levels on Rainbow ward did not reflect Royal College of Nursing (RCN) standards and on the neonatal unit did not always meet standards of staffing recommended by the British Association of Perinatal Medicine (BAPM).

Nurses on Rainbow ward routinely covered additional shifts, sometimes at short notice. Staffing rotas on Rainbow ward did not identify an appropriately trained member of staff for the High Dependency Unit (HDU) for each shift.

Additionally, only one member of the nursing staff on Rainbow ward had current Advanced Paediatric Life Support skills and therefore the service could not meet the RCN standards to have a nurse with APLS skills on every shift. We also noted that there were no staff on Rainbow ward who were fully competent to care for patients with tracheostomies; the trust relied on parents to provide this care.

Resuscitation equipment was available however this was not consistently checked and items were noted to be missing or present in incorrect numbers, we raised this matter with the trust who took action to address this concern immediately.

We also found a ligature risk in a relatives bathroom on Rainbow ward which could be accessed by patients. This required and received immediate attention during our inspection.

The trust did not effectively monitor medicine storage, fridge temperature recordings were not consistently completed and did not always include temperature range. A medicines audit completed in September 2015 found additional practice issues that needed improving however an action plan to address this had been completed.

There was also significant concern around how well led the service was. There was no defined paediatric strategy within the trust although the staff were aware of the trusts wider vision, mission and strategy. Senior nurses and managers did not have a robust overview of the performance or risks relating to the service which had resulted in limited identification or escalation of risks to corporate level.

Leadership on the ward was compromised by the inability of senior staff to fulfil management duties as they regularly supported clinical care in the light of nurse shortages. Risks were not escalated appropriately and therefore did not gain robust executive scrutiny or the required response to mitigate risks in the longer term. The monitoring of the performance of the service was through the paediatric dashboard which covered sickness rates, hand hygiene, admissions to the High Dependency Unit and readmission rates.

However, care was provided by committed, compassionate and hard -working staff who were enthusiastic about their role and worked in a cohesive, multidisciplinary way. Staff were aware of their roles and responsibilities with regard to safeguarding and knew how to raise concerns appropriately.

The wards and clinical areas were visibly clean and tidy.

All nursing documentation was completed to a good standard. The outcomes for children were in line with expectations in most cases and national targets to achieve referral to treatment for patients on incomplete pathways were achieved overall. However the readmission rates within 12 months for children with asthma was over 10% worse than the national average.

Parents told us they had been treated with kindness and compassion and they were supported to be with their child during their stay if they wished to do so. We saw compassionate care was given to children, young people and their carers based on their individual needs.

Services for children and young people

Are services for children and young people safe?

Inadequate

Nurse staffing levels on Rainbow ward did not reflect Royal College of Nursing (RCN) standards (August 2013) and had resulted in 13 incident reports between 1 July 2015 and 18 December 2015. We raised this with the trust who trust took immediate action. .

We found nurse staffing levels on the neonatal unit did not meet standards recommended by the British Association of Perinatal Medicine (BAPM) on five occasions out of 48 shifts reviewed (10.4%).

Staffing rotas on Rainbow ward did not identify an appropriately qualified member of staff for the HDU for each shift.

The Royal College of Nursing (RCN) standards to be applied in services providing health care for children and young people (August 2013) recommends that at least one nurse per shift in each clinical area be trained in Advanced Paediatric Life Support (APLS). Only one member of the nursing staff on Rainbow ward had current APLS and only 19 out of 28 eligible staff were up to date with Paediatric Life Support training, however there was at least one member of nursing staff with current New born Life Support (NLS) on every shift in the neonatal unit.

There were no staff on Rainbow ward who were fully competent to provide care for patients with tracheostomies. Staff were reported to have had some training and plans were in progress for staff to attend other areas to build up skills.

Resuscitation equipment was available however this was not consistently checked and items were noted to be missing or present in incorrect numbers. This was reported to the Director of Nursing who ensured all resuscitation trolleys were checked and appropriately stocked before we left the hospital.

Despite a recent incident a ligature risk was found in a bathroom on Rainbow ward used by relatives. This could be accessed by patients. We raised this matter with the trust who took the required immediate actions.

Medicines were stored correctly. Documentation on Rainbow ward indicated controlled medicines should be checked twice a day which was inconsistently adhered to. However on review of the trusts policy dated May 2013 controlled medicines were only required to be checked once a day. A medicines audit completed in September 2015 noted that some practice issues needed improving. The action plan to address this had been completed and changes made including use of bungs and syringes for controlled drugs measurements. Fridge temperatures were not consistently checked and recorded.

Safeguarding policies and procedures were in place. Staff were aware of their roles and responsibilities and knew how to raise matters of concern appropriately however the trust did not have a current Female Genital Mutilation policy with the mandatory reporting requirements.

The early warning tool used to assess a child's condition was not actioned robustly as staff deviated from the system using clinical judgement for escalation. However we did not see any evidence of a negative impact on the care and treatment of patients.

Staff knew how to report incidents and reported receiving feedback.

Mortality and morbidity audit meetings took place three monthly. These were attended by a range of clinicians, minutes of the meetings were produced and learning points identified and shared with staff.

All areas were visibly clean, hand gel was available and staff were observed adhering to current infection prevention and control guidelines.

Incidents

- Between August 2014 and October 2015 there was one Never Event reported by the Trust. A Never Event is a very serious, wholly preventable, patient safety incident that should not occur if the relevant preventative measures have been put in place. This involved a wrong tooth extraction however following an investigation using root cause analysis tools the incident was reclassified as a Serious Incident.
- Data from the trust showed the trust recorded 56 incidents relating to the neonatal unit and 100 incidents relating to paediatrics between 1 July 2015 and 18 December 2015. Most incidents were categorised as minor or low harm however this number also included

one neonatal death and one suicide attempt. Inadequate staffing was cited in six incidents reported by staff in the neonatal unit and in 13 incidents by staff on Rainbow ward.

- Staff knew how to report incidents and reported receiving feedback.
- Managers shared lessons learned from incidents with frontline staff through governance bulletins sent by email. Not all staff reported receiving the trust wide email however we saw evidence this was also available as a paper copy which included an overview of all incidents rated as red or amber highlighting actions and learning points.
- Mortality and morbidity audit meetings took place three monthly. These were attended by a range of clinicians, minutes of the meetings were produced and learning points identified. and shared with staff.

Cleanliness, infection control and hygiene

- The wards and clinical areas were visibly clean and tidy. Staff were observed adhering to current infection prevention and control guidelines such as "bare below the elbow" guidance . Hand hygiene audits March-August 2015 indicated that Rainbow ward and the neonatal unit achieved 100% compliance.
- Hand gel was readily available on entry to each clinical area and visitors were reminded to use this by staff however no hand washing facilities were available at the entrance to Rainbow ward or the neonatal unit.
- Cleaning services were visible on Rainbow ward and domestic staff described processes to identify and deal with areas that were potential infection risks.
- Cleaning checklists were visible and complete in theatres.
- All teats used for formula feeding were in individual sterile packaging and formula milk in the neonatal unit milk room was in date and stored in date order.
- Infection control audits completed between March and August 2015 indicated that Rainbow ward and the neonatal unit consistently achieved above 95% compliance.

Environment and equipment

- Emergency resuscitation equipment was in place but records indicated that it had not been checked daily as required. Staff on the neonatal unit advised that if the seal on the resuscitation trolley was intact the items within the trolley were not checked. On the 9 December 2015 the seal had the date of 30 November 2015 however when the seal was broken and the contents reviewed multiple items were missing or present in incorrect numbers. This situation was highlighted to staff and immediately rectified. This was also recorded as an incident on the datix reporting system. This was reported to the Director of Nursing who ensured all resuscitation trolleys were checked before we left the hospital.
- Rainbow ward provided a bright and welcoming environment for treating children with a spacious playroom and a sensory room however a bathroom used by relatives which could be accessed by patients was noted to have a pull cord that was a ligature risk. This was highlighted to staff and immediate action was taken. We were advised by the Matron that a risk assessment was planned on 10 December 2015. A service wide assessment was subsequently undertaken and this was submitted on 9 February 2016.
- The two bedded High Dependency Unit (HDU) within the ward was positioned to the extreme left along several corridors and staff told us this was an intentional design so patients who were poorly and needed additional care were not visible to other patients or visitors.
- The ward and neonatal unit we visited had controlled access on both external doors and to treatment or utility areas.
- Theatres used for paediatric surgery had a dedicated reception and recovery area and the Paediatric Emergency Care Centre within the Accident and Emergency department (A and E) had a separate waiting area however no dedicated facilities were available for children attending the x-ray department.
- Medical equipment had stickers indicating when it was next due to be serviced. We observed some items of equipment had passed the service date for example baby weighing scales in the treatment room on Rainbow ward were due to be recalibrated in November 2015.

- There were arrangements in place for the handling, storage and disposal of clinical waste including sharps. The sharps box we observed in the clean utility area on Rainbow ward was dated and signed indicating when it came into use.

Medicines

- Controlled medicines were stored correctly and checked daily as per trust policy.
- Between 1 July 2015 and 18 December 2015 there were five incidents recorded on Rainbow ward relating to medicines. Three detailed discrepancies with the amount of a sedative in the medicine cupboard and two stated that medicines were missing. A medicines audit completed in September 2015 noted that there were some practice issues that needed improving. The action plan to address this was completed. This included the nurse in charge holding the keys for the controlled drug cupboard at all times and checking any controlled drug to be given and a bung to be in place on a sedative bottle to facilitate accurate measurement and prevent wastage.
- All medicines reviewed were in date however refrigerator temperature records were not consistently recorded and did not always include temperature range.
- A medication fridge on the neonatal unit was noted to be stored in a room where the temperature was 25.4 degrees centigrade. The trust policy stated that if the room temperature rose above 25 degrees centigrade the pharmacy team should be contacted and a report made to the estates department. A member of the pharmacy team advised that a new fridge had been ordered and that medication stored in the fridge was short-dated to mitigate the risk.
- We reviewed a sample of prescription charts on the neonatal unit and rainbow ward and found them to be complete, legible, signed and dated.
- Processes were in place to ensure the safe issue of medicines at the point of a patients discharge.

Records

- We reviewed 12 sets of patient records and all nursing notes were completed to a good standard.
- All records had documented evidence of patient observations and daily ward round, 11 records had a diagnosis and management plan documented, nine records had clear evidence the patient was seen by a consultant within 12 hours of admission and nine had evidence that discussion had taken place with family members. However only seven where clearly signed and dated.
- Loose papers were found in one set of records belonging to a child with complex needs that included ward audit information and notes and a letter written on paper unrelated to the trust.
- Records were stored in lockable draws at the nurses station.

Safeguarding

- Safeguarding policies and procedures were in place across the trust. Staff were aware of their roles and responsibilities and knew how to raise matters of concern appropriately.
- All children were admitted from the A and E department where a proforma was completed to identify any safeguarding issues and the IT system in A and E would automatically identify if there had been any previous safeguarding concerns. Ward staff could describe how they would make enquiries with social care regarding a child both during the day and out of hours if required.
- Staff advised that part of the ward admission process was to enquire if children had an allocated social worker and this information would be documented on a communication and critical incident record filed with the childs' medical records. We observed the documentation however we did not see a situation where this was used during our inspection.
- Safeguarding training formed part of the trusts mandatory training programme. The trust had a target of 95% and data indicated that 97% of staff on the neonatal unit and 81% of staff on Rainbow ward had completed level 3 safeguarding children training. Level 3 training is required for all clinical staff working with children, young people and their parents or carers.
- At the time of our inspection the trust did not have a current Female Genital Mutilation policy with the mandatory reporting requirements or a domestic abuse policy. There was no evidence of staff training that included modern slavery, human trafficking or domestic violence prevention orders.

- The trust produced a safeguarding bulletin to keep staff up to date with current safeguarding issues and to share learning following Serious Case Reviews.

Mandatory training

- Only one member of the nursing staff on Rainbow ward was current with Advanced Paediatric Life Support (APLS) training and data from the resuscitation team showed that 28 staff on Rainbow ward fulfilled the criteria for Paediatric Life Support training (PLS) but only 19 members of staff were up to date at the time of our inspection. This information was shared with the Matron and Head of Childrens Services during our inspection. Records also showed that 13 staff were non-compliant with Basic Life Support (BLS). Following our inspection a risk assessment was completed and plans were made by the trust to ensure all band 6 nurses were APLS trained by April 2016.
- 50% of staff on the neonatal unit had completed New born Life Support training (NLS) and staff rotas showed there was at least one NLS trained member of staff on each shift.
- All tier 2 doctors and consultants were trained in NLS and APLS however junior doctors who were GP trainees were not NLS trained.
- The trust had 10 anaesthetists that were APLS trained and a paediatric anaesthetist was always available when paediatric patients were in surgery or recovery. However no other theatre staff had the qualification.
- Newly qualified staff were assigned a preceptor and new staff to Rainbow ward and the neonatal unit had competency assessments to meet.
- Staff received training in areas such as infection control, fire safety, medicine safety and emergency planning. Training was delivered via on-line courses as well as face to face sessions and staff received email reminders when training was due.
- The trust target for compliance with mandatory training was 95% and records showed that mandatory training compliance for Rainbow ward was 94% and 91% for the neonatal unit.

Assessing and responding to patient risk

- Staff described the early warning tool based on a colour coded system used to monitor a childs' condition. This indicated what action should be taken if a childs' observations such as temperature, pulse rate or breathing altered from the expected normal range. It prompted the nurse caring for the child to monitor more closely and seek a medical review if needed.
- This system was not robust as staff told us they deviated from this however out of 12 records reviewed all had observations completed and the two records where the system was triggered indicated action was taken appropriately.
- Staff on Rainbow ward were not fully trained to care for patients with tracheostomies and this was recorded on the Corporate and Divisional Risk Register. Staff were reported to have had some training and plans were in progress for staff to attend other areas to build up skills.
- Any children admitted were cared for by their parents during their hospital stay. Rainbow ward had one patient with a tracheostomy during our inspection. We reviewed information relating to an incident recorded on 3 September 2015 which stated that there had been a patient with a tracheostomy on the ward but no staff on shift trained to deliver specific care requiring a parent to remain resident.
- Children requiring child and adolescent mental health services (CAMHS) were admitted to the ward from the A and E department and were seen by the CAMHS team. Children remained inpatients until a specialist bed became available however the ward had no Registered Mental Health Nurses.
- Procedures were in place to deal with emergency situations in theatres.

Nursing staffing

- Nurse staffing was slightly above the established number. However the nursing establishment had not been reviewed since 2008 despite a significant increase in activity. Managers told us that a risk assessment was completed on Rainbow ward in September 2015 due to concerns regarding staff numbers.
- The paediatric dashboard for November 2015 indicated that levels of unfilled shifts were 16% for the neonatal unit, up from 9% and 30% on Rainbow ward, up from 26%.

- No acuity tool was being used to plan staffing levels or skill mix on Rainbow ward. The neonatal unit used guidance from the British Association of Perinatal Medicine (BAPM) with regard to staffing levels.
- The expected and actual staffing levels were displayed on notice boards at the entrance to Rainbow ward and the neonatal unit and were updated on a daily basis.
- Rainbow ward had a two bedded bay designated as a High Dependency Unit (HDU). Staffing rotas on Rainbow ward did not identify an appropriately trained member of staff for the HDU should any patients be admitted and completed documentation we reviewed showed that against the criteria used by the ward, on six shifts between the 1st and 7th of December 2015 there were three patients requiring HDU care on the ward and on one shift there were five patients requiring HDU care.
- Royal College of Nursing (RCN) standards (August 2013) recommends a staff ratio of 1:3 for children under two years of age and 1:4 for children above 2years of age. Staff informed us there were often only four trained staff on each shift and the trust had trialled having three trained staff on a night shift in July and August 2015. We reviewed staff rotas and found that between the 1st and 7th of December allowing for one trained nurse for HDU, ratios of trained staff to patients ranged from 1:4 to 1:8 on morning shifts, 1:4 to 1:9 on afternoon shifts and between 1:6 and 1:10.5 on night shifts. During this time there were no reported incidents of harm related to staffing.
- A risk assessment was performed by the trust on 10 December 2015 following the issues we raised with regard to staffing on Rainbow ward. This rated staffing levels on Rainbow ward for compromising patient care as likely to occur daily. Remedial actions taken included implementing four hourly senior nurse reviews of occupancy, acuity and staffing levels and implementing effective bed management and escalation plans to increase nurse staffing or reduce bed compliment accordingly.Since that time a further assessment has reduced the likelihood to occur weekly.
- The trust reviewed safe minimum staffing levels and developed a Standard Operating Procedure (SOP) for Rainbow ward including escalation processes while the Inspection Team were still on site.
- We reviewed the actions taken on the unannounced visit and for the period 14 December to 20 December 2015 and found that 19 of 21 shifts had achieved the trusts safe minimum staffing levels described in the SOP and action such as closing beds had been taken on a number of occasions to mitigate risks to patients.
- We saw evidence that a nurse had been allocated to cover HDU on each shift, staff handover safety briefings were taking place four times a day and decisions regarding nurse staffing were being made by the nurse in charge, however it was acknowledged that the staffing tool required further work as it did not account for the ages or acuity of the children admitted to the ward.
- A sample of staff rotas reviewed for the neonatal unit showed that on 28, 29 and 30 September and the 5 and 6 of December 2015 the unit did not meet standards of staffing recommended by the British Association of Perinatal Medicine (BAPM). However no incidents were recorded in this time that highlighted any impact on the quality and safety of patient care. Further impact was caused by pressure across the clinical network.
- From 1 July 2015 to 18 December 2015 inadequate staffing was reported on six occasions by staff on the neonatal unit and on 13 occasions by staff on Rainbow ward. During this time the neonatal unit closed to admissions from the cot bureau on four occasions and on 23 November 2015 three patients from out of the area were not accepted by Rainbow ward due to inadequate staffing levels. On two occasions it was recorded there were intentional rounding omissions and one occasion observations were omitted demonstrating a direct impact on patient care.
- We observed a nursing handover that was completed using a tape recorder. Staff pre-recorded the nursing handover which was subsequently played to the staff at change over at the start of their shift. This approach meant that staff could not ask questions or seek clarification however ,we were told that there was the opportunity for information to be handed over by staff in person near the bedside if required.

Medical staffing

- The percentage of consultants working in paediatrics within the trust was 37% which was better than the England average of 35%. The percentage of registrars

was 46% which was less than the England average of 51% and only 3% of the medical staff were junior doctors which was lower than the England average of 7%.

- The trust had seven paediatric consultants in post who took part in a 'hot week' rota when they would be present on Rainbow ward 9am to 5pm. The neonatal unit had one neonatologist and was also covered by the paediatric consultants on a rota but only 7 sessions out of 10 during the week had designated consultant cover. This was recorded as a risk on the corporate and divisional risk registers, additional cover was provided by the 'hot week' paediatric consultant. On call paediatric consultant cover was also available 5pm to 9am and at weekends.
- We observed a clinical handover at 9am on Rainbow ward that was led by the 'hot week' consultant and included the neonatal unit however there was no formal neonatal verbal handover and the neonatal consultant was not present at this meeting.
- We observed a clinical ward round on the neonatal unit and noted that the nurse in charge was not present during the ward round and nursing staff were not included in all discussions regarding a patient's plan of care.

Major incident awareness and training

- The trust had a documented Major Incident Plan which listed key risks that could affect the delivery of services and a Corporate Business Continuity Plan. Emergency Planning was included in the mandatory training schedule.
- There was a bed management system that ensured managers had a clear picture of where the demands and spare beds were in the hospital however no speciality had an exclusive bed manager.

Are services for children and young people effective?

Good

Operational policies and procedures were in place and staff knew how to access them.

Pain was monitored using age appropriate assessment tools. Patient outcomes were reviewed through a series of local and national audits.

There was effective multi-disciplinary working and staff were familiar with appropriate guidance to obtain consent for treatment.

Care and treatment was delivered in line with evidence based guidance however a review of Child Health guidelines was on going and recorded as a risk on the Divisional Risk Register.

The rate of multiple (two or more) emergency admissions within 12 months among children and young people with asthma was worse than the England average with the trust having a readmission rate of 28% compared to the England average of 17%. However work was in progress to address this issue and senior management explained that lack of an assessment unit meant that after four hours children were treated as an admission. In the period 2014/15 the percentage of children with controlled diabetes was 21.5% compared to the England average of 18.5%.

Annual appraisal rates for staff were below the trust target of 95%.

Evidence-based care and treatment

- The service used National Institute for Health and Care Excellence (NICE) guidelines to determine care and treatment provided such as the pathway for Diagnosing Bronchiolitis in Children.
- An on going review of Child Health guidelines was in progress and recorded on the Divisional Risk Register. Once reviewed guidelines were discussed at monthly Clinical Cabinet meetings.
- Guidelines had been developed for the management of children with Attention Deficit Hyperactivity Disorder (ADHD) and a pathway for injuries in non-mobile children.
- There was a pathway in place to support Children with life limiting illnesses and those at the end of life.
- Play specialists were part of the North West Play Specialist benchmarking group which met twice a year to share good practice.

- The neonatal unit had level 2 Baby Friendly accreditation and were signed up to the Bliss baby charter.
- Many of the staff on Rainbow ward had attended breastfeeding training allowing consistent evidence based advice to be provided to nursing mothers and any child that was admitted under 30 days of age with feeding problems was referred to the Infant Feeding Team.

Pain relief

- A variety of assessment tools were used to assess pain depending on the age of the child.
- Patients told us their pain relief was monitored for efficacy.
- Children and their parents received clear explanations regarding medication and analgesia.
- Analgesia and topical anaesthetics were available to children who required them in the ward and outpatients department.

Nutrition and hydration

- Daily menus were displayed on Rainbow ward and provided a choice of meals however parents told us there was not many options available particularly at lunchtime.
- Fresh fruit and drinks were available at any time on request.
- Sandwich options were provided in 'child friendly' packaging and staff endeavoured to find alternatives for children if required.
- Dietetic support was available on Rainbow ward and on the neonatal unit Monday to Friday.

Patient outcomes

- The rate of multiple (two or more) emergency admissions within 12 months among children and young people with asthma was worse than the England average with the trust having a readmission rate of 28% compared to the England average of 17%. However, senior management explained that due to lack of an assessment unit all children who waited four hours or more were treated as an admission which potentially increased readmission rates.
- The hospital took part in the National Paediatric Diabetes Audit. This identified that in the period 2014/15 the percentage of children with controlled diabetes was 21.5% compared to the England average of 18.5% demonstrating the quality of the diabetes service for children.
- The trust provided data for the National Neonatal Audit Project. The latest published report was 2015 using 2014 data and showed there was a documented consultation with 95% of parents within 24 hours of admission; this ensures that parents have a timely explanation of their baby's condition and treatment. Thirty-nine per cent of eligible babies were discharged feeding only mother's milk and 30% taking some mothers milk and 97% of children were screened on time for Retinopathy of Prematurity (ROP). ROP is an eye condition that can affect babies born weighing under 1501g or 32 weeks gestation.
- A Child Health Audit programme was in place to monitor all aspects of clinical care including an autism and assessment diagnosis pathway and injuries in non-mobile children pathway. These had been presented for clinical input and sharing practice.

Competent staff

- Staff identified their learning needs through the trusts appraisal process and the trust target was 90% however trust data showed that only 72.2% of staff on the neonatal unit, 42.2% of staff on Rainbow ward and 40% of staff in the paediatric outpatients department were compliant with the annual appraisal process. This was a missed opportunity for staff to discuss and plan with their manager future professional development.
- All trained staff on Rainbow ward were qualified paediatric nurses.
- Six of the staff on Rainbow ward were reported to have completed formal university led training for patients requiring High Dependency care however 'in house' training was provided.
- Children were cared for in Paediatric Emergency Care Centre (PECC) within the A&E department by paediatric nurses between 07.30 and 01.00, after this time children were treated by staff in the adult A &E department however ward staff could be called to provide support in

the department if required. Following an incident on 4 August 2015 when the ward was left short staffed this procedure was revised to include a nurse from the A &E department providing ward cover during that time.

Multidisciplinary working

- We observed good Multidisciplinary team working (MDT) and clinical staff confirmed there were good working relationships between medical and nursing staff. Within Rainbow ward every child had MDT input and team members communicated regularly.
- Occupational therapy and physiotherapy services were available for all children, including those with chest problems, mobility issues and complex needs. Physiotherapy could be accessed at night.
- Play specialists supported patients undergoing procedures on the ward and completed a play specialist assessment form which was filed with the child's nursing care plan.
- Play specialists did preparation work with all children requiring surgery using photographs and visual aids and accompanied all children and parents to theatre.
- Play specialists attended x-ray and outpatient clinics however paediatric outpatient's services did not have a designated play specialist .
- Children referred to child and adolescent mental health services (CAMHS) were usually seen within 24 hours however staff reported long delays to access specialist inpatient beds which is a recognised national issue.
- Formal MDT planning meetings were arranged as required and discharge planning meetings took place across the paediatric and neonatal service particularly if the child or family had involvement with social care.

Seven-day services

- Seven-day services were provided on Rainbow ward, the neonatal unit, X-ray and the Paediatric Emergency Care Centre however outpatient appointments were scheduled only Monday to Friday.
- Play Specialists provided a seven day service on Rainbow ward and covered Monday to Friday 07.30am to 8pm and 07.30am to 3.30pm Saturday and Sunday.
- Consultant on-call cover was provided out of hours.

Access to information

- Policies and procedures were kept on the trusts intranet and staff were familiar with how to access them.
- Measurements and any vaccinations given were recorded in a Personal Child Health Record (PHCR) on the neonatal unit and staff on Rainbow ward would document weight measurements if the PHCR, if available, particularly if the admission was related to a childs' weight.
- GP discharge letters for infants from the neonatal unit were sometimes delayed however any information regarding medication was sent to the GP electronically to mitigate the risk of a baby going home without any information regarding their care.
- Discharge summaries were provided electronically to Parents and GPs from Rainbow ward however during our inspection we observed four sets of notes relating to discharged patients that required formal discharge letters to be completed, one related to a child who had been discharged on 1 December 2015.

Consent

- Staff were aware of appropriate procedures in obtaining consent and described how Gillick competence was assessed to establish if a child had the maturity to make their own decisions and understand the implications of treatment.
- Staff described how they worked on the principle of verbal consent for some procedures such as changing dressings and that consent was documented in the patient's notes.
- Support from play specialists was frequently enlisted to ensure information was provided to children at an appropriate level.
- Consent forms had the option for the signature of the child as well as the parents however staff told us medical staff tended to approach parents only.
- Control and restraint policy for paediatrics was requested from the trust but we were advised that there was no policy in place.

Are services for children and young people caring?

Services for children and young people

Good

Care was provided by committed, compassionate staff who were enthusiastic about their role. Staff were observed interacting with patients and their relatives with kindness and respect.

Patients were positive about their interactions with staff.

Parents and carers were positive about the care and treatment provided. They felt supported and involved in the planning and decisions regarding their childs' healthcare.

The NHS Friends and Family Test data collected from Rainbow ward between May 2015 and October 2015 (with the exception of September due to a lack of responses) showed the percentage of patients that would recommend the hospital to friends and family ranged from 96% to 100%. The response rate ranged from 50% in May to 11% in August compared to the England average of 36%.

Compassionate care

- Care was provided by committed, compassionate staff who were enthusiastic about their role. Staff were observed interacting with patients and their relatives with kindness and respect.
- Patients were positive about their interactions with staff.
- Parents told us they had been treated with kindness and compassion and we observed examples of compassionate and individualised care given to children, young people and their carers.
- Staff were observed treating patients and their visitors with kindness and respect. Parents told us they felt supported and "nothing could be done better".
- In the 2014 CQC Children's survey 22 out of 23 questions relating to care were about the same as other trusts however the trust scored worse than others with regard to staff asking if parents had questions about their childs' care.
- The NHS Friends and Family Test data collected from Rainbow ward between May 2015 and October 2015 (with the exception of September due to a lack of responses) showed the percentage of patients that would recommend the hospital to friends and family ranged from 96% to 100%. The response rate ranged from 50% in May to 11% in August compared to the England average of 36%.
- The Friends and Family Test was not undertaken on the neonatal unit however its introduction was planned and comment cards were available for parents to provide feedback.

Understanding and involvement of patients and those close to them

- Parents were involved in the care planning for their children and were asked on admission about their childs' behaviour patterns and routines.
- Patients and parents told us they felt fully informed about their care and future plans including details of any medication required and what to expect as part of the recovery process. One parent told us they had been "told everything that was going on" and another that staff "take on parents views". Parents felt they knew the options for care and were fully involved in decision making.
- We observed good communication between a patient, parent and member of staff that resulted in a procedure taking place without the need for sedation.

Emotional support

- Children admitted requiring Child and Adolescent Mental Health Services (CAMHS) were supported by ward staff however there was no Registered Mental Health Nurse on the ward.
- Parents told us they felt supported by staff and one family who had attended regularly with their child with complex needs said "it feels like home from home".
- Parents were given the contact number for the ward on discharge to allow them to telephone for advice if they had any problems.
- Observations of staff interactions showed that staff were aware of the worry and anxiety felt by parents with a sick child and supported them accordingly.

Are services for children and young people responsive?

Services for children and young people

Good

Areas that delivered services specifically for children were child friendly and took the diverse needs of children into account. Access to wi-fi allowed the children to keep in touch with friends and relatives. There was open visiting and facilities available to enable parents to stay with their children although the shower was not working at the time of the inspection. Interpreting services were available as required.

Services were available to meet the individual needs of patients and their families both formally through transition processes, care plans and information leaflets and informally by use of the sensory room.

National targets to achieve 92% for referral to treatment for patients on incomplete pathways were achieved overall. Bed occupancy was below 76% which is below the recognised level when occupancy can affect the quality of services. The service received a small number of complaints and lessons learned were shared with staff via governance bulletins.

However, beds were occupied by sex rather than age which meant teenagers and young children were often in beds next to each other. Delays were reported in accessing specialist beds for children requiring Child and Adolescent Mental Health Services (CAMHS).

Service planning and delivery to meet the needs of local people

- The environment on Rainbow ward was bright and friendly with a variety of toys available. Games consoles and games were available as well as DVDs and we observed robot television units which incorporated a DVD player and games system.
- Children were mainly accommodated in same sex bays however this meant teenagers were accommodated next to infants.
- Free wi-fi was available to enable patients to access Facebook via telephone or laptop so they could keep in contact with friends and family.
- In the 2014 CQC Childrens survey the trust scored worse than others for overnight facilities available to parents and carers. One parent told us the chairs that reclined by the bedside were not good for sleeping on while another parent said “they could be more comfy but not too bad”.
- A parent’s room with tea and coffee making facilities and a refrigerator was available on Rainbow ward and parents had a designated shower however this was not working during our inspection. There was also a vending machine that was stocked daily with a variety of food options.
- Parents were encouraged to stay with their child on the ward. There were chairs at the bedside that reclined or converted to beds on Rainbow ward.
- An overnight stay room with en suite facilities could be used by parents on the neonatal unit if available as it was also used for ‘rooming in’ prior to discharge.
- Meals were offered to parents in the neonatal unit if present for lunch and tea and a refrigerator was available to store cold drinks. Parents had access to facilities to make a drink.
- Open visiting was available to parents with infants on the neonatal unit and no charge was made for parking.

Access and flow

- National targets to achieve 92% for referral to treatment for patients on incomplete pathways between April 2015 and October 2015 were achieved overall within the paediatric specialities. Individually two specialities missed the target on one occasion in this period but this accounted for a total of two children only.
- Additional dental surgery lists took place at weekends to ensure patients were treated in a timely manner. The last initiative list had taken place on 6 December 2015.
- Some urgent clinic appointments were available within the paediatric outpatient department.
- Patients were admitted to Rainbow ward via the A and E department and bed occupancy for the period April 2014 to November 2015 ranged from 49.3% in June 2014 to 75.9% in December 2014. The median length of stay was the same as the England average.

Services for children and young people

- A dedicated waiting area and recovery area was used for paediatric surgery. Oral surgery ran a theatre list specifically for paediatrics, paediatric patients for theatre in other specialities were listed at the beginning of the session to minimise waiting and fasting times.
- Children referred to child and adolescent mental health services (CAMHS) were usually seen within 24 hours however staff reported long delays to access specialist inpatient beds which is a recognised national issue. Between 17/08/14 and 16/08/15 the trust had 178 admissions receiving care from the CAMHS team.

Meeting people's individual needs

- Interpreting services could be arranged to support families whose first language was not English and staff confirmed they knew how to access these. Translators could accompany patients and parents to theatre however we did not see this system in use during our inspection.
- A sensory room had been developed on Rainbow ward with donations and funds raised by the play team. This was used for calming anxious children and some procedures could be performed there such as the passing of nasogastric tubes if the child found it easier. Portable sensory equipment was also available for use at the bedside.
- The X-ray department did not have a dedicated paediatric waiting area however staff liaised with the ward staff to ensure children were seen quickly.
- Children requiring CAMHS were nursed on the ward however staff reported pressure of workload meant that while safety was maintained they could not spend as much time with patients as they wanted to.
- Formal transition processes were in place for children moving to adult services who had Diabetes Mellitus or Cystic Fibrosis .
- Children approaching the end of life had a care plan. Staff described how advice had been sought and provided from a local children's hospice for a child who was approaching the end of life
- Care plans were completed electronically which automatically produced information for parents. We observed this process during a patients' admission with Bronchiolitis.
- Information leaflets were available on the ward in a variety of subjects such as breastfeeding support and Epistaxis (nose bleeds). None observed were in a child friendly format however we were informed they were available on request.

Learning from complaints and concerns

- Patient advice and liaison service (PALS) leaflets were available in the parent's room on Rainbow ward and members of the PALS team visited the ward to speak to parents when they did not want to leave their child.
- There were a total of 12 complaints relating to patients under the age of 18 years old between January 2015 and November 2015.
- Staff were aware of the complaints process and told us they would try and resolve any issues immediately but if unsuccessful would refer to PALS.
- Managers shared lessons learned from incidents, complaints and claims with frontline staff through governance bulletins sent by email. Not all staff reported receiving the trust wide email however we saw evidence this was also available as a paper copy on the neonatal unit.

Are services for children and young people well-led?

Requires improvement

There were no specific strategies for individual directorates, all strategies were held at divisional and trust level. This meant there was no definition around the trusts paediatric strategy. Staff were aware of the trusts wider vision and organisational values.

Clinical cabinet meetings took place monthly and were well attended by a managers and clinicians. There was a Corporate and a Divisional Risk Register in place. However managers were not fully aware of all the risks in their department. Risks regarding nurse staffing levels had been recognised by managers in September 2015 however this was not recorded on the risk register. It was recognised again on a leadership 'walk around' on 1 December 2015 but no immediate action was taken.

Services for children and young people

Lack of coherence between the executive team, service managers and staff meant identified risks were not clearly escalated, documented or robust actions taken to mitigate them in a timely way. There was also a lack of proactive action in the case of nurse staffing on Rainbow ward. The lack of protected management time for the ward manager limited their ability to address managerial duties including addressing the staffing concerns. The lack of robust risk rating had resulted in the risk not being escalated appropriately to a level where it would have received executive scrutiny and support.

As part of our inspection we raised concerns about staffing both in terms of numbers and skill mix. In response the trust assessed the situation, held an emergency meeting and formalised the Rainbow Ward Escalation Standard Operating Procedure.

Decision making regarding the capacity of the ward to accept new admissions was undertaken solely by the senior medical staff without input from senior nurses with responsibility to maintain safe staffing numbers.

However, the nursing and medical teams worked very cohesively and demonstrated commitment to the safe care of the children on the ward. Staff were passionate about their work and were committed to providing high quality care in sometimes difficult circumstances as a result of busy periods or low staff numbers. Staff routinely performed additional shifts to ensure better staffing levels but this had become an accepted way of working and was not challenged by senior staff as being inappropriate or unsustainable.

Vision and strategy for this service

- Staff were aware of the trusts vision to be in the "To be in the top 10% of everything we do; the trusts mission "To provide the best possible health care for all our patients" and the trusts strategy "To be safe, effective and caring
- The trust was part of the "Healthier Together Programme" in Manchester.
- There were no specific strategies for individual directorates, all strategies were held at divisional and trust level.

Governance, risk management and quality measurement

- Child health clinical cabinet meetings took place monthly which were well attended by a wide range of managers and clinical staff as well as the governance lead. Meeting minutes reviewed indicated that issues such as audit, infection control, MRHA alerts(alerts relating to medicines and healthcare products) and safeguarding matters were discussed as well as risks, incidents and complaints.
- Safety huddles took place three times a day however this increased to four times a day due to concerns we raised regarding staffing levels.
- Managers had recognised nurse staffing was an issue however despite completing a risk assessment in September 2015 this was not recorded on the risk register at the time of our inspection.
- There was a Corporate and Divisional Risk Register in place however managers were unable to articulate the risks or mitigating actions within their department.
- The lack of robust risk rating in relation to staffing shortfalls had resulted in the risk not being escalated appropriately to a level where it would have received executive scrutiny. This was evident from the risk assessment performed during the inspection when the lack of APLS training for nurses meant that they could not meet the RCN standards for a nurse with APLS skills to be on every shift. This was rated as 8 which is a low to moderate risk. The policy only escalates risks that score 15 or more for executive scrutiny.
- Prompt action was taken by senior managers when concerns were raised as part of our inspection regarding staffing levels which included formalising the Rainbow Ward Staffing and Escalation Standard Operation Procedures (SOPs).
- Admission decisions were made by the medical lead with no direct input from the senior nursing staff despite the staffing levels being raised as concerns.
- Quality and performance were monitored through the paediatric dashboard. This covered data such as sickness rates, hand hygiene, admissions to the High Dependency unit and readmission rates on the neonatal unit and Rainbow ward. Quality and performance measurement also included additional information such as appointment cancellations and DNA (Did Not Attend) rates in the outpatients department.

- Decision making regarding the capacity of the ward to accept new admissions was undertaken solely by the senior medical staff without input from senior nurses with responsibility to maintain safe staffing numbers.

Leadership of service

- The paediatric service was led by the Head of Midwifery and Childrens Services, supported by a Matron. An advanced nurse practitioner and ward manager were in post on Rainbow ward and a lead nurse provided clinical and managerial support on the neonatal unit.
- There was a lead for the service on the executive board but service managers did not know who it was.
- Nursing staff felt managers were visible and were aware that the Chief Executive did walk rounds but not necessarily on Rainbow ward.
- Staff told us the Matron and Head of Service were visible however staff shortages remained a concern despite escalation to them.
- A leadership walk around was conducted on Rainbow ward on 1 December 2015 by a Director; a Non-Executive Director and a Governor. They were supported by three senior members of the ward team.
- The report stated there were challenges; not least with staffing however the ward managed these very well through the flexibility and willingness of staff to pick up extra shifts and change their plans at short notice.
- The report also stated that all staff raised concerns about staffing levels and the ability to staff HDU appropriately at all times, as there is no separate staffing numbers for the unit. There are currently gaps in the rota due to vacancies and sickness; these are generally covered by the staff on the ward working extra and changing duties around to cover.
- The report had only one action from the visit which was to address the staffing concerns and that this was an issue that has been raised and was subject to an on going piece of work.
- Nursing staff told us they escalated concerns regarding staffing levels and this was supported by the number of incidents raised relating to staffing including two that cited a lack of observations being done due to the low staff numbers.
- The Ward Manager on Rainbow ward was scheduled for two management days and three clinical days per week. However low staff numbers meant that in the 15 weeks preceding our inspection this had only been achieved on a third of the weeks (5 occasions) as the ward manager had undertaken clinical duties. This meant that some management aspects of the role could not be completed in a timely way.
- Consultants were reported to be supportive however staff stated that bed managers had over ruled ward staff regarding admissions.
- The trust formalised the Escalation SOP which stated that the nurse in charge of the ward had the primary responsibility to ensure staffing levels were safe subsequent to us raising our concerns at the inspection.

Culture within the service

- Staff were passionate about their work and were committed to providing high quality care in sometimes difficult circumstances as a result of busy periods or low staff numbers.
- Staff routinely performed additional shifts to ensure better staffing levels but this had become an accepted way of working and was not challenged by senior staff as being inappropriate or unsustainable
- Staff we spoke with were candid about their service area and challenges they faced.
- Nursing staff told us that morale on the ward varied. A staff survey conducted in August 2015 on Rainbow ward was reported to have had some negative results and the staff engagement team were working with staff to make improvements.
- The nursing and medical teams worked very cohesively and demonstrated commitment to the safe care of the children on the ward. The leadership walk around noted that staff were flexible and willing to pick up extra shifts and change their plans at short notice.
- Staff were familiar with the principle of duty of candour which is a legal duty for hospital, community and mental health trusts to inform and apologise to patients if there have been mistakes in their care that have led to harm. We saw evidence that the service had exercised its duty of candour in its response to a serious incident.

Public and staff engagement

Services for children and young people

- Rainbow ward and the paediatric outpatient department were designed with the involvement of local children and staff.
- The views of patients and their carers were actively sought by asking them to complete the NHS Friends and Family Test which demonstrated positive responses.
- A 'mood board' had been put up in a staff only area on Rainbow ward so that staff could leave feedback after a shift particularly if it had been busy or stressful rather than taking negative feelings or worries home. Staff counselling services were available.

Innovation, improvement and sustainability

- The neonatal unit had achieved level 2 baby friendly accreditation.
- Rainbow ward had sensory room which was developed by play the team staff using charitable donations and fund raising events.
- A trust wide pathway had been developed for Injuries in Non-Mobile Children.

End of life care

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

Information about the service

We visited Royal Albert Edward Infirmary as part of our announced inspection on 9, 10 and 11 December 2015 where patients with end of life (EOL) care needs were cared for on the general wards.

The specialist palliative care (SPC) multi-disciplinary team is based at the Royal Albert Edward Infirmary (RAEI) but also covers Wrightington hospital, Leigh Infirmary and Thomas Linacre Centre if required. Due to the very low numbers of deaths at Wrightington hospital, Leigh Infirmary and Thomas Linacre Centre we visited the locations but have not written reports for end of life care in those location reports as care was directed by the same team.

The SPC team accepts referrals for patients with progressive life threatening illness when life expectancy is likely to be less than one year. Referral criteria include difficult pain and symptom control, complex psychosocial problems and/ or specialist needs related to EOL care and support.

On the 9 December we met with the SPC team lead clinician, the head of nursing, two Macmillan palliative care nurse specialists and the assistant director of nursing for bereavement and donation to gain an overview of the palliative and EOL service. The SPC team provides specialist advice, education and support as requested for patients on the general wards.

Individual wards have EOL champions who have chosen to take on additional training for this role to provide support and guidance to other members of the ward team. There is a bereavement nurse specialist who provides support for families following the death of a relative.

Between November 2014 and December 2015 there were 1164 deaths at the Royal Albert Edward Infirmary (RAEI) and two deaths at Leigh Infirmary. These figures include all deaths for patients over the age of 7 years. Figures for adults were requested from the trust but not provided. Between January 2015 and October 2015 there were 982 referrals made to the specialist palliative care team.

During this inspection we visited six inpatient wards at RAEI; Ince (cardiology), Astley (gastroenterology), Standish (geriatric), Shevington (care of the elderly), Winstanley (respiratory) and the medical admissions unit (MAU). We observed a nursing handover and a white board handover at RAEI. We visited the clinical decision unit (CDU), the mortuary and viewing room, the spiritual centre, pharmacy, the portering department, the medical devices loan department and the bereavement office. We also visited Taylor ward at Leigh Infirmary.

The Mortuary department at RAEI has been licensed by the HTA since May 2007 for the making of a post mortem (PM) examination, removal of relevant material from the deceased and storage of the deceased and relevant material for use for scheduled purposes. Between 650 and 700 adult PM examinations are conducted each year.

We observed care, looked at records for 14 people, 11 prescription charts and spoke with four relatives and 30 staff across all disciplines, including doctors, nurses and

health care professionals. We spoke with members of the management team, the gold standards framework (GSF) facilitator, bereavement specialist nurse, porters, chaplains, bereavement officers, and mortuary staff.

Summary of findings

We found that there were good EOL services in Safe, Effective and Well Led but outstanding for being caring and responsive.

Incident reporting systems were in place and actions were followed up at ward level via handover. There had been no recent serious incidents related to EOL care. Anticipatory EOL care medication was prescribed appropriately and training for the use of syringe drivers was included in mandatory training for which the SPC team were 100% compliant. EOL services were adequately staffed and as well as the SPC team which was clinically led by a consultant in palliative medicine, there was a bereavement specialist nurse, a gold standards framework (GSF) facilitator and two EOL champions on each ward.

There was evidence of the service delivering treatment and care in line with best practice, including the individual plan of care (IPOC) document which facilitated support for the dying person in the last days and hours of life. The service was starting to implement the gold standard framework (GSF) and had appointed a facilitator to introduce and embed this in the two pilot wards. We saw that the service had made changes to their practice to address some of the targets not met in the last National Care of the Dying Audit of Hospitals (NCDAH), May 2014 and there was evidence that some actions were in place as a result of other clinical audits however there were not always action plans in place which met the criteria for being specific, measurable, achievable, realistic and timely (SMART). This meant there was a potential risk that some recommendations or findings from audits may not be translated into actions in a timely manner or may be missed altogether.

We saw evidence that pain relief and nutrition and hydration needs for patients were being met. The SPC team provided a seven day service and worked well, across all the hospitals, with other teams and disciplines.

EOL care services were provided by compassionate, caring staff who were sensitive to the needs of seriously ill patients. The service was delivered by staff who were committed to providing a good service and there was

End of life care

good clinical leadership from a consultant in palliative medicine. There was a coordinated approach across the Wigan borough to design EOL services to meet the needs of the local population. There were systems in place to prioritise EOL patients for side rooms at RAEI and this was working well. Facilities and systems were in place to minimise stress for families staying with their EOL relatives and to allow them to spend as much time as they wished with them in their last days and hours. This included the use of the swan logo which identified EOL patients and their families, enabling staff to treat them accordingly.

The visibility of senior management was good and staff felt well supported and there was an open door policy by senior staff.

Are end of life care services safe?

Good

Staff said they were encouraged to report incidents and they were knowledgeable about the incident reporting process. Incidents were investigated and learning took place within the SPC team at meetings and for staff at ward level during handover.

Anticipatory EOL care medication was prescribed appropriately and training for syringe drivers was included in mandatory training. We found good evidence of nursing care documentation, nutrition and hydration reviews and documentation standards. Individual plan of care (IPOC) documentation was comprehensive and complete in those that we reviewed and medical staff found it user friendly.

Staff were aware of their role and responsibilities in relation to safeguarding and knew how to contact the safeguarding team.

The mandatory training programme provided by the trust had recently been revised to include an hour each from the palliative care team and the bereavement nurse.

The service used paper based records with some information from the paper records also recorded on electronic systems. There was a plan to move to electronic records in May 2016.

Of the 11 uDNACPR forms we reviewed only four had been completed appropriately. In three cases there were no capacity assessments recorded, despite a lack of capacity being given as the reason why a discussion with the patient had not taken place.

End of life services were adequately staffed and as well as the SPC team which was clinically led by a consultant in palliative medicine, there was a bereavement specialist nurse, a gold standards framework (GSF) facilitator and two EOL champions on each ward.

Incidents

- There were systems and processes in place to report incidents and staff told us they were encouraged to do so.

- Incidents were graded using three criteria; harm resulting from the incident, the severity of that harm, and the incident reporter's initial risk grading. A final risk grading was made by a senior manager following review and any subsequent investigation of the incident.
- We reviewed a selection of incidents reported relating to EOL services and found they were appropriately followed up. The service provided evidence of incident reviews with recommendations and actions in place as required. Lessons learned were documented and newsletters were used in some areas as a method of disseminating information to staff.
- Ward staff knew how to report incidents but could not recall any that related specifically to palliative care or EOL.
- Feedback from incidents and complaints was discussed on the wards at handover and was repeated for each shift to ensure that all staff received the information. Incidents were also discussed at the monthly palliative care team meetings.
- There was a low number of incidents reported by mortuary staff; five incidents were reported between June and August 2015. Staff were able to give examples of incidents reported but were not always aware of the outcome. The manager attended a monthly risk and governance meeting when she was able but this was not always possible due to workload. Mortuary team meetings were held every two months where possible. Incidents were discussed at these meetings when they were held.

Medicines

- The service had achieved its National Care of the Dying Audit of Hospitals (NCDAH) organisational key performance indicator for clinical protocols for the prescription of medications for the five key symptoms at EOL.
- We reviewed 11 prescription charts and found that medication had been prescribed and administered appropriately, including EOL anticipatory medication.
- There was a swan sticker on drug charts for EOL patients; this meant that when pharmacy received these, they knew the drugs had to be dispensed within half an hour to facilitate a rapid discharge.
- Syringe pumps were kept in a medical devices loan store and staff could telephone to have them delivered during normal working hours. An electronic system was in place to track the equipment, supported by a paper spreadsheet used to log and 'chase' pumps for return.
- There was an up to date schedule for servicing and calibrating the equipment which we saw. Staff said stocks of syringe drivers occasionally ran low but had never run out. There was no plan in place should this happen.
- Syringe drivers were provided in a box with a pump, lockable case and key. Wards were expected to provide their own batteries.

Records

- The service used paper based records with some information from the paper records also recorded on electronic systems. There was a plan to move to electronic records in May 2016.
- We reviewed 14 care records and found good evidence of nursing care documentation, nutrition and hydration reviews and documentation standards including dates and signatures. Of the 14 care records we reviewed, 11 had uDNACPR documentation.
- The service used a unified document for recording do not attempt cardiopulmonary resuscitation (uDNACPR) status. This meant the document was valid across a number of organisations. We found variable consistency in the standard of uDNACPR documentation. There was limited evidence of ceiling of care plans and discussions with family or next of kin. In three cases a lack of capacity was stated as the reason for not discussing the uDNACPR with the patient, but there was no record of a mental capacity assessment having been completed. Only four of the 11 uDNACPR documents, including one from community, were correctly completed.
- We reviewed two individual plans of care (IPOC) which were correctly completed. We spoke with two junior doctors who said they found them easy to use.
- There was a weekly SPC MDT meeting held on a Wednesday morning. Prior to the meeting the MDT co-ordinator collected the relevant patients' records and information was recorded directly into the notes with a stamp to indicate that it was discussed at the meeting. This information was also recorded on an electronic end of life care information system.

End of life care

- In the bereavement office there was shelving with designated areas for each ward where deceased patients' notes were stored.
- Cremation forms were completed in the bereavement office by junior doctors who would then ring the Mortuary to arrange to examine the deceased patient and check if they had a pacemaker in situ, check their identity and observations, for example any unexplained bruising. The details were entered in a cremation book, with the patient's name, and entries were signed by two doctors who also documented their General Medical Council (GMC) numbers for identification purposes.
- There was a system in place for raising safeguarding concerns. Staff were aware of the process and safeguarding advice was accessible for staff 24 hours a day, seven days a week
- There was a senior specialist nurse acting as the safeguarding lead, with two other safeguarding team members in support. One of the ward managers also had a part time role in the safeguarding team.
- When a safeguarding issue arose on the wards one of the safeguarding team would come to support the ward staff in investigating the situation and would escalate as necessary.

Mandatory training

- The SPC team were 100% compliant with mandatory training.
- The mandatory training programme provided by the trust had recently been revised to include an hour each from the palliative care team and the bereavement nurse. This included an introduction to the SPC team, their referral processes, the key priorities of care for EOL patients and an explanation of the individual plan of care (IPOC) and support for the dying person in last days and hours of life.
- New communication training was being developed which was to be mandatory for the palliative care team and would include training on breaking bad news. The nurses in the SPC team had completed the advanced communications skills course.
- Syringe driver training was included in the mandatory training programme for existing staff and for new starters was part of the trust's clinical skills induction programme for all registered nurses who worked in a clinical area. The clinical skills induction programme included reference to the appropriate use of syringe drivers within the context of the end of life care session and also the pain management session. It was supported by the trust preceptorship policy and framework.
- A work-based competency assessment was undertaken as part of this process in those clinical areas where syringe drivers were deemed a core skill of the nurse in response to patient need.
- Ward managers monitored mandatory training and received a monthly report detailing which modules were due to be undertaken by staff in the next two months. Details were kept on an electronic database. On Astley ward a poster identifying compliance was displayed in the staff room.

Assessing and responding to patient risk

- A modified early warning score system (MEWS) was in place to alert staff if a patient's condition was deteriorating. Early warning indicators were regularly checked and assessed.
- Patients' documentation was transferred to an IPOC when it was recognised the patient was expected to die within days or hours.
- Ward staff had contact details for the SPC team and confirmed the team responded promptly when needed.

Nursing staffing

- Staffing for EOL care was the responsibility of all the staff and not restricted to the SPC team. The SPC MDT included six palliative care nurses and a clinical lead who was a consultant in palliative medicine.
- There was a full time bereavement nurse and a palliative care nurse temporarily seconded to the position of gold standards framework (GSF) facilitator.
- Each ward had two nursing palliative care champions whose roles included raising awareness of EOL processes, and educating and supporting more junior staff.
- We observed a nursing handover where eight patients including a recently deceased patient were discussed appropriately and efficiently.
- There were three full time staff in the Mortuary; the manager, a senior technician who worked as the deputy manager and an assistant technical officer who worked as an administrator. Two part time staff, a technician and an assistant technical officer, worked in the mornings when the post mortems were conducted.

End of life care

Medical staffing

- The palliative care consultant worked 9am-5pm Monday to Friday and conducted two clinical sessions per week reviewing inpatients on ward round, however she said she was very flexible dependent on other commitments. She took referrals from the SPC team based on the complexity of their needs. She also worked together in an advisory capacity with consultants in other specialities.

Major incident awareness and training

- There were documented major incident plans on the wards and these listed key risks that could affect the provision of care and treatment. There were clear instructions for staff to follow in the event of a fire or other major incident.
- There was a business continuity plan in place for the Mortuary which had access to a 40 bay storage unit at Leigh Infirmary and a further mobile 12 bay unit at Leigh if capacity was reached.
- A regional major incident plan was also in place, with dedicated post mortem suites identified.

Are end of life care services effective?

Good

We observed that staff at different levels were aware of evidence-based guidance and best practice, and that senior managers were using these when developing the service. The IPOC incorporated the priorities set out by the Leadership Alliance for the Care of Dying people and we saw this being used and completed appropriately.

The service was starting to implement the gold standard framework (GSF) and had appointed a facilitator to introduce and embed this in the two pilot wards. There was evidence that some issues identified in audits were being addressed, however there were not always action plans in place which met the criteria for being specific, measurable, achievable, realistic and timely (SMART). This meant there was a potential risk that some recommendations or findings from audits may not be addressed in a timely manner or may be missed altogether.

Pain relief including anticipatory medication was being managed appropriately, and nutrition and hydration needs for patients were being monitored and documented.

The SPC team were 100% compliant with their personal development review targets and were positive about receiving and delivering training around EOL care. They had good links with the consultant oncologists, the bereavement nurse specialist and Wigan and Leigh hospice. The SPC team provided a seven day service from 8.30am to 4.30pm.

There were some issues identified in a DNACPR audit including a number of occasions where patients had been identified as lacking capacity but no formal mental capacity assessment was recorded. This was borne out by the records that we reviewed, as mentioned earlier in this report. The service should develop an action plan to address the shortcomings identified in the DNACPR audit.

Evidence-based care and treatment

- The service used an individual plan of care (IPOC) document which facilitated support for the dying person in the last days and hours of life. This was an extremely comprehensive document used to record the patient's individualised tailored care in line with best practice guidance including priority outcomes of care as outlined in The NHS England Leadership Alliance for the Care of Dying People 'One Chance to Get it Right', June 2014.
- Policies were available on the intranet and key documents were also in files on the wards. These included information about religious information, 'bereavement matters' and user manuals on equipment used to keep deceased patients cool while awaiting transfer to the mortuary.
- The Gold Standards Framework (GSF) is a programme that enables staff to provide a gold standard of care for people nearing EOL by planning care in line with their needs and preferences.
- Two wards, Astley and Standish, had started a pilot phase of the GSF accreditation for acute hospitals. Staff on Astley spoke of their focus on identifying EOL patients, communicating this with GPs and taking a more pro-active approach to forward planning for palliative patients. There were files on these wards, highlighting the roles and responsibilities around communication for the medical and nursing team.

End of life care

- Staff understood the importance of the patient's preferred priorities for care (PPC) which helped patients prepare for the future by thinking and talking about their preferences and priorities for EOL care, and having these documented. These were incorporated in an advance care planning document.
- The SPC team were responsible for ensuring that care was given according to recognised guidelines. Senior staff said this was monitored by the cancer external peer view process which included inspections. This peer review report was requested from the trust but the document we received referred only to gynaecology therefore it was not possible to use this to review evidence that care across the service was being given in accordance with recognised guidelines.
- The trust's specialist palliative care operational policy stated there was agreed participation by the team in the North West Audit Group (NWAG) programme, however the team had not participated in any network audits between April 2014 and March 2015. Staff told us they had participated in an EOL care audit in the summer of 2015 but the results were not due until February 2016.
- An audit was completed in February 2015 on standards from the trust's multi-specialty care in the last hours of life and care after death policy. Some good practice was identified; however the audit showed that many of the procedures were not followed to ensure compliance of the care after death policy and standard operating procedure. Recommendations were made for each specialty, to improve compliance with the standards, however no action plan to implement these recommendations was reported.
- A second audit was completed on the same policy but related to the standards from a bereavement officer and mortuary perspective. The audit report concluded there were many areas of concern within both sections (bereavement officer and mortuary) showing audit findings below the acceptable standards. Despite a number of recommendations being identified there was no audit plan to ensure that these were implemented in a specific, measurable, achievable, realistic and timely (SMART) manner.
- One of the recommendations made in the above audits and in the national care of the dying audit for hospitals was to increase training around EOL patients. A bereavement care study day had been introduced, held each week where one hour sessions were facilitated by the palliative care team, the bereavement nurse, porters, mortuary staff and patient advice and liaison service (PALS). These were open to all staff across the trust and 411 staff had attended in the first 12 months.
- The bereavement nurse specialist had completed some work on the verification of death training policy, and in particular on transfer from ward to mortuary times which now had to meet a target of four hours. If this did not happen, staff submitted an incident report.
- Mortuary team meetings were held every two months where possible where any changes to procedures were discussed. We saw the minutes from the April 2015 meeting which showed that audits had been discussed.
- In the mortuary when there was no known identity confirmed for the deceased patient the body was stored in a specified fridge and high risk precautions are used including gloves and aprons. Human Tissue Authority (HTA) and Association of Anatomical Pathology Technology (AAPT) guidelines were followed.

Pain relief

- The NCDAH in 2014 showed that clinical protocols for the prescription of medications prescribed for the five key symptoms that may develop at the end of life were achieved at a better rate (72%) than the national average (50%) for England. These included pain relief.
- The IPOC document contained a section for reviewing pain, with prompts to refer to the network palliative care pain and symptom control guidance if needed.
- Pain relief was managed on an individual basis and was regularly monitored for efficacy.
- We reviewed 11 prescription charts and saw evidence of appropriate prescribing, administration and documentation of medication including anticipatory medicines.
- We observed a review of a patient by one of the SPC team nurses, including a symptom control plan and completion of the IPOC documentation.
- The SPC team provided advice and guidance to other staff around pain management and a pain management session was included in the clinical skills induction programme.
- Referrals to the SPC team for patients who were in pain were prioritised, seven days a week.

Nutrition and hydration

- We saw evidence that nutrition and hydration needs for patients were being met. The IPOC included a comprehensive list of nutrition and hydration considerations for staff to address. This included prompts for nutrition and hydration assessment at every review, mouth care, swallowing difficulties and respecting the dying person's choice to eat and drink even at risk of aspiration.
- Staff we spoke to showed a good understanding of the above.
- We reviewed 11 prescription charts and all had completed nutrition and hydration review information.

Patient outcomes

- The service reported that it had taken part in the most recent national care of the dying audit for hospitals (NCDAH) but the report was not due until March 2016.
- The previous NCDAH results for the period 1 May -1 July 2013 were published in May 2014. This service achieved only two of the seven organisational key performance indicators (KPIs). Of the five KPIs not achieved, one had already been addressed at the time of the 2014 report following the audit; this was access to specialist support for care in the last hours or days of life (KPI 2) as a seven day service has been provided since October 2013.
- Those not achieved were: Access to information relating to death and dying (KPI 1), Care of the dying: continuing education, training and audit (KPI 3), Clinical provision/ protocols promoting patient privacy, dignity and respect, up to and including after the death of the patient (KPI 6) and Formal feedback processes regarding bereaved relatives/ friends views of care delivery (KPI 7).
- Recommendations included the development of a borough wide education strategy and individual plan of care audit in February 2015 (KPI 3).
- There was no action plan with the report, and no recommendations regarding KPI 1, KPI 6 or KPI 7. Despite this it was clear that the service had made changes to their practice to address these issues, for example in relation to information (KPI 1) an EOL care booklet had been developed and information and training around this was delivered at ward level and on the bereavement care study day. Patient information about palliative care and the SPC team was also provided to EOL patients in the personal care file they were given on referral to the SPC team.
- For clinical indicators the service achieved a score higher than the national average for seven of the ten indicators. The domains where the service scored lower than the national average included the recommendation that health professionals had discussions with both the patient and their carers regarding their recognition that the patient is dying (clinical KPI 2) and this had been included in the individual plan of care. A uDNACPR was introduced to address review of interventions during the dying phase (clinical KPI 6) and hourly rounding was in place to address the audit recommendation that patient assessments should be undertaken and documented at least four hourly over a 24 hour timeframe (clinical KPI 9).
- In summer 2015 Standish ward started a formal pilot phase of the Gold Standards Framework (GSF) accreditation for acute hospitals. A second ward, Astley, was also participating as this ward had previously piloted the programme. A specialist palliative care nurse had been temporarily seconded to facilitate this.

Competent staff

- The SPC team were 100% compliant with their personal development review targets.
- The nurses in the SPC team had completed the advanced communications skills course.
- Staff reported "massive changes" in bereavement services in the last 12 months, for example the introduction of tissue donation. Staff said there was some initial reluctance to approach bereaved families about tissue donation but link nurses have received training from an external source which also provided information leaflets to support staff. The bereavement nurse specialist had held an awareness meeting and the training was due to be repeated in the New Year. The ward manager on Shevington ward said this had given her staff the confidence to broach the subject with families.
- There was a competency framework in place for verification of death.

Multidisciplinary working

- We observed a white board MDT handover led by a ward sister with two doctors, a physiotherapist, occupational therapist and social worker in attendance. Patients with palliative care needs were identified and planning for social care needs was in place. There was good MDT working and we observed the different disciplines working together to identify patients approaching EOL.

- There were good links between the wards, the palliative care team and the bereavement nurse specialist.
- On the GSF pilot wards there were good links with the GSF lead.
- The palliative care team worked closely with the Wigan and Leigh hospice nurse specialists. If a patient from the hospice attended the hospital then hospice staff provided a handover of current information in relation to the patient.
- Ward staff described good relationships between nursing staff and consultants.
- There was close involvement between the SPC team and two consultant oncologists employed by the Christie hospital but based at Wigan.
- An electronic palliative care coordination system was being piloted by local GPs whereby some information could be shared between GPs, the ambulance service, community and hospital staff. Training on using the system had begun, and at the time of our inspection GPs could amend the information and some hospital could staff could access it, but not amend it.
- There was a volunteer service on Mondays which stocked the wards with bereavement information leaflets and comfort packs for use by families.

Seven-day services

- The SPC team provided a seven day service from 8.30am to 4.30pm. At weekends routine referrals would be left until a Monday to be dealt with but if a patient was in pain the team would attend.
- Out of hours there was 'Palliative care matters' information available on the intranet and support from the team at the hospice could be accessed.
- The bereavement office was open between 8am and 4pm Monday to Friday and out of hours the MCCDs were completed by the mortuary manager on duty.
- In special circumstances arrangements could be made with the mortuary for relatives to view a deceased family member outside normal working hours; between the hours of 6pm and 8pm Monday to Friday or 10am and 8pm over a weekend or bank holiday. This was via the out of hours service.
- The chaplaincy team worked on Sunday mornings and were on call on Saturdays and Sunday afternoons.
- The medical devices loan store was not staffed out of hours so if syringe drivers were required they had to be collected by ward staff. There was a booking out system in place, however this could take staff twenty minutes and was exacerbated by the basement location of the store and the lift being out of use. Staff also raised a concern about a lack of security in the basement area.

Access to information

- The SPC team was using a software application designed to collect relevant data throughout a patient's cancer journey that had been adapted for use with all palliative care patients. This programme linked into EOL care pathways and was useful for providing information without having to access the patient's notes; however it could not be accessed by ward staff.
- There was an electronic records system used by the hospice and by some GPs which the SPC team could access which was useful when palliative patients attended the emergency department to check their details, for example their medication.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The service used a unified document for recording do not attempt cardiopulmonary resuscitation (uDNACPR) status which meant the document was valid across a number of organisations.
- A local uDNACPR audit was reported on in November 2015 which highlighted some issues with this process. In 11 (29%) of 38 reviewed cases there was no written evidence in medical notes for the DNACPR decision or why a discussion had not taken place and five patients were documented as lacking capacity but a formal mental capacity assessment was recorded for only one patient.
- The report identified that the regional DNACPR audit tool requires 100% in 13/17 elements to achieve compliance. WWL was compliant in three elements but non-compliant in 14 cases. There was no action plan with the report detailing how these issues were to be addressed.
- Staff on Astley ward demonstrated good knowledge of capacity protocols, with specific examples such as when a patient had difficulty swallowing. They would consult with the family and offer access to advocacy, including a specialist Independent Mental Capacity Advocate (IMCA) where appropriate. Best interest meetings were held when necessary, and in the example given they said that if the patient just wanted a drink a 'feed at risk'

decision could be taken with involvement from the family. There was a good understanding of meeting the needs and wishes of the patient and family, while keeping the patient safe.

Are end of life care services caring?

Outstanding ☆

We rated end of life care services as outstanding because there was a visible person-centred culture. End of life care services were provided by compassionate, caring staff who were sensitive to the needs of seriously ill patients. People were respected and valued as individuals, and staff throughout the service demonstrated a commitment to recognising the needs of the patients at end of life, and of their families. There were systems in place to support this, including the use of the swan logo. The use of the logo was seen to be identified universally and promoted high quality care to patients at the end of life and their families. Family members we spoke with were positive about the way they and their relatives were treated. Patients received care with privacy and dignity.

The SPC team and bereavement nurse consistently sought feedback from patients and their families including sending out questionnaires to every family after a relative's death. Where issues were identified, work was undertaken to address these.

People's emotional and social needs were highly valued by staff and this continued after a patient had died when families were offered support and wellbeing advice from the bereavement nurse specialist.

Ward and mortuary staff were respectful and caring when they spoke about their patients who were at the end of life. They understood that each set of circumstances was different and each family had different needs which they did their best to accommodate. Portering staff took pride in their role of transporting deceased patients to the mortuary, despite this being challenging during wet or icy weather due to the environment on site.

However, there were some occasions where the lack of designated bereavement office space suitable for families including wheelchair users had caused difficulty.

Compassionate care

- Bereavement surveys were sent to families two to four weeks after their relative's death. An action plan was shared with the Wigan borough palliative and end of life care committee in September 2015 following a recent bereavement survey where a 46% response rate was achieved. The survey responses included 24 positive and 20 negative comments which were fed back to the relevant ward managers so that actions could be put in place to address the findings. These included leaflets not being given out, delays in registering deaths, raising awareness of Chaplaincy and noise at night. Staff we spoke with were positive about making changes to improve EOL care.
- We witnessed the EOL process and saw all 'swan' arrangements in place. Care for the deceased patient was calm, coordinated and compassionate. The family were taken to a quiet place while the care team performed last offices to enable a dignified viewing for them.
- Mementos including photographs, locks of hair and hand prints of the patient were available for bereaved families. There were also ring boxes for wedding rings.
- Staff demonstrated compassion when discussing their patients. One member of staff described how every death was different and gave examples of how they had to anticipate the changes in their patients' conditions and prepare the relatives for these changes.
- In the mortuary the deceased were treated with dignity and respect. Bodies were laid out as if in bed for viewing, with a quilt and pillow with flowers on.
- The ante room environment was pleasant, with seating and a modern cupboard with flowers on. Families could look through the glass from the ante room to see their deceased relative and could decide whether or not to go into the viewing room itself.
- The mortuary manager met with relatives, introduced herself and allowed them the chance to compose themselves. She explained what to expect and accompanied them initially, before offering privacy.
- Porters aimed to attend within 30 minutes of being called to transport a deceased patient to the mortuary and reported they usually achieved this although it was not audited. They knew how to contact the bereavement nurse specialist if necessary.
- Porters raised some concerns over having to transport bodies in inclement weather across a rear car park and down a slope to reach the mortuary, however they reported no incidents to date.

End of life care

Understanding and involvement of patients and those close to them

- The relatives we spoke with were happy with the care their family members had received. Symptom control was good for the patient and the family had been "fed and watered and looked after". One relative said that all the care was excellent and they had no complaints.
- One family member we spoke to said they had benefited from the rapid discharge process, involvement from the bereavement nurse specialist and the IPOC. They had made use of the free car parking allocated to families with relatives at end of life and felt fully supported and well informed.

Emotional support

- A bereavement nurse specialist offered post death wellbeing advice and support for families. She had undertaken 27 home visits in the 12 months prior to our inspection, and provided additional face to face support to more than 70 families. Access for families to the bereavement nurse specialist was via the bereavement office.
- There was a 'helping hands' volunteer service which met families at the hospital entrance and chaperoned them to the bereavement office when collecting medical certificates of cause of death (MCCD).
- There was a small counselling room used for giving MCCDs to families and for appointments with the bereavement nurse specialist; however the doorway was not wide enough to allow wheelchair access. There were other rooms which could sometimes be used, for example quiet rooms on the wards, however there had been a recent occasion in August 2015 when a family member who was a wheelchair user had to wait in the corridor.
- In the counselling office there were information leaflets on a range of subjects including bereavement counselling services, organ donation, arranging a funeral and a free memorial website service.
- In the chapel there was a basket in which families could place a heart with message on it, for the chaplains to place on a remembrance board. There was an 'anniversary diary' where people could write messages for their loved ones on the date of their death.
- Twice a year (in May and November) a memorial service was held and relatives bereaved in the six months prior to each service were invited to attend. In May they were given a butterfly to write a message on which would then be attached to a memorial tree and in November there were stars with messages, for a Christmas tree. The services were held off site so that relatives did not need to go back to the hospital.
- A bereavement officer was available to support families at inquests and said they had attended 10 in the previous 12 months.
- There were flowers in the family areas of the mortuary. These were donated by a local company who came regularly to change them. There was also an 'in memorium' visitor's book where the bereaved could leave messages for their relatives.

Are end of life care services responsive?

Outstanding ☆

We rated end of life care services as outstanding because there was a coordinated approach involving other organisations across the Wigan borough to design EOL services to meet the needs of the local population.

Staff were familiar with the best ways to facilitate getting the individual needs and preferences of their patients met and were dedicated to achieving this. This included referring to the Specialist Palliative Care (SPC) team, applying for NHS continuing healthcare (CHC) funding, referring to the advance care planning document and implementing the benefits of the swan logo initiative including open visiting, relatives staying on the ward, free designated car parking, comfort packs and bereavement trays for relatives.

Patients referred to the SPC team underwent a thorough assessment which took into account their physical, social, psychological and spiritual needs so that support could be drawn from the appropriate source or service. The swan logo represented dignity in death and staff across the trust, at all levels, knew the patient was EOL or the family was recently bereaved and they responded accordingly.

There were systems in place to prioritise EOL patients for side rooms at RAEI and this was working well. Flexible facilities and systems were in place to minimise stress for families staying with their EOL relatives and to allow them to spend as much time as they wished with them in their last days and hours.

End of life care

There were comprehensive arrangements in place for rapid discharge to allow patients who chose to leave hospital to do so as soon as possible and these were being monitored. Staff were pro-active about seeking out patients' views and there were good opportunities for patients and families to raise concerns with the service. There was evidence that when concerns were raised, these were addressed appropriately.

Service planning and delivery to meet the needs of local people

- Service planning and delivery was addressed at the Wigan borough palliative and end of life care committee whose members consisted of senior professionals from all organisations within the borough involved in commissioning or providing services to patients with palliative and EOL care needs. This included local acute NHS trusts, the local clinical commissioning group (CCG), Wigan and Leigh hospice and Marie Curie representatives. Strategy meetings held by the committee were chaired by Wigan, Wrightington and Leigh hospital trust.
- The committee aimed to work in partnership in the development of local palliative care services, to ensure that palliative care was provided in an integrated way across settings (community, care homes, hospital and hospice).
- There were no specific beds for EOL patients at RAEI but they were usually cared for in side rooms on the wards. If these rooms were occupied by other patients who needed to be in a side room, for example due to infection control precautions, they could be transferred to Pemberton isolation ward where all 12 beds were in side rooms. This meant that a patient at the end of life could move into the newly vacated side room without having to be transferred off the ward.
- Where the swan logo was in use there was opening visiting for families throughout the organisation and there were dedicated free car parking spaces for families with relatives at the end of life and recently bereaved families attending the bereavement office or mortuary.
- For families who wanted to stay on the wards with their relative there were folding beds available. Families were offered comfort packs containing toiletries donated by a supermarket chain and a 'bereavement tray' with sandwiches and biscuits. Ward staff said the kitchens would do their best to provide what the families wanted in terms of meals, so that they did not have to leave their relative to go and eat.
- There was an 'in-reach bleep' which meant that when a patient with palliative care needs attended the accident and emergency department, CDU or MAU, the SPC team would go and see the patient. The bleep was also used for urgent referrals and the hospice could use it to speak with the SPC team about a patient known to both services.
- The mortuary provided a simple viewing facility where immediate family could arrange to spend time with the deceased; this was by appointment only. Visits could be arranged between 1.30pm & 3.30pm or 6pm to 8pm Monday to Friday.
- Post mortems were conducted in the mornings when pathologists were available which is why visitors were asked to attend in the afternoons.
- The mortuary had 48 fridge spaces for bodies, including eight spaces for larger bodies. Bariatric facilities were provided at another site (Leigh Infirmary).

Meeting people's individual needs

- Ward staff said if a patient was identified as EOL there would be a consultant review. A decision to refer to SPC team would be based on medical need, support or advice around difficult pain and symptom control, complex psychosocial problems and/ or any other specialist needs related to EOL care and support. This included supporting patients with dementia, and their families.
- Patients referred to the SPC team underwent a comprehensive assessment which included physical, social, psychological and spiritual needs. Support could then be provided for mobility needs, speech and language therapy and dietetics as required, and there was a financial advice service provided in the cancer care suite.
- Where appropriate and with the consent of the patient, NHS continuing healthcare (CHC) funding was applied for, which enabled a patient to have their needs urgently met, for example to enable them to go home to die or to provide appropriate support to be put in place either in their own home or in a care setting. The fast track

pathway tool was used to ensure that patients with a rapidly deteriorating condition, which may be entering a terminal phase, were supported in their preferred place of care as quickly as possible.

- As part of CHC process staff asked the families what they wanted, and where. Staff on Astley ward were knowledgeable about the different options available for families in Wigan, including nursing homes that were CHC funded and different packages of care offered in the community.
- There was an advance care planning document in use which had been adapted for borough wide use and incorporated the national preferred priorities for care guidelines.
- We visited the chapel which had prayer and ablution rooms for patients and relatives to use.
- Information was on display with details of the chaplaincy team, and a multi faith calendar. We spoke with two assistant chaplains who told us they were visible on the wards, and would go 'bed to bed', offering their services and leaving contact details with patients. They were allocated specific wards to cover but would follow a patient if they moved wards to ensure continuity.
- If a patient from a faith other than the Christian belief wanted support from another source the chaplains could facilitate that, for example they were in contact with the local Imam (Islamic leader).
- Information about translation services was on display in the counselling office used by bereaved families. On the wards the bereavement nurse provided extra support with language for families who needed it, for example picture charts and access to translation services.
- There was a waiting area in the mortuary with drinks facilities and information for families in large print and braille. The booklets available included guidance and support for the bereaved and information about the post mortem process.
- There was a hearing loop available for people with hearing difficulties who called the mortuary.
- Doorways into the mortuary ante room and viewing room were wide enough to accommodate wheelchairs.
- Arrangements were in place in the mortuary to facilitate rapid preparation of deceased patients for release to families of faiths where particular rituals are carried out within a short timeframe following death. For example the mortuary manager or a bereavement officer issued medical certificates of cause of death (MCCD) out of hours. Rituals were usually undertaken at the funeral directors.
- A swan logo was used on the wards (on the doors of patients' rooms and on the whiteboard) to indicate that a dying or deceased patient was being cared for. This logo represented 'dignity in death' and was also on the bags containing property or valuables being collected by carers of a deceased patient. This meant that all staff including non-clinical staff around the hospital could see immediately that people carrying these bags were recently bereaved and they could be treated accordingly.
- When a patient died ward staff spoke with the family to agree what they would like the patient to be dressed in for transfer to the mortuary. Families were encouraged to stay with their relative while they were prepared for transfer and could accompany them part of the way to the mortuary if they wished.

Access and flow

- There was a telephone referral system for the SPC team, where information was taken by the administrative staff ready to be reviewed the following day by the team. However, informal triaging took place throughout the day and any urgent referrals, for example where a patient was in pain, were prioritised.
- Between January and October 2015 there were 982 referrals made to the SPC team. Of these, 62 (6%) were either late being seen or were not seen at all due to the referral being late and/ or the patient dying or being discharged before being seen.
- The team aimed to see referred patients within 48 hours but often it was within 24 hours. Information provided by the trust showed that between 1 September 2014 and 31 August 2015 SPC team met the 48 hour criteria for 87% of referrals and 61% were seen within 24 hours.
- There was a rapid discharge process in place which usually took place on the same day. Around four hours was the expected time, although sometimes there were delays if equipment needed ordering over a weekend or oxygen was required. There was liaison between the hospital and the community staff who had a 'hospice in your home' service whereby community staff would visit patients at home for up to two hours and liaise with GPs, for example regarding equipment.

- The protocol for rapid discharge was included within the IPOC as was the hospital statement of intent. The statement of intent was put in place by the hospital with the aim of avoiding unnecessary police attendance when someone at EOL died out of hours in the community so their GP may not be available to issue the MCCD. The statement of intent was valid for 72 hours and meant the issuing medical practitioner could complete the MCCD should the patient die during that time and their GP was unavailable.
- The organisation had an agreement with a private ambulance service to transport patient's home, managed by the bed managers. There were 23 rapid discharges between June 2015 and December 2015, of which 18 (78%) were completed in less than 24 hours, three took 48-72 hours and 2 took longer than 72 hours. The service did not provide more detailed information.
- The service was in the process of developing a bereavement survey for families of a relative or friend who was discharged using the rapid discharge process and this was with the trust lay readers for approval at the time of our inspection.
- The service was not auditing whether the four hour target for discharge was being regularly met and whether there was any learning for the times when it was not met.
- An earlier review provided by the service reported that there were 34 rapid discharges between July 2014 and May 2015. The service was monitoring the process; including looking at the diagnoses of these patients and following up on the quality of care once the patient had been discharged.
- If a member of the SPC received a bleep call from the accident and emergency (A&E) department they were released from other duties to go to A&E and assess the symptoms of the patient. A symptom control plan would be drawn up with an IPOC and drugs were obtained from pharmacy within the hour to facilitate rapid discharge.
- The mortuary had access to a 40 bay storage unit at Leigh Infirmary and a further mobile 12 bay unit at Leigh if required. There was an escalation policy in place and if the mortuary was reaching capacity and the weekend was approaching some of the deceased patients would be moved to Leigh, or to local funeral directors. There was a system in place for transfers over the weekend when required.

Learning from complaints and concerns

- Staff reported receiving very few complaints in relation to EOL care but were pro-active in seeking out patients' views.
- Ten semi-structured interviews were undertaken with patients using the service between December 2014 and February 2015 to gather feedback. Some recommendations were made as a result of this and an action plan was put in place to implement these. Actions included the introduction of a personal care file including information leaflets and MacMillan contact details to be given to patients on the point of referral to the SPC team.
- The mortuary manager provided an example of a complaint which had been investigated and the learning from this resulted in a change to practice. Staff had met with the family involved and apologised.

Are end of life care services well-led?

Good

EOL services were well led with evidence of effective communication within and between staff teams. The strategy for the service was developed in collaboration with other services across the borough and although the strategy was due for review there was a clear reasoning behind this which staff were aware of.

The visibility of senior management was good and staff felt well supported. There was an open door policy by senior staff.

Risk registers were in place and had actions identified, however, there were no target date for completion of the actions although the risks were reviewed regularly.

Staff were proactive in seeking out feedback from patients and families and there had been work to engage the public around tissue donation. There was good staff engagement with staff being involved in making improvements for services. The staff we met were committed to delivering good, compassionate care and were motivated to work at the hospital

Vision and strategy for this service

- The vision and strategy for specialist palliative care and EOL care was developed as a borough. There was a borough wide palliative and end of life care committee and the strategy meetings were chaired by the deputy director of nursing from Wigan, Wrightington and Leigh hospital trust.
- The strategy was illustrated in a diagram entitled the Wigan wheel which had patients at the centre and outlined the trust's vision, mission and priorities for the future. Senior staff told us the Wigan wheel underpinned everything they worked towards. The current strategy was overdue for review but development of the new strategy was on hold pending publication of the new NICE guidelines to improve care for people at EOL due to in December 2015. These needed to be taken into consideration when developing the new strategy.
- Nursing staff on the wards, the SPC team and senior managers all made reference to the standards laid down in the Ambitions for Palliative and End of Life Care: A national framework for local action 2015-2020.
- A representative from the SPC team attended the bi-monthly borough committee meetings where an education strategy had been agreed by the members for 2014-2017.

Governance, risk management and quality measurement

- There was a quarterly bereavement committee meeting in development to replace the previous monthly bereavement improvement group as many of the changes overseen by the monthly group were now in place.
- There was a corporate and divisional risk register in place but there were few risks identified which specifically related to EOL services. There was an awareness of the potential risk of using folding beds although the exact nature of the risk was not specified and three risks related to the mortuary.
- Each risk had control measures in place and a review date but there was no target date for completion of the action on the information received from the trust. Some of the risks appeared to have been on the register for several years including all three related to the mortuary which were dated 2011. This meant it was not clear whether all risks were being managed as effectively as possible.
- The Mortuary policy does not specify how frequently the fridge temperature should be checked but staff reported that it should be recorded weekly. There was a records log for recording the fridge temperature but at the time of our inspection it had not been recorded on the log since 23rd October 2015, i.e. for more than six weeks. Prior to that it was recorded every few days. It would aid consistency and promote good governance if the policy was specific about when this should take place.
- Good practice in the mortuary included the use of stickers for the fridges to alert staff when the deceased patient had an 'implant device' such as a cardiac pacemaker or 'the same or similar sounding name' to another.

Leadership of service

- Very senior staff were visible on the wards and the medical director had an open door approach and sent out regular emails of encouragement to staff.
- There was a very enthusiastic assistant director of nursing for bereavement and donation who covered three organisations including Wrightington, Wigan and Leigh. She had led the changes on linking bereavement care and organ and tissue donation. Everyone we spoke to in the service agreed that huge progress had been made in these areas.
- The clinical lead for the SPC team was very committed and enthusiastic about the service, and also had dedicated time at the hospice.

Culture within the service

- Ward staff told us they felt well supported by the SPC team and the bereavement nurse specialist who were available all the time and provided a 'very good' service.
- Senior staff told us they had an 'open door culture' for heads of nursing and matrons.

Public engagement

- We saw evidence of the service actively seeking input from patients and families, and acting to address concerns when they were raised.
- There had been an awareness day held off site to raise awareness around tissue donation. Fifty members of the public attended and there had been 20 tissue donors since 1 April, 2015.
- Bereavement questionnaires were sent out two weeks after a patient died, to every bereaved family. The bereavement nurse specialist collated the results from

these questionnaires and sent the responses to the relevant wards where the bereavement link nurse would highlight any concerns. These were discussed in handover.

Staff engagement

- There was a quality champion initiative whereby staff were supported to develop skills in quality and safety improvement through a dedicated training course. Quality and safety champions were awarded bronze, silver and gold badges at the annual staff 'Recognising Excellence Event' which celebrated the achievements of staff over the year. Bronze was awarded on completion of the training and when work on an improvement project has begun; silver was awarded to champions who had delivered measurable and sustained improvements and gold was awarded to champions who had delivered multiple large scale improvements and shared their good practice beyond the trust. Of the six nursing staff in the SPC team two were silver quality champions and one was bronze. The bereavement nurse specialist was a bronze quality champion.

Innovation, improvement and sustainability

- In January 2014 the trust launched the 'always events' which were ten events that should always happen. Challenges experienced by the trust were considered during the development of the always events, which included the length of time taken for deceased patients to be transferred from the ward to the mortuary. One of the always events was to "ensure patients who have died receive dignified care and leave the ward within two-four hours". An audit to measure compliance with whether this target was being met had not been undertaken.
- From 1 April 2016, every patient at the end of life would be offered the opportunity to donate their tissue.

Outpatients and diagnostic imaging

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

Information about the service

The Royal Albert Edward Infirmary (RAEI) is the largest of the hospital sites for Wrightington, Wigan and Leigh NHS Foundation Trust. Outpatients and diagnostic services are managed under the specialist services division.

Outpatient services employ over 140 whole time equivalent nursing and clerical staff across four sites and sees approximately 500,000 patients per year trust wide which includes many out of area referrals. Approximately 122,000 patients attended the outpatients at the Royal Albert Edward Infirmary between January and December 2014, 29% of which were new patients and 55% were follow up appointments. The remaining 16% of appointments made were either cancelled (10%) or the patient failed to attend (6%)

Chemotherapy and supportive treatment to patients with breast, bowel & haematological cancers is delivered in the new cancer care suite at the Royal Albert Edward Infirmary site and is in partnership with a local cancer specialist hospital. The chemotherapy administration area was a 12 bedded area with one isolation room. The cancer centre opened in January 2015. Patients were involved at the planning stages and created a building with counselling rooms and a patient garden.

The outpatients department offers a range of clinics including trauma and orthopaedic, diabetes, oral surgery and orthodontics as well as general medical and surgical conditions. Most outpatient departments operate between Monday and Friday with some Saturday clinics. The trust offers a comprehensive service providing diagnosis and treatment in one attendance, where possible

Radiology operates across all four trust sites and undertakes in excess of 250,000 examinations per year. More than 150 whole time equivalent staff are employed including 16 consultant radiologists. Some staff rotate across the various trust sites and the management structure is the same for all locations. The trust provide virtual consultations in radiology, where staff have access to a consultant radiologist on another site, and also offers many nurse led services for the local community.

During our inspection we visited several outpatient clinics, including fracture, hand, children and young people, orthopaedic, pre-operative, cardiology, physiotherapy, pathology, the cancer centre and radiology. We spoke with 41 staff including departmental managers, nurses, receptionists and radiology staff and 20 patients, relatives and carers. We looked at two sets of case notes and two radiological requests.

Outpatients and diagnostic imaging

Summary of findings

We found the services of the outpatients and diagnostic imaging to be good overall. Patients had clear access to the clinics and radiology, though car parking was an issue. Areas were visibly clean and waiting times for appointments were short. The departments had sufficient staff and where shortfalls existed there were plans in place to ensure continuous service. There was some weekend clinics and acute radiology services was open 24 hours a day. The outpatient waiting area was dated but the new cancer centre, opened in January 2015, was bright and spacious in comparison.

Staff at Royal Albert Edward Infirmary told us they were proud of where they worked and would recommend it as a workplace and a place to treat their family. Staff training was up to date and the trust encouraged learning. Incidents and errors were treated as a learning opportunity to keep patients safe in the future. Patients told us that staff were caring and compassionate and they were given sufficient information about their treatment.

The management were visible and approachable to staff. Audits to assess the departments were continuous and innovation and change was promoted. Staff felt supported by the managers.

Are outpatient and diagnostic imaging services safe?

Good

We rated the outpatient and radiology services at Royal Albert Edward Infirmary as good for providing safe care.

Services adopted a culture where incidents were reported and investigated, with action taken to limit recurrence. Staff were open and honest in their approach when things went wrong.

The hospital had a good record of cleaning and hygiene audits. Medicines were stored correctly and were within expiry dates. Outpatient dispensing of prescriptions met the 15 minute target for most months. Records were available routinely and of good quality.

Patient risks were identified and managed with appropriate measures in place to mitigate them. There was an acceptable level of staffing across outpatient and diagnostic imaging and some strategic, innovative planning in radiology to predict and meet shortfalls.

There was a focus on safeguarding practice with a dedicated trust team available to support staff. Mandatory training was monitored by managers, and staff were given time to complete training.

Staff were familiar with major incidents and aware of the process should a major incident be declared.

Incidents

- Staff reported incidents electronically and received email notifications to confirm receipt and outcome of investigations.There was a culture of learning from incidents amongst staff.
- Between May and August 2015, the outpatients and Magnetic Resonance Imaging (MRI) imaging departments reported two incidents both of which resulted in no harm.
- Each clinical group reviewed incidents and shared learning with staff. For example, in the hand clinic the unit manager shared learning from incidents with

physiotherapists and occupational therapists in the team. Radiology staff used a rapid review model for finding causes and making improvements. Management described the process as a 'name and train' exercise.

- In August 2015 there was a serious incident reported following a misreporting of a computerised tomography (CT) scan by an external reporting agency. A rapid review was performed and systems were examined. As a result of the investigations, the radiologist was removed from the trust panel of reporters. However the trust continued to use the agency as a source of additional capacity.
- There had been one incident relating to Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER) in the last 12 months. The trust held an Environment Agency permit which allowed 30GBq/month of radioactive waste to be discharged via drainage system from patients who have received injections of radiopharmaceuticals. Due to an increase in workload during the month of July 2015 it was exceeded by 5GBq thus breaching the permit regulations. The permit was amended to 50GBq per month at the time of the inspection. The Radiation Protection service were informed and involved with the application.
- Senior staff had an awareness of the Duty of Candour. This is a legal duty to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. Information about Duty of Candour was displayed on the staff noticeboard.

Cleanliness, infection control and hygiene

- The outpatients and diagnostics departments were visibly clean and tidy.
- Results of cleaning audits were displayed in outpatient public areas and infection control audits for cleanliness were displayed as 100%.
- The outpatient department displayed the results of a domestic supervisor's audit of cleanliness of equipment and the environment. The outpatients department displayed a rating for this audit of 96% for the two months prior to the inspection.
- Hand hygiene results for the outpatients department between April 2015 and August 2015 was 100% for each month except June, which was 94.4%. In the department, the results for the previous two months were displayed for staff to review.
- There were hand gel dispensers at the entrance and exit to the outpatient clinic. We observed all staff adhering to the 'bare below the elbow' policy.

Environment and equipment

- The Royal Albert Edward Infirmary was an old building adapted to accommodate the requirements of a busy hospital.
- The outpatient department comprised five separate clinical areas, each used by different specialities. The reception area was situated approximately two meters away from patients waiting which meant space was limited affording little privacy.
- Resuscitation trolleys were present in the outpatient and radiology areas and records showed they were checked daily before being sealed. There were automatic defibrillators in the departments which were ready to use should they be required.
- The equipment we inspected had undergone portable appliance testing to ensure electrical safety.
- Mobile plaster cutters were annually serviced. Occupational health performed annual dust and noise level checks and results conformed to safe working conditions.
- Appropriate radiological and hazard signage was displayed throughout the department that complied with Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER). The radiology department had a set of 'local rules' displayed which followed radiation protection guidance and supported the safe use of equipment.
- The hospital had a nuclear medicine department where medical imaging using small amounts of radioactive material took place to diagnose or treat patients. Patients in this department were segregated to prevent other people being exposed to radioactivity but the waiting area was small with only four chairs and one toilet for patients to use. Radioactive material was handled approximately two meters from administrative

staff. Whilst environmental monitoring results showed levels of radiation were acceptable, any spillage of the material might mean staff had to leave the area. We asked staff about this and they explained that, although they were aware of the potential issue, no incidents had occurred.

- There were systems and processes in place for maintenance and servicing of all imaging equipment. The department had two CT scanners. One of these was an older device which, although still operational, limited the number and type of patients that could be seen.
- The department had one gamma camera which had been in the department for a number of years and therefore no longer supported in terms of maintenance and servicing. This meant that it could not be repaired if it were to develop a fault.
- The service lead told us the issue of aging equipment was on the risk register but we were unable to locate this on the register provided to us. However, new equipment was cited on the directorate's five year strategy plan published in July 2015. The strategy described plans to replace the gamma camera on lease in 2015/16 followed by the CT scanner the year after.

Medicines

- Medicines, including chemotherapy preparations were stored in locked cupboards in clinical areas. We checked a range of medicines, which were all within expiry date.
- In the x-ray department, contrast media was stored appropriately. We observed staff handle media using appropriate pre-procedures and taking into account patients with impaired renal function who were more at risk of renal failure than others.Radiology staff had access to two anaphylaxis kits (anaphylaxis is a serious allergic reaction) to use for patients who might react to contrast media. These were stored securely and were within expiry date.
- Four trained clinicians were license holders for the Administration of Radioactive Substances Advisory Committee (ARSAC). This complied with the Medicines (Administration of Radioactive Substances) Regulations 1978.
- Where appropriate, medicines were administered using patient group directives (PGDs). PGD's are written instructions which allow specified healthcare professionals to supply or administer particular medicines when prescriptions are not available. We checked a sample of these and found that they were up to date and authorised appropriately.
- Fridges storing medicines requiring low temperature were monitored regularly and were found to be within the recommended temperature range.

Records

- Records were paper based but staff also had access to an electronic patient record (EPR) system where they could source duplicate copies of some notes if paper records were missing. Administrative staff explained that temporary paper records were prepared when notes were missing and were subsequently transferred to existing paper records later.
- Figures provided by the trust showed that between June and November 2015, between 10 (July 2015) and 13 (July, September and November 2015) records per month were unavailable for clinic.
- We inspected two outpatient records. These contained comprehensive details about the patient as well as listing procedures, treatment outcomes, appointment attendance, and future plans. We reviewed diagnostic referrals for CT and nuclear medicine patients. These were completed accurately with pertinent details such as height and weight recorded.

Safeguarding

- The trust had a team dedicated to safeguarding for children and adults which supported staff with advice if required. Staff were familiar with this team and felt comfortable contacting them. However, this team was only available during core working hours.
- Adult and child safeguarding training was mandatory and completed annually or twice yearly depending upon the level on contact staff had with patients. Ninety-seven per cent of outpatient staff and 98% of radiology staff were compliant with adult safeguarding training. Child safeguarding training was provided in one of three levels depending upon the level of patient involvement. Ninety-eight per cent of non-clinical staff were up to date with level one safeguarding training,

due every two years. Ninety-five per cent of clinical staff were up to date with the annual level one training, 91% had completed level two and 88% had completed level three training.

- Staff in the fracture clinic were aware of procedures relating to child safeguarding. These included contacting the safeguarding team if patients failed to attend two appointments. The staff kept a file in the department which held up to date information, and two link nurses worked in the department to keep files updated and provide information to colleagues.

Mandatory training

- Mandatory training was predominantly completed annually via e-learning modules, accessible via the trust intranet. Topics included basic life support, manual handling and safeguarding.
- The exception to this was resuscitation, and high risk conflict resolution training which were both delivered face to face.
- There was a robust process of reminder emails sent to staff at 90, 60 and 30 days prior to training days and a copy of the email was also sent to the line manager. This helped ensure compliance.
- The trust target was for 95% of staff to be up to date with mandatory training.The trust provided figures for specific areas of the outpatient department. These showed that 97% of dental outpatient staff, 87% of diabetic outpatient staff, 98% of paediatric outpatient staff and 100% of fracture clinic staff were up to date with mandatory training. We were unable to obtain training figures for the Royal Albert Edward Infirmary radiology staff. However the trust did provide us with the percentage of radiology staff across all sites which was ninety-seven per cent.

Assessing and responding to patient risk

- There were reliable systems, processes and practices in place to assist in keeping patients safe.
- The trust had a comprehensive resuscitation policy that defined the levels of competency each level of staff needed in order to manage a patient suffering a cardiopulmonary arrest. Basic life support training was given to all staff who had patient contact whether clinical or non-clinical. There were designated radiation protection officers on site in the radiology department that offered advice and guidance on radiation and diagnostic imaging matters and ensured procedures were in place.
- The trust had a policy in place for confirming pregnancy status prior to radiological imaging taking place and staff were aware of the procedure.
- In the radiology department, environmental monitoring had taken place over a nine week period, between April and June 2015. The results showed that all areas adjacent to x-ray rooms, throughout the hospital, were projected to be within the allowable limit of 0.3mSv per year, with the exception, of one office next to the accident and emergency room one (projected 0.39mSv). The recommendation from a local cancer specialist trust's Medical Physics and Engineering department was that the study was repeated.
- The radiology department were not compliant with good practice in the use of the World Health Organisation (WHO) surgical safety checklist. We saw no evidence that the trust used the Safety Checklist for Interventional Radiology. This is a set of standards derived from the WHO Steps to Safer Surgery by the National Patient Safety Agency.

Radiology and Nursing staffing

- There was a process in place to ensure enough nurses were available during clinic times. Staffing in the outpatient department was planned in advance using appropriate skill mix. Staffing levels were adequate at the time of our inspection. Due to the close proximity of clinics, staff could be moved from one area to another during clinics should this be required.
- The trust utilised radiographers to participate in reporting qualifications and as such alleviated difficulty recruiting reporting radiologists. There was a good skill mix of specialist radiographers within the diagnostic department.
- Low staff numbers were recently flagged on the incident reports for the cancer centre. Staff were utilised from the local cancer specialist trust that had specialised trained staff. This was more advantageous than agency workers as the hospitals used the same systems and processes.

Medical staffing

Outpatients and diagnostic imaging

- The trust recognised there were shortages of medical staff and were actively recruiting at the time of inspection. In house training took place to develop nurses which enabled them to run nurse led clinics. This meant fewer consultants were required for clinics. .
- Radiology staff recognised issues with delays in reporting due to lack of trained staff and some work was passed to outside agencies (called 'outsourcing'). Outsourcing to external agencies was not only expensive but created risks Some of these risks included external IT issues (security and reliability), differences in reporting protocols and unfamiliarity with trust policies and procedures. The Human Resources department had agreed that part time staff could be paid an overtime rate to cover shortfalls in the service. However additionally, between 1.1 and 7.6% agency staff were employed between April 2014 and March 2015.
- Staff with reporting radiographer qualifications were also utilised to meet the demands of the service.
- The Clinical Director of Radiology used a forecasting tool to predict workload and staffing difficulties. Managers then predicted the number of reporters required which had improved reporting times.

Major incident awareness and training

- A trust major incident policy and a business continuity plan were in place to help support staff and maintain core business during major incidents.
- Staff explained what they may be required to do should a major incident be declared, such as changing clinic areas to wards and reallocating patients to alternative clinics.
- Comprehensive plans were available on the intranet and hard copies were available in the office. Staff knew where to find the appropriate information.
- Staff were familiar with trust plans for treating patients with suspected Ebola symptoms. Ebola is a serious virus originating in Africa.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

Staff used guidelines, procedures and policies to support them when providing care for patients. Radiology staff had access to 'local rules' in line with Ionising Radiation Regulations 1999.

Departments regularly took part in audits and presented them to colleagues which promoted learning and improved services. Nursing staff assisted medical staff and patients when collecting audit data. Hand hygiene and cleanliness audits were completed regularly.

Staff were appropriately trained and we were told that staff felt supported to further their education and participate in national groups. There were many examples of multidisciplinary working across teams and learning was shared.

Staff received appraisals, and were given opportunities to enhance their learning. They worked together to share knowledge and provide better care for patients. Services were not routinely provided on a seven day basis but clinics were held in the evening and occasionally on a Saturday morning to prevent waiting lists growing.

Staff were able to access the information required to provide services to patients and reported few occasions when information was unavailable.

Staff understood consent and we saw evidence that consent was obtained in writing when required. Staff also understood mental capacity and explained their actions should a patient lack the capacity required to make decisions about their care.

Evidence-based care and treatment

- Staff used local guidelines (such as peri-operative anti-coagulant guidelines) and national guidelines (such as guidance for suspected cancer) by the National Institute for Health and Care Excellence (NICE) and the Royal College of Nursing (RCN).
- Guidelines, protocols and policies such as the radiation protection policy were available on the trust intranet.

Outpatients and diagnostic imaging

- Standard operating procedures (SOPs) devised by the trust and used across directorates supported staff providing specific care for patients (such as ultrasound scans of the abdomen or testes). We saw evidence that SOPs were reviewed and changed when required.
- Radiology staff used 'local rules' in line with Ionising Radiation (Medical Exposure) Regulations 2000 to ensure they administered radiation safely to patients. We saw evidence that these had been reviewed and updated in 2014. Reviews and updates for 2015 were due in January 2016.

Pain relief

- Entonox gas was used to relieve pain for patients attending fracture clinic. Nursing staff were trained to administer the gas. If a child required pain relief whilst in clinic a member of the paediatric staff were called to administer it.
- We spoke with a parent of a child attending fracture clinic who told us pain relief had been provided which was adequate.

Patient outcomes

- Outpatient and diagnostic services undertook audits to improve care. Monthly audit and reviews were produced by radiology staff, such as reviewing the protocol for undertaking adrenal computerised tomography (CT) scans, a study of magnetic resonance imaging (MRI) brain scans under sedation, and an audit of thyroid fine needle aspiration. Conclusions were in line with National Institute for Health and Care Excellence (NICE) guidance.
- An audit to examine international normalised ratio (INR) rates in patients was done by anticoagulation nurses in 2014/15. This audit examined the causes for heightened results and reviewed effects and outcomes. The audit identified both cause and symptoms of raised INR levels, as well as the need for good communication to enable effective monitoring and management of patients.
- The orthopaedic service had recently implemented a fracture risk assessment tool called FRAX. This diagnostic tool, developed by the World Health Organization (WHO), helped staff evaluate the 10-year probability of bone fracture risk and early warning signs of osteoporosis in patients over the age of 50. The tool had not been in practise long enough to assess its success.
- The orthopaedic service contributed to national and local audits which outpatient staff assisted with. These included participation in the hip fracture database, enhanced recovery programmes and cryo-compression for total knee replacements.

Competent staff

- Staff received annual appraisals where development and performance was discussed with a line manager. The trust provided figures for outpatient staff across two sites; Royal Albert Edward Infirmary and the Thomas Linacre Centre. Across these two sites, 74% of staff had received an appraisal within the last 12 months. Only 65% of radiology staff had received their appraisal.
- A training package was in place for students in the fracture clinic, which was developed by staff. Students spent half a day in the plaster room and received a certificate on plastering skills when competent.
- Tissue viability nurses told us that wound care and tissue viability meetings were held monthly and information gathered was cascaded to other outpatient's staff. Specific one day conferences were available for staff to attend to enhance their knowledge.
- Staff were given documents such as guidelines for plaster application and operating procedures for x-ray. Once they had read the documents they signed the competency sheet to confirm this. We reviewed the competency file and saw lists of staff that had read and signed to confirm competency.

Multidisciplinary working

- We saw evidence of staff from different specialities working together to learn and provide a good service for patients. For example, staff in the cancer centre ran a cancer strategy group which invited consultants, GPs and any other stakeholders involved in arranging care for patients.
- The Macmillan team were integrated within the cancer centre and provided additional services for cancer patients such as drop in sessions, leaflets and information about benefits.

Outpatients and diagnostic imaging

- Staff participated in chemotherapy network groups in the North West area to share ideas and initiatives.
- The radiology directorate worked with a neighbouring specialist cancer trust to implement a new CT service for patients diagnosed with cancer, which was due to start in March 2016. Physiotherapy staff told us they worked closely with other specialities across the trust sites to optimise service provision.

Seven-day services

- The majority of clinics and radiology services, including the cancer centre, were provided Monday to Friday during working hours. However the radiology department did operate seven days a week, except for ultrasound scans which was highlighted in the strategic plan
- The hand clinic provided appointments between 7.30 and 17.30 Monday to Friday. Saturday morning clinics had been trialled but patients did not attend, so were discontinued.

Access to information

- In the outpatient clinic a set of case notes were examined and these demonstrated that access to information was appropriate. Pro-formas were used where possible. Referrals, outcomes and a typed copy of clinic attendance details were sent to the GP.
- Staff operated a system whereby patients underwent diagnostic tests such as x-rays and blood test before being called for consultation. This ensured the results were available for the consultant to review during the appointment.
- Radiography images were available to staff across all sites regardless of where the scan took place. The Clinical Director of Radiology spoke of his vision to have x-rays performed, reported and sent to the referrer before the patient left the department.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff worked under the assumption of implied consent. Verbal and written consent were also obtained depending upon the care or treatment being provided. Plain film x-ray was performed under implied consent if the patient followed instructions without refusal, barium enemas required verbal consent and interventional radiology procedures required written consent.
- We saw evidence that parental consent was obtained for a child attending a nuclear medicine appointment.

Are outpatient and diagnostic imaging services caring?

Good

We rated services as good in the caring domain.

Staff were sensitive to the needs of patients and this was reflected in the friends and family feedback. One patient said that the staff was the best thing about the hospital.

We saw staff attending to patients in a polite and respectful manner. Emotional support given to patients was excellent with the trust offering staff the opportunity to study counselling.

Patients visiting the cancer centre were particularly impressed with the level of information and compassion given during their treatment.

Compassionate care

- Staff were mindful of individuals with complex needs or a learning disability. Staff could assess patients who attended with extreme anxiety and use a side room that was away from the busy clinic.
- We observed that staff maintained patients' privacy and dignity during our inspection.

Understanding and involvement of patients and those close to them

- We spoke with five patients and relatives in the cancer centre who spoke positively about their experience and felt involved in making decision about their treatment. They also felt that processes were explained and they were told what to expect. One patient complemented the facilities and described staff as kind and caring.
- Patients were given tours of the cancer centre prior to treatment to familiarise themselves with the facilities.

Outpatients and diagnostic imaging

- Results of the Cancer Care Centre Patient Experience Survey conducted in May 2015 showed that 84% of patients felt staff were the best thing about their visit to the Cancer Care Centre. One patient said "I met some of the kindest most caring staff and helpers. I will never forget their kindness".
- The cancer centre organised patient groups that provided information and promoted friendship amongst patients.

Emotional support

- The cancer centre staff were trained to assist patients deal with the psychological impact of cancer.
- A clinical psychologist was employed in the cancer centre for one and a half hours per month to provide counselling for patients.
- Fracture clinic outpatients were issued with information about their treatment for issues such as plaster cast or wound care. These were called 'passports' and contained aftercare information out of hours contact telephone numbers for support when clinics were closed.
- Pre-operative assessment clinic saw up to 6000 patients per year. An enhanced recovery nurse worked in the pre-operative assessment clinic. The nurse helped patients with information and support and visited patients on the ward following their operation.

Are outpatient and diagnostic imaging services responsive?

Good

We rated the outpatient and diagnostic imaging department as good for responsive.

Services were provided for local patients as well as patients referred from other services. Pagers were available, enabling patients to leave waiting areas while waiting for their appointment.

Access and flow was monitored in a number of ways. The hospital met the Department of Health target in providing appointments for patients within 18 weeks. Waiting times in clinic varied depending on the type of appointment.

Reporting times for diagnostic scan results varied between one hour and 8 days. The trust reported a backlog of 1,367 x-rays in September 2015, across all five sites, awaiting results reports but action to recruit extra staff was in progress to reduce this.

Translation services were available and staff knew how to provide this service for patients if required. Dementia care was promoted on notice boards.

The majority of complaints related to waiting times. Verbal complaints were dealt with at the time of complaint if possible and we saw this take place during our visit. Complaints were monitored and reported to senior management on a monthly basis. They were also shared with staff to promote learning.

Service planning and delivery to meet the needs of local people

- In the fracture clinic waiting area there was no television or refreshment facilities available. The children's fracture clinic was also held in this area but the area was not a child-friendly environment in that there were no books, toys or decoration to enhance the experience for children.
- Wheelchairs were available on request for patients attending clinic appointments.
- Outpatient reception staff considered patient and relative or carers' circumstances such as travelling distance and school times.
- However, two patients attending the fracture clinic told us the carpark was a significant distance from the clinic which made it difficult to reach the clinic area.
- Within the hospital the corridors were well lit and clean, with clearly signposted directions to outpatients and x-ray areas.

Access and flow

- Access and flow was measured in a number of ways. These included; the percentage of patients referred for treatment within the Department of Health target of 18 weeks, or two weeks for suspected cancer, waiting times following arrival at hospital, and time taken to report diagnostic imaging results. Clinic cancellation rates and patients who did not attend appointments were also monitored.

Outpatients and diagnostic imaging

- The 18-week referral-to-treatment performance between January 2015 and October 2015 showed the trust had exceeded the trust's 95% target and was better than the England average and standard with an overall average of 98%.
- For cancer targets the trust performed better than the England average with 97% of patients with suspected cancer seen within two weeks. Ninety-one percent of patients received their first treatment within 62 days of referral and 98% of patients received their first treatment within 31 days of the decision to treat being made.
- Between January 2015 and October 2015 the trust's performance against the 6 week's diagnostic standard showed an average 1% which was better than the England average of 1.5%.
- Between January 2015 and October 2015 the proportion of clinics where the patient did not attend for this trust was 5.8% which was better than the England average of 7%. Patients who did not attend (DNA) were sent a second appointment. Patients were assessed if they did not attend the second appointment and safeguarding procedures were followed for children and vulnerable patients.
- Wait times for outpatient prescriptions at the Royal Albert Edward Infirmary were between 12 and 16 minutes from April 2015 to August 2015. The target set by the department was 15 minutes. In the outpatients department we followed two patients' journeys. They were both booked in, seen and left the department within 45 minutes.
- The outpatients department assisted colleagues in the Emergency Department to cope with delays and maintain patient flow by providing staffing and clinical areas.
- The radiology department had been working on reducing waiting for appointment times. The management were proud to tell us that the 6 week target had been achieved and in fact the average waiting time for a plain film study between April and August 2015 was 0.8 days. The only radiological study that had a waiting for appointment time of more than 6 weeks was for an angiogram where the average wait for appointment was 65 days.
- The trust told us that the average time taken to report scan results varied from three days for plain film x-ray to thirteen days for an angiogram. However a radiology report dated 20 August 2015 highlighted a significant back log of 1,867 reports waiting to be reported. This figure was a total of all x ray departments in the trust and equated to 16% of the number of x-rays performed. The trust took action to reduce this by training radiographer staff to report on plain film chest x-rays, and alleviate the workload for radiologists. In August 2015, 967 films were reported by radiographers.

Meeting people's individual needs

- Translation services were available for patients whose first language was not English. Staff were familiar with the process for organising translation by telephone or face to face.
- Patients with a learning disability had access to a quiet room to use while waiting for their appointment which gave the option of a less stressful environment than the main waiting area.
- We saw patients living with dementia being treated with dignity and respect in clinic. They underwent an x-ray which was reviewed by the consultant prior to their appointment to speed up the process.
- We saw that patients who arrived in fracture clinic without an appointment were reassured that they would be seen that day.
- The NHS friends and family test results showed that patients were unhappy about car parking charges following delays in clinic. Staff explained that extra car parking charges were waivered under these circumstances.
- In the radiology waiting area water dispensers were available for patients as required.

Learning from complaints and concerns

- Senior nurses told us formal complaints were rare and records confirmed this, with only five formal complaints received for outpatient and diagnostic services at the hospital between September 2014 and December 2015.
- Radiology staff told us that complaints were often addressed by meeting with the complainant to show them their scans and explain the process.

Outpatients and diagnostic imaging

- Actions were taken following the outcome of complaints. These included offering apologies, explanation and further consultations to reassure people where necessary. Formal reflection was undertaken by staff involved in complaints as well as changes to practice such as the way magnetic resonance images (MRI) were carried out.
- A weekly complaints panel was held, which the outpatients and diagnostic imaging department contributed to. This panel looked at closer working with divisions on shared responses and also incorporated complaint's training for managers.

Are outpatient and diagnostic imaging services well-led?

Good

We have rated the outpatient and diagnostic imaging service as good for well led.

Senior staff were passionate about the department's strategy and the trust values were evident in the places we visited. Governance meetings were held monthly. Risk was managed through a local risk register which contained information about mitigation, risk scores and review dates.

Staff felt supported by managers and safe to raise issues. The management team were visible and known to staff. The outpatient department engaged with the public, holding group meetings and obtaining their thoughts about services through the use of questionnaires. They also liaised with a local school to promote cleanliness, and local art work produced by the children was displayed in the waiting area.

The trust had a department dedicated to staff engagement and produced reports which demonstrated improvements annually.

There was good innovation and vision in the radiology department. There was engagement with the public and patient groups were involved in decisions. Some management staff took part in doing extra shifts in their original profession.

Vision and strategy

- The trust vision and values were displayed throughout the outpatients and diagnostic imaging department. Staff were familiar with these and explained what the department vision was.The vision is to be in the top 10% of everything they do.
- Senior managers had clear visions for the future and were passionate about their approach to improvement. Ideas included improving the reporting time for radiology results from within one day to within two hours. These ideas formed part of the radiology directorate's strategy for improvement. This strategy was in place to help the department achieve goals such as reducing reporting times, improving service delivery at weekends and succession planning.
- Future plans for the trust included potential joint service provision with two neighbouring trusts. However, the service leads were concerned that the positive culture in the trust could be lost by this change.
- The clinical director for radiology told us that the service currently had a 96% same day reporting service at the time of inspection and the vision of the service was to report diagnostic images within 2 hours.

Governance, risk management and quality measurement

- Monthly governance meetings were held in each of the different specialities.
- Team meetings were held daily, weekly or monthly depending upon the department. Senior staff told us that minutes were taken at these meetings and emailed to staff or were available to view on the trust intranet. Copies were also displayed in staff rooms and on notice boards.
- The radiology department had a local quality improvement process in place. Initiatives which focused on improvement were put forward, such as standardising the way radiology worked. Processes were monitored and methods of learning through practice were devised.
- Throughout the trust each department participated in a 'Com Cell' meeting. This was a gathering of all departmental staff, or heads of sections, to discuss

cases for the day, high risk patients and any incidents, alerts or learning. This demonstrated that participating staff could influence and assist in the planning of the daily work flow.

- There was a divisional risk register in place which recorded risks for each specialism. The register included a description of the risk, a risk score, current and additional mitigation action, a named person responsible for dealing with the risk and a review date. Risks corresponded with the issues senior staff highlighted to us and their action plan for addressing those risks.
- We saw evidence of quality and safety audits throughout the specialties and evidence of staff involvement with implementation of change.
- Lessons learned newsletters were distributed to staff in the outpatients department, which gave staff up to date information on issues such as Duty of Candour, preventing falls and medication errors.
- Local quality improvement work in radiology included improvement in image quality. The rationale for this was to identify sub optimal images and subsequently three staff members examined the images and made recommendation for improvement. The staff members who produced the image was included in the responses in order to improve overall departmental quality and staff competencies.

Leadership of service

- The leaders of the services were passionate and driven to achieve good outcomes for patients.
- Staff were familiar with future challenges such as local mergers and budget constraints. Despite this, senior staff had a passion that demonstrated their commitment to the service.
- Some leaders maintained their clinical registration and worked with staff in clinic to maintain an awareness of how service delivery impacts on patients and staff.
- Clinical staff told us they had contact with their line managers and staff at the cancer centre described having a partnership with the executive team who gave them freedom to develop services. They described the team as visible and approachable.
- An outpatient productivity group was newly formed within the management team and was to focus on specific key performance indicators within the business support group. The outpatient manager told us that issues such as cancellation rates, addition of text reminders to breast screening patients and first appointment average wait times were on the agenda.

Culture within the service

- Clinic staff felt engaged with the trust and felt able to suggest improvements, learn lessons and tackle issues together. Staff described an “excellent team spirit” and a “no blame culture”.
- Staff including senior staff felt they had a rewarding job and were proud of the trust and its achievements.
- Fracture clinic staff reported a good team atmosphere where they felt comfortable and encouraged to raise concerns.
- The trust ’10 Always events’ were on display in outpatient areas in the Thomas Linacre Centre. Staff discussed them with us and we saw evidence of the events being followed. The 10 Always Events are aspects of care that should always happen. For example, Patients will always be addressed by their preferred name and Staff will always challenge colleagues if they are not doing the right thing.

Public and staff engagement

- The staff we spoke with were proud to be part of the WWL trust. They felt appreciated and supported by managers. There was an enthusiasm in the outpatients and the breast screening unit to provide good quality care and strive to be the best. Radiology managers were passionate and determined that their goals could be met and the journey for excellence was under way.
- As part of the National Cancer Survey, localised results were developed into a trust action plan annually. The Lead Chemotherapy Nurse stated that patient feedback was key to their plans.
- A ‘staff engagement’ department employed practitioners to support teams in engaging with staff. The department also produced staff engagement reports. We reviewed the anticoagulation team staff

engagement survey report dated August 2015 which showed improvements in aspects of staff engagement such as work relationships and staff mind set, since February 2015.

- Twenty two staff were recruited for a project to improve the outpatient service in June 2015. Here staff met with thirty two patients and carers to review their personal experience of services. Key themes were then identified of aspects of care that should always happen such as offering appointments to suit patients and making sure that whiteboards were updated regularly to highlight delays. We saw both of these in practice during our inspection. Further review of the themes was due to take place to measure the efficacy of the actions.
- All new patients were given a feedback form to source their views on the service.
- Despite having a low response rate of 38%, the centre scored 99.5% in the NHS Friends and Family test.
- The WWL staff engagement tool has been adopted by other trusts in the North West to examine and improve their staff engagement

Innovation, improvement and sustainability

- There was a trust-wide initiative to train volunteer counsellors from current trust staff. Externally accredited courses up to level seven were offered. This enabled staff to support their own staff groups and have an empathy with patients.
- There was a focus throughout the outpatients and diagnostics department to continually improve care and quality for patients.
- Patient passports were utilised in some outpatient clinics. These were given to patients, in areas, including plaster clinic, to ensure better continuity of care.
- In-sourcing of radiology staff to backfill staff shortages provided knowledge and saved money.

Outstanding practice and areas for improvement

Outstanding practice

- The department used an electronic dashboard (A&E APP) that constantly monitored flow through the department. It used predictive information based upon seasonal variances and data from previous years to generate likely numbers of attendees to the department. The system also used live data of ambulances on route to the department. Where demand was strong at particular times of the day the department was able to flex staff from other areas to ensure response rates were maintained.Meetings were held several times per day to discuss flow throughout the hospital to avoid delays in patients moving through the Hospital system.
- The trust recognised that an important element of achieving high quality care was to ensure that the staff had the capacity and capability to deliver improvement. The trust had set up a 'Quality Champion' programme to support the delivery of service improvement and recognise the achievements of the staff. All Quality Champions who had completed the training programme and commenced an improvement project were awarded a bronze badge. Silver and gold badges were awarded to those Champions who sustained their improvements and disseminated them to other organisations. The department had a number of staff of various grades who were quality champions, and had identified staff who were about to start the programme.
- Within radiology there was effecting in-sourcing of staff to cover shortfalls
- Staff were supported to undertake a counselling qualification in order to improve the staff support network.
- The use of the swan logo, symbolising dignity in death, included some outstanding practice. The swan logo identified patients at the end of life and bereaved families, enabling staff to treat them accordingly and the initiative included open visiting, relatives staying on the ward, free designated car parking, comfort packs and bereavement trays for relatives. These facilities and systems in place were intended to minimise stress for families staying with their relatives and allowed them to spend as much time as they wished together in their last days and hours.
- Access to support for relatives from a bereavement specialist nurse following the death of a loved one was particularly noteworthy. The specialist nurse would attend inquests or visit at home if required.
- Within Maternity, the development of the 'sim man' as part of the 'skills and drills' mandatory training was part of the poster presentation at a conference last year.

Areas for improvement

Action the hospital MUST take to improve

Action the hospital MUST take to improve

In Emergency Department:

- The trust must ensure that there are sufficient numbers of staff who are trained to resuscitate children at all times.

In Medicine:

- The trust must deploy sufficient staff with the appropriate skills on wards.
- The trust must ensure that all staff receive appraisals and complete mandatory training to enable them to carry out the duties they are employed to perform.
- The trust must ensure that records are kept secure at all times so that they are only accessed by authorised people.

In Children and Young People:

- The service must ensure staffing levels are maintained in accordance with National professional standards.

Outstanding practice and areas for improvement

- The service must ensure that there is one nurse on duty on Rainbow ward trained in Advanced Paediatric Life Support each shift.
- The service must ensure that staff are trained and competent to deliver the care required by patients with a tracheostomy.
- The service must ensure that risk rating and escalation is robust to ensure mitigating actions are taken in a timely way.
- The service must ensure the ward manager has sufficient time to perform the managerial tasks associated with the role.
- The service must ensure the senior leaders of the service are cited on the risks and actions being taken.

Action the hospital SHOULD take to improve

Action the hospital SHOULD take to improve

In Emergency Department:

- The trust should ensure that incidents are reported and that all staff are aware of the types of incidents they should report.
- The trust should ensure that all risk assessments are reviewed, managed and mitigated in a continuous and timely way.
- The trust should ensure that documentation in patient records is accurate and fully completed.
- The trust should take action to improve performance in the monitoring of vital signs for children.
- The trust should ensure that leaflets are available across the department in different languages to reflect the needs of the local population.
- The trust should ensure that screening for infectious diseases, such as Ebola, are in place across the department.
- The trust should ensure that policies and procedures relating to the time patients should spend in the clinical decision unit (CDU) are followed.
- The trust should ensure that the children's emergency department (CED) has a robust cleaning regime and there is evidence that it has been completed.

In Medicine:

- The trust should ensure that patients are discharged as soon as they are fit to do so.
- The trust should ensure that patients are not moved ward more than is necessary during their admission and are cared for on a ward suited to meet their needs.
- The trust should consider implementing formal procedures for the supervision of staff to enable them to carry out the duties they are employed to perform.
- The trust should ensure that all staff seek consent for the use of bedrails and if they lack capacity apply the Mental Capacity Act (2005) principals and this is reflected in procedures and that relevant staff complete mental capacity act training.
- The trust should ensure that the endoscopy unit is fit for purpose.
- The trust should ensure that oxygen for patients is prescribed when required.
- The trust must ensure that patients' privacy and dignity is maintained at all times in the discharge lounge.

In Surgery:

- The provider should ensure that trolleys containing patient's notes are kept locked.
- Records should be fully completed with name and designation always clearly recorded and printed.
- All equipment should display dated green 'I am clean' stickers.

In Critical Care:

- Implement supernumerary shift leaders on each shift.
- Reduce the number of patients with delayed discharges greater than four hours.

In Maternity:

- Ensure that emergency equipment and medicines are checked in line with trust policies and procedures and that a record is held.
- Ensure that equipment is checked and records are kept to ensure equipment is maintained and fit for purpose.
- Review accessibility procedures into the maternity unit.

Outstanding practice and areas for improvement

- Review procedures related to temporary staff and ensure that there are robust monitoring arrangements in place.
- Ensure that guidelines are up to date and include evidence of the use of latest recognised publications.
- Review communication methods used to deliver key messages to midwifery staff.
- Ensure that the ongoing problems with the drainage problem on the maternity unit are resolved.
- Ensure there are robust systems in place to ensure the security of both the postnatal ward and delivery suite.

In Children and Young People:

- Consideration should be given to the provision of accredited Newborn Life Support training for junior Doctors working on Rainbow ward and the neonatal unit.
- The trust should take steps to ensure that resuscitation equipment is available and fit for use.
- Ensure a record is maintained of the maximum and minimum fridge temperatures for each medication fridge.
- Ensure equipment is maintained within the required timeframe.
- Ensure controlled medicines are checked twice daily in line with trust policy.
- Ensure a current Female Genital Mutilation policy is in place which includes the mandatory reporting requirements and a domestic abuse policy and training that includes modern slavery, human trafficking and domestic violence prevention orders.
- Staff should have their learning needs identified through the trusts appraisal process.
- A Registered Mental Health Nurse should be employed to care for children requiring Child and Adolescent Mental Health Services.
- Ensure shower facilities for parents staying with their children are in good working order.

In End of Life Care:

- The service should improve their compliance with the regional DNACPR standards which were not being met particularly with regards to the use of MCA and best interest decisions. This should include an action plan to address the shortcomings identified in the DNACPR audit.
- The service should consider improving access to medical devices out of hours. At the time of our inspection syringe drivers which may be required at the weekend were kept in a loan store in the basement. The lift was out of order and security was minimal. Staff reported that it took twenty minutes to fetch a syringe driver out of hours. The service should improve the review and updating of the risk register in a timely manner, with target dates for actions, to ensure all risks are being managed effectively and are not left on the register without being addressed for an extended time.

In Outpatient:

- Consider improving outpatient facilities such having drinking water available and children's facilities in the outpatient waiting area.
- Consider the implementation of the use of the Safety Checklist for Interventional Radiology.
- Review the outpatient area in proximity to the reception desk to explore options for improving privacy for patients.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **How the regulation was not being met:** There was not always sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed to meet the needs of the patients. This was because there were low numbers of staff trained to resuscitate children. Additionally there were lower numbers of trained staff than planned on some of the wards at night and not all staff had received their appraisal and mandatory training.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** Records were not always secure. This was because record trolleys were left unlocked on medical wards.

Regulated activity	Regulation
Diagnostic and screening procedures Nursing care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** Staff on Rainbow ward were not compliant with Advanced Paediatric Life Support training and were not competent to care for patients with tracheostomies. Regulation 12 (2) (c)