Care Quality Commission

Wirral University Teaching Hospital NHS Foundation Trust

Clatterbridge Hospital

Quality Report

Clatterbridge Road
Bebington
Wirral
CH63 4JY
Tel: 0151 334 4000
Website: www.wuth.nhs.uk

Date of inspection visit: 16 – 17 September 2015
Date of publication: 10/03/2016

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
Medical care	Requires improvement
Surgery	Good
Outpatients and diagnostic imaging	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

Clatterbridge Hospital is one of two hospital sites managed by Wirral University Teaching Hospitals NHS Foundation Trust. The hospital provides a range of health care services including elective orthopaedic surgery (planned operations), specialist stroke and neuro-rehabilitation services, elderly care and dermatology treatments. The elective surgery and stroke rehabilitation wards each have a total of 20 beds. In addition, the hospital offers a variety of outpatient services for a full range of specialities including dermatology, podiatry, cardiac, plastics, phlebotomy, x-ray, and the Wirral Breast Centre. Magnetic Resonance Imaging (MRI) scanning appointments were available but delivered by an external provider.

The hospital is located on the Wirral peninsula in the North West of England and serves the people of Wirral and neighbouring areas.

Wirral University Teaching Hospitals NHS Foundation Trust became a Foundation Trust on 1 July 2007. The trust provides services for around 400,000 people across Wirral, Ellesmere Port, Neston, North Wales and the wider North West footprint with 855 beds trust-wide, including 106 at Clatterbridge Hospital.

We carried out an announced inspection of Clatterbridge Hospital on 16 – 17 September 2015 as part of our comprehensive inspection of Wirral University Teaching Hospitals NHS Foundation Trust.

Overall, we rated Clatterbridge Hospital as 'requires improvement'. We have judged the hospital as 'good' for effective and 'outstanding' for caring. 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, 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.
- Staff followed good practice guidance in relation to the control and prevention of infection in line with trust policies and procedures. We observed staff following hand hygiene practice, bare below the elbow guidance and using personal protective equipment where appropriate.
- There had been no cases of methicillin resistant staphylococcus aureus (MRSA) bacteraemia infections or clostridium difficile infections identified in surgical services across the trust between March 2015 and August 2015. However, across the same period, medical care services reported 21 cases of clostridium difficile infections, two cases of MRSA and six cases of MSSA. The data could not be split so as to separate cases that specifically occurred at Clatterbridge Hospital.
- Side rooms were used where possible as isolation rooms for patients at increased risk of cross infection. There was clear signage outside the rooms so that staff were aware of the increased precautions they must take when entering and leaving the room.
- The majority of wards we visited were visibly clean and free from odour. Wards used the 'I am clean' stickers to inform colleagues at a glance that equipment or furniture had been cleaned and was ready for use.
- 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.
- Patient-led assessments of the care environment (PLACE) audits for 2013 and 2014 scored higher than the national average for cleanliness across the trust, specific data for Clatterbridge Hospital was not available.

Nurse staffing

Summary of findings

- Matrons met each day to discuss nurse staffing levels across the divisions to ensure that there was good allocation of staff and skills were appropriately deployed and shared across all wards. In July 2015 there were still 70 nursing vacancies in medical and acute services across the trust.
- The trust had a high vacancy rate for nursing staff in medical services trust wide, which was 13% at the time of the inspection. The turnover of nursing staff was 9.7%.
- There were concerns regarding the number of nurses on duty during the night on the Clatterbridge Rehabilitation Centre (CRC) and ward 36, which were both medical wards. The staffing figures provided by the trust, showed that there were only ever two trained nurses planned to be on duty during the night. This was a ratio of one nurse to 13 patients on ward 36 and a ratio of one nurse to 15 patients on the CRC. Patients on the CRC had neurological conditions and some had suffered a stroke, whilst ward 36 was an elderly care ward.
- The staffing and skill mix on surgical ward areas and in theatre areas was sufficient, with some periods of reduced staffing in areas because of last minute sickness and unexpected events. However, there was a lack of surgical staff trained in paediatric life support. This training was not mandatory for staff, despite them working with children.
- The vacancy rate for nurses in surgical services was below 3% for the five month period prior to the inspection. At the time of the inspection the vacancy rate for nurses across surgical services trust-wide was 2.4%.

Medical staffing

- Medical treatment was delivered by skilled and committed medical staff.
- There were sufficient numbers of suitably qualified medical staff during the daytime hours. However, there was only one junior or middle grade doctor on duty during the night and at weekends. The doctor was of a medical and not surgical specialty, and may not be able to offer specialist surgical care and advice as a result.
- There were no surgical doctors, anaesthetic or critical care support on the Clatterbridge site after 8pm. If a patient suffered a collapse or became critically unwell, the staff at the hospital would have to call an ambulance.

Mortality rates

- Nine patients died on the Clatterbridge Hospital site between April 2014 and March 2015. Mortality and morbidity themes and trends were discussed as part of clinical governance meetings; however, it was unclear if any actions for improvement were agreed at the medical care meeting.
- The Summary Hospital-level Mortality Indicator (SHMI) is a set of data indicators which is used to measure mortality outcomes at trust level across the NHS in England using a standard and transparent methodology. The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated at the hospital. The risk score is the ratio between the actual and expected number of adverse outcomes. A score of 100 would mean that the number of adverse outcomes is as expected compared to England. A score of over 100 means more adverse (worse) outcomes than expected and a score of less than 100 means less adverse (better) outcomes than expected. Between October 2013 and September 2014 the trust score was 97.

Nutrition and hydration

- The majority of patients we spoke with said they were happy with the standard and choice of food available.
- Staff in surgical services managed the nutrition and hydration needs of patient's well, both pre and post operatively. Patients were given information in the form of leaflets about their surgery and told how long they would need to fast pre-operatively.
- In all the records we reviewed, a nutritional risk assessment had been completed and updated regularly. This helped identify patients at risk of malnutrition and adapt to any ongoing nutritional or hydration needs.
- A coloured tray system was in place to highlight which patients needed assistance with eating and drinking. The trust had an internal target to ensure that 75% of patients got assistance with eating when they required it. Information provided by the trust showed that they were not meeting this target in medical specialties.

Summary of findings

- Staff consistently completed charts used to record patients' fluid input and output and where appropriate staff escalated any concerns.

We saw several areas of outstanding practice including:

- We observed staff interacting with patients on a one to one basis and displaying a caring person centred attitude that went beyond what was expected. Staff encouraged patients and their relatives to be partners in their care. Staff went above and beyond to meet patient's preferences. We observed strong relationships between staff, patients and their relatives.
- Patients' needs and preferences were central to the planning and provision of services at Clatterbridge Hospital. One example of this was the repurposing of a clinical area into a domestic dwelling. This was designed to help prepare medical and surgical patients for discharge to their own home and bridge the gap between acute patient care and community rehabilitation. Patients could 'move' into the dwelling with their relatives for short periods before discharge. This helped staff identify whether any further measures were needed before patients were discharged. It also empowered patients to maintain their independence and improve their confidence prior to discharge. Staff told us that this had been introduced partly due to issues which were raised around patients discharge home when they felt they weren't ready.
- The sentinel stroke national audit programme (SSNAP) latest audit results rated the trust overall as a grade 'A' which was an improvement from the previous audit results when the trust was rated as a grade 'B'. Since October 2014 the trust had either been ranked first or second regionally in the SSNAP audit.

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

Importantly, the trust must:

Medical care (including older people)

- The trust must ensure that robust information is collected and analysed to support improvements in clinical and operational practice.
- The trust must deploy sufficient staff with the appropriate skills on the Clatterbridge rehabilitation unit at night.
- The trust must ensure there is adequate medical cover out of hours for the hospital.
- The trust must ensure there is a clear operational protocol for the transfer of patients who deteriorate on the Clatterbridge Hospital site.

Surgery

- The trust must ensure that all staff involved with the care and treatment of children receive adequate life support training.
- The trust must ensure there is sufficient medical cover out of hours for the hospital.
- The trust must ensure there is a clear operational protocol for the transfer of patients who deteriorate on the Clatterbridge Hospital site.
- The trust must ensure that the doors which lead to high balconies on the ward areas are suitably secured.

Outpatients and diagnostic imaging

- The trust must take action to reduce the delay in referral to reporting times of urgent diagnostic investigations.
- The trust must resume radiation safety committee meetings and hold them at least annually.
- The trust must take steps to fill vacancies to ensure compliance against their current staffing establishment.

In addition the trust should:

Medical care (including older people)

Summary of findings

- The trust should ensure that all patients consent to the use of bedrails and if they lack capacity to consent, the principles of the Mental Capacity Act (2005) are adhered to. Practice should be supported by clear policies, procedures and training.
- The trust should ensure that records are kept secure at all times so that they are only accessed and amended by authorised people.
- The trust should ensure that actions to improve standards of medicines management are identified and addressed in a timely way.
- 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.

Surgery

- The trust should ensure that senior managers are visible at the Clatterbridge Hospital on a regular basis and that staff at the site are engaged with the overall trust strategy and vision.

Outpatients and diagnostic imaging

- The trust should ensure all resuscitation trolleys are checked within the defined timescales and that documentation is completed to confirm it has been done.

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?
Medical care	Requires improvement 	Staffing was generally sufficient across the wards we inspected. However, there were some concerns regarding the number of staff on duty at night on the rehabilitation unit. There were also concerns about how a patient whose health was deteriorating would be transferred to the acute hospital site as there were no protocols in place to support this. Incidents were reported but not all staff were aware of lessons learnt or improvements that had been made following investigations. There were governance structures in place. However, some risks on the register had been there since 2012 and had not been managed in a timely way to lower the risk. Multi-disciplinary team meetings were not held on regular basis. All staff knew the trust vision but were unaware of the strategy for medical services. Care and treatment was provided in line with national and best practice guidelines. Patients received compassionate care and their privacy and dignity were maintained. Patients were involved in their care, and were provided with appropriate emotional support. The service took into account the needs of the local people and had a lot of systems in place to meet the needs of patients living with a cognitive impairment, such as dementia.
Surgery	Good 	Medicines were well managed and appropriately stored. Patient records were clear, legible and up to date. There were low rates of avoidable harm including infections and pressure ulcers. The auditing of care and treatment was undertaken on regular basis. Patients were treated with kindness, dignity and compassion and their relatives were involved in their care and treatment. The service took into account the needs of the local population. Complaints were well managed. The service was responsive to patient needs and had repurposed a clinical area into a flat in order to prepare patients and their families for discharge. Local ward managers and matrons were visible and known to staff. Staff did not always report incidents because of a lack of training on how to use the system. Medical staffing was sufficient to meet patient need

Summary of findings

during the day time but not out of hours because there was only one doctor to cover the whole hospital out of hours and the doctor was of a medical, not surgical speciality. There were also concerns about how a patient whose health was deteriorating would be transferred to the acute hospital site as there were no protocols in place to support this. The environment and equipment were visibly clean and equipment was well maintained. However, there were two unsecured doors which led directly from ward areas which presented a risk to patients who may leave the ward or from visitors entering undetected.

Outpatients and diagnostic imaging

Requires improvement

There were significant staff vacancies across the whole trust in diagnostic and imaging services. The service failed to meet the national target in July and August 2015 for referral to treatment times. In addition, the trust failed to meet their internal target for urgent reporting of plain x-rays between April 2015 and August 2015. There were a large number of clinic appointments cancelled due to the process in place for rebooking appointments. Managers had plans to implement a partial booking system to reduce cancellation of appointments and to offer patients more choice. Some clinical governance measures were in place for radiology however, there had been no radiation safety committee meetings since September 2012. Patients were treated in a dignified and respectful way by caring and committed staff. There was a clear process for reporting and investigating incidents and staff received feedback. Records were available for 99% of outpatient appointments. Mandatory Training was well attended and staff were aware of their role and responsibilities in relation to safeguarding.

Clatterbridge Hospital

Detailed findings

Services we looked at

Medical care (including older people's care); Surgery; Outpatients & Diagnostic Imaging

Detailed findings

Contents

Background to Clatterbridge Hospital

Clatterbridge Hospital is one of two hospital sites managed by Wirral University Teaching Hospitals NHS Foundation Trust. The hospital provides a range of health care services including elective orthopaedic surgery (planned operations), specialist stroke and neuro-rehabilitation services, elderly care and dermatology treatments. The elective surgery and stroke rehabilitation wards each have a total of 20 beds. In addition, the hospital offers a variety of outpatient services for a full range of specialities including dermatology, podiatry, cardiac, plastics, phlebotomy, x-ray, and the Wirral Breast Centre. Magnetic Resonance Imaging (MRI) scanning appointments were available but delivered by an external provider.

The hospital is located on the Wirral peninsula in the North West of England and serves the people of Wirral and neighbouring areas.

Wirral University Teaching Hospitals NHS Foundation Trust became a Foundation Trust on 1 July 2007. The trust provides services for around 400,000 people across Wirral, Ellesmere Port, Neston, North Wales and the wider North West footprint with over 850 beds trust-wide.

We inspected Clatterbridge Hospital as part of our inspection of Wirral University Teaching Hospitals NHS Foundation Trust.

Our inspection team

Our inspection team was led by:

Chair: Jenny Leggott

Head of Hospital Inspections: Ann Ford, Care Quality Commission

The team included a CQC inspection manager, five CQC inspectors and a variety of specialists including: a director of nursing, a deputy medical director, a medical care nurse, a consultant surgeon, a consultant haematologist a renal histopathologist, a senior nurse for theatres and day care, a ward manager, a senior lecturer in radiography and a student nurse. We also used an expert by experience who had experience of using healthcare services.

Detailed findings

How we carried out this inspection

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

• Is it safe?

• Is it effective?

• Is it caring?

• Is it responsive to people's needs?

• Is it well-led?

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

We held a listening event for people who had experienced care at either Arrowe Park Hospital or Clatterbridge Hospital on 8 September 2015 in Oxton. The event was designed to take into account people's views about care and treatment received at the hospital. Some people also shared their experiences by email and telephone.

The announced inspection of Clatterbridge Hospital took place on 16 – 17 September 2015. The inspection team inspected the following core services:

- Medical care (including older people's care)
- Surgery
- Outpatients and Diagnostic Imaging

As part of the inspection, we held focus groups and drop-in sessions with a range of staff in the hospital, including nurses, trainee doctors, consultants, student nurses, administrative and clerical staff and we also spoke with staff individually as requested.

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

We 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 Clatterbridge Hospital.

Facts and data about Clatterbridge Hospital

Clatterbridge Hospital is one of two hospital sites managed by Wirral University Teaching Hospitals NHS Foundation Trust. There are 855 beds across the trust in total, with 106 at Clatterbridge Hospital.

Wirral University Teaching Hospitals NHS Foundation Trust provides services for around 400,000 people Wirral, Ellesmere Port, Neston, North Wales and the wider North West footprint.

On the Wirral, there are higher than average levels of deprivation and about 15,300 children are estimated to live in poverty. Life expectancy for both men and women is lower than the England average.

In 2014/15 there were 41,693 elective day case admissions across the trust, 111,874 new outpatient attendances and 338,834 diagnostic examinations. The trust employs 4,782 members of staff.

Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Surgery	Requires improvement	Good	☆ Outstanding	Good	Good	Good
Outpatients and diagnostic imaging	Requires improvement	Not rated	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement

Notes

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

Medical care (including older people's care)

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

Information about the service

Clatterbridge Hospital provides medical care and treatment for predominantly low risk patients on an elderly care ward, patients undergoing rehabilitation and patients with dermatology conditions.

We visited Clatterbridge Hospital as part of our announced inspection on 17 September 2015.

As part of the inspection, we visited the dermatology unit and Clatterbridge rehabilitation centre (CRC) which had 10 beds for neurological patients and 20 beds for patients who had suffered a stroke.

We considered the environment and staffing levels as well as observing patient care within a multi-disciplinary setting. We spoke with ten patients, and five staff of different grades including a band 5 nurse, a sister, two ward managers and a doctor.

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

Summary of findings

Overall, at this inspection, we found that medical services at Clatterbridge Hospital required improvement.

Staffing was generally sufficient across the wards we inspected. However, there were some concerns regarding the number of staff on duty at night on the rehabilitation unit. There were also concerns about how a patient whose health was deteriorating would be transferred to the acute hospital site as there were no protocols in place to support this.

Incidents were reported by staff through effective systems but not all staff were aware of lessons learnt or improvements that had been made following investigations.

There were governance structures in place which included a risk register. However, some risks on the register had been there since 2012 and had not been managed in a timely way to lower the risk.

Multidisciplinary team meetings were not held on regular basis on all wards which meant that important information was not formally discussed by all members of the care team. All staff knew the trust vision but were unaware of the strategy for medical services.

There was good evidence of multidisciplinary team working and staff were aware of their responsibilities in relation to the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards.

Medical care (including older people's care)

Patients were observed receiving compassionate care and their privacy and dignity were maintained. Patients were involved in their care, and were provided with appropriate emotional support.

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 the falling leaf symbol to indicate that a patient was at risk of falls. This helped alert staff to patient needs.

Clinical staff had access to information they required, for example diagnostic tests and risk assessments and best practice guidance in relation to care and treatment was usually followed and medical services participated in national and local audits.

Are medical care services safe?

Requires improvement

Incidents were reported by staff through effective systems but not all staff were aware of lessons learnt or improvements that had been made following investigations.

Staffing was generally sufficient across the wards we inspected. However, there were some concerns regarding the number of staff on duty at night on the rehabilitation unit. There were also concerns about how a patient whose health was deteriorating would be transferred to the acute hospital site as there were no protocols in place to support this.

Record trolleys were left unlocked on the rehabilitation unit but records we looked at were documented accurately and medical decisions were documented clearly. However, there were some aspects of record keeping that required improvement.

On the dermatology ward, there were two areas of flooring which required attention as the flooring had started to lift which could be hazardous to staff and patients.

Staff were aware of how to ensure patients' were safeguarded from abuse.

The wards we inspected were visibly clean and staff displayed good hygiene practice. There was good monitoring of infections though we did not see any evidence of actions to improve standards.

There were systems in place to manage the safe administration and prescribing of medication. Audits had been undertaken but actions had not always been identified to help staff improve when standards had not been met. None of the medication errors in medical services had been recorded as high risk.

Staff attended mandatory training courses and compliance rates were above the trust target. There were effective systems in place to ensure patient safety was monitored and maintained.

Incidents

- Staff were familiar with and encouraged to use the trust's policy and procedures for reporting incidents. Incidents were reported through the trust's electronic reporting system and we spoke with a range of staff across the service who were all aware of how to report incidents. However, not all staff received feedback or learning from incidents they reported.
- Between May 2014 and June 2015 there had been two serious incidents reported throughout medical services at the hospital. Information provided by the trust showed these were down to pressure ulcers and slips, trips and falls.
- A root cause analysis tool was used to investigate serious incidents, and we saw that where required an action plan was put in place to reduce the risk of similar incidents happening again. Action plans included evidence of feedback and actions for learning and where necessary, action plans indicated where further training for staff was required.
- Between March 2015 and June 2015 medical services across the trust, reported 569 incidents. Of these, two were related to treatment delay at the Clatterbridge Rehabilitation Centre (CRC) which did not cause any harm and actions taken were documented.
- Information about incidents was discussed for medical care as part of clinical governance meetings each month, but it was not always clear how identified learning was going to be cascaded to ward staff or whether it had already been shared.
- Incidents were not discussed during the May 2015 divisional management team (DMT) business performance meeting. The clinical governance meetings reported into the DMT meeting and the terms of reference for this meeting included considering trends in relation to incidents and to consider escalation of concerns about compliance with root cause analysis actions. It did not appear that incidents were being considered in the DMT meetings.
- Mortality and morbidity themes and trends were discussed as part of the service clinical governance meeting; however, it was unclear if any actions for improvement were agreed at the meeting.
- The trust had a duty of candour process in place to ensure that people had been appropriately informed of an incident and the actions that had been taken to prevent recurrence. The aim of the duty of candour regulation is to ensure trusts are open and transparent with people who use services and inform and apologise to them when things go wrong with their care and treatment.

Safety thermometer

- The NHS safety thermometer is a national improvement tool for measuring, monitoring and analysing avoidable harm to patients and 'harm free' care. Performance against the four possible harms; falls, pressure ulcers, catheter acquired urinary tract infections (CAUTI) and blood clots (venous thromboembolism or VTE), was monitored on a monthly basis.
- Safety thermometer information was for medical services across the trust and not separated into different sites. The number of pressure ulcers, falls and CAUTI's remained relatively consistent throughout June 2014 to June 2015. The total number of pressure ulcers was 37, the total number of falls that resulted in harm was 10 and the total number of CAUTI's was six over the 12 month period. The trust was monitoring incidents of pressure ulcers and falls through their performance dashboard each month and these were discussed at the divisional management team (DMT) meeting. The number of falls showed that they were above the trust target on the performance dashboard.
- Safety thermometer information was prominently displayed on all of the medical wards and units we visited.
- A ward manager told us that they did not receive feedback on the findings although they were aware of changes in practice that had taken place as a result of a recent safety thermometer audit.
- There was a trust policy for the prevention of slips, trips and falls but did not include information about what staff should do after a patient fall. This was on the trust risk register with actions identified such as looking at record keeping after a fall.

Cleanliness, infection control and hygiene

- Staff followed good practice guidance in relation to the control and prevention of infection in line with trust policies and procedures. There was a sufficient number of hand wash sinks and hand gels. Hand towel and soap dispensers were adequately stocked. We observed staff following hand hygiene practice, bare below the elbow and using personal protective equipment where appropriate.

Medical care (including older people's care)

- Between March 2015 and August 2015 the trust reported 21 cases of clostridium difficile infections, two cases of MRSA and six cases of MSSA. The data could not be split so as to separate cases that specifically occurred at Clatterbridge Hospital.
- Wards used the 'I am clean' stickers to inform colleagues at a glance that equipment or furniture had been cleaned and was ready for use.
- Although the majority of wards we visited were visibly clean and free from odour, we observed that there was some staining to flooring and fixtures on the dermatology ward. Staff said this related to treatments used.
- Monthly infection control audits were undertaken across all wards which looked at standards such as cleaning schedules and if hand wash basins were accessible, in a good state of repair and clean We looked at the results of the dermatology ward which showed that ward was 97% compliant with the standards. However, no actions were identified on the audit tool to improve infection control standards.
- Weekly hand hygiene audits were undertaken by staff being observed. Results were mostly around 100% across medical wards at the hospital. If the results were below 100%, ward managers were informed to raise with staff individually.
- All wards had antibacterial gel dispensers at the entrances and by people's bedside areas and that appropriate signage, regarding hand washing for staff and visitors, was on display
- Side rooms were used where possible as isolation rooms for patients at increased risk of cross infection. There was clear signage outside the rooms so that staff were aware of the increased precautions they must take when entering and leaving the room.
- 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.

Environment and equipment

- In order to maintain the security of patients, visitors were required to use the intercom system outside wards to identify themselves on arrival before they were able to access the ward and staff had access codes.
- Each clinical area had resuscitation equipment readily available. There were systems in place to ensure it was checked and ready for use on a daily basis. Records indicated that daily checks of the equipment had taken place on the wards we visited.
- Throughout our inspection we did not identify any major environmental risks or hazards. However we did notice that wheelchairs were being stored in patient bays on CRC as there was a lack of storage space. This posed a safety risk to patients. There was a bathroom that was no longer used that was awaiting refurbishment into a store room, however staff were not aware of the timeframe for this to happen. There were other bath and shower facilities for patients.
- The dermatology ward decoration was dated and one bathroom was stained due to the treatments used. The flooring in this room, and one other toilet, was coming away at the edge, which could present a risk of injury to patients. This was highlighted to the ward manager for action.
- Patient led assessments of the care environment (PLACE) in 2014 showed a standard of 96% in the trust for condition, maintenance and appearance.

Medicines

- Medicines were prescribed electronically throughout the medical specialities.
- Between August 2014 and September 2015 there had been 332 medication errors reported in medical services across the trust but we could not disaggregate this to show how many occurred at Clatterbridge Hospital. Of those, 270 reported the primary cause as prescribing and 75 had the primary cause as administration. Medication errors were categorised into low, moderate or high risk. None of the reported errors were recorded as high risk.
- Medication errors were discussed at the clinical governance meeting although it was unclear what learning had taken place. Actions to address the trends identified from 2012/13 incidents were only just being formally discussed in March 2015. This meant there was a risk that learning was not happening in a timely way.
- Medicines requiring cool storage at temperatures below eight degrees centigrade were appropriately stored in fridges. Daily temperature checklists were consistently

completed on the wards we visited. Minimum and maximum temperatures of between two and eight degrees were documented alongside the daily fridge temperature.

- Controlled drugs (medicines which are required to be stored and recorded separately) were stored and recorded appropriately. Access was limited to qualified staff employed by the trust. Two nurses were observed following the correct procedures for the recording and administration of controlled drugs for a patient.
- There was a pharmacy top-up service for medicines that the ward stocked and other medicines were ordered on an individual basis.
- A pharmacist visited medical wards each week day. Pharmacy staff said they checked that the medicines patients were taking when they were admitted to the wards were correct and that records were up to date.
- There were matron monthly medicines management audits which looked at compliance with storage of medicines. We looked at the findings for August 2015 audit and saw that the dermatology ward met all the standards but the CRC did not meet all the standards. No actions had been identified for the ward sister to implement.
- We looked at two patient's electronic prescription charts, which were fully completed and both had the patient's allergy status documented.

Records

- We reviewed two care records and saw that recent entries were legible, signed and dated. They were easy to follow and medical staff had detailed information for patient's care and treatment. Documentation kept to record people's vital signs, fluid balance charts and food intake were fully completed.
- The hospital used paper-based and electronic records. Patient records included a range of risk assessments and care plans that were completed on admission and were updated throughout a patient's stay.
- We observed that for each patient there were up to three sets of records which were a mixture of paper based records and electronic records. This meant there may be a risk that important information may be difficult to find in an emergency.
- Wards had lockable patient note trolleys. On CRC we observed that trolleys containing patient notes were left opened and unattended in the corridors. This increased the potential for patient confidentiality to be breached. However, on the dermatology ward we visited patient note trolleys were not left unlocked or unattended.
- The trust recently reintroduced a monthly medical records audit. We reviewed the information between August 2015 and September 2015. The two wards we visited fell below the 75% compliance target in three of the standards. For example, out of the records reviewed on CRC only 33% had the patient NHS number on each page which is a key patient identifier. However all the records reviewed did have a treatment plan. The trust recommended services put in place action plans to improve compliance levels.
- The patient information boards that were visible in ward corridors respected patient confidentiality by patient names being covered up. Patient information boards were used to provide an overview of the key risks, medication and discharge plans for each patient at a glance.

Safeguarding

- Safeguarding policies and procedures were in place and staff knew how to refer a safeguarding issue to protect adults and children from abuse. The trust had a safeguarding team which provided guidance during the day in the week. Staff had access to advice out of hours and at weekends from the hospital co-ordinator or the local authority duty social worker.
- Between April 2014 and April 2015 there had been 900 referrals made to the trust safeguarding team which was a 5% increase from the previous year for medical services across the trust
- Training statistics provided by the trust showed that in medical services across the trust, 65% of medical staff and 76% of nursing staff had completed safeguarding level 1 training. In addition, 78% of medical staff and 70% of nursing staff had completed safeguarding level 2 training with only 20% of nursing staff and no medical staff had completed safeguarding level 3 training. The trust target was 90%.
- Basic 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 18 month programme (block B) in areas such as infection control and medicines management and a three year rolling programme (block A) in areas such as safeguarding, manual handling and fire.
- At the time of our inspection, 76% of staff in medical services across the trust had completed their required mandatory 18 monthly training and 90% of staff had completed their required three yearly training. The trust target was 95%.
- We saw a monthly spreadsheet on the dermatology ward to review staff training dates and compliance.

Assessing and responding to patient risk

- The trust did not have a standard protocol in place for patients who deteriorated and required transfer to an acute hospital. Staff said they would telephone 999 for an emergency ambulance.
- A modified early warning score system (MEWS) was used throughout the trust to alert staff if a patient's condition was deteriorating. This was a basic set of observations such as respiratory rate, temperature, blood pressure and pain score used to alert staff to any changes in a patient's condition.
- Early warning indicators were regularly checked and assessed. When the scores indicated that medical reviews were required, staff knew how to escalate their concerns.
- There was a medical emergency outreach team which was used for patients whose early warning score was above a certain level (a score of seven or above).
- Upon admission to medical wards, staff carried out risk assessments to identify patients at risk of harm. The risk assessments included falls, use of bed rails, pressure ulcer and nutrition (malnutrition universal screening tool or MUST).
- The trust undertook a modern matron ward round every month where the allocated matron visited the ward area to look at leadership, documentation, patient safety, and nutrition and infection control.
- The matron's ward round documentation for the CRC showed that the overall score for the standards being met was 92% in January 2015. The audit was not completed again until June 2015 when the overall score fell to 76% and then improved in July 2015 to 82%. Forward 36, the overall score for the standards being met was 72% in December 2014. The audit was not completed again unit June 2015 when the overall score was 71% and then improved in July 2015 to 83%. The documentation provided by the trust did not include any actions required to improve the overall score or patient care.

Nursing staffing

- Matrons met each day to discuss nurse staffing levels across medical services to ensure that there was good allocation of staff and skills were appropriately deployed and shared across all wards. In July 2015 there were still 70 nursing vacancies in medical and acute services across the trust and this was recorded on the risk register. There were actions identified to mitigate this risk such as a rolling recruitment programme. Managers knew when there were shortfalls and where there was surplus on other wards so that staff that could be called on if needed.
- Medical wards displayed nurse staffing information on a board at the ward entrance. This included the planned and actual staffing levels. This meant that people who used the services were aware of the available staff and whether staffing levels were in line with the planned requirement.
- The trust had a target that 95% of nursing shifts should be filled as planned during the day and night. We reviewed staffing figures for the dermatology ward. For September 2015 all nursing shifts were filled as planned for day and night shifts. The staffing figures for the CRC between June 2015 and September 2015 were also meeting the trust target.
- However, there were concerns regarding the number of nurses on duty during the night on the CRC and ward 36. The staffing figures provided by the trust, showed that there were only ever two trained nurses planned to be on duty during the night. This was a ratio of one nurse to 13 patients on ward 36 and a ratio of one nurse to 15 patients on the CRC. Patients on the CRC had neurological conditions and some had suffered a stroke, whilst ward 36 was an elderly care ward.
- There were 11 incidents recorded for CRC between September 2014 and September 2015 due to staff shortages. These mainly related to obtaining extra staff for patients requiring one to one care.
- We looked at the latest acuity assessment of the unit which showed a comparison of the total staffing establishment against The British Society of

Medical care (including older people's care)

Rehabilitation guidelines and a neighbouring NHS Trust. The assessment was completed in May 2014 resulting in the increase in staffing of one band 6 and 4.14 whole time equivalent (WTE) band 2 clinical support workers.

- A planned review of staffing for the CRC was scheduled for November 2015 utilising the 'Shelford Group' safer nursing care tool. The trust was also looking at best practice at neighbouring hospitals.
- The vacancy rate for nursing staff in medical services trust wide was 13% at the time of the inspection. The turnover of nursing staff was 9.7%.
- Most wards at the hospital had recently begun to use the e-rostering system. This was a central system for managing information such as shift patterns, annual leave, sickness and staffing skill mix.

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 trust. All medical trainees contributed to this rota. The information we reviewed showed that medical staffing during the day was appropriate at the time of the inspection.
- At night there was only one junior doctor on duty for Clatterbridge Hospital. One incident had been recorded in June 2015 for medical staffing. The incident report stated that issues of insufficient medical cover for CRC had been raised on many occasions.
- There were still some medical staffing vacancies in medical services across the trust and this was on the medical risk register. There were actions identified to mitigate this risk such as a rolling recruitment programme.
- The percentage of consultants working in medical services trust wide was 41% which was higher (better) than the England average of 34%. The percentage of registrars was 30% which was below (worse) the England average of 39%. Middle grade and junior doctor levels were about the same as the England average.
- The vacancy rate for medical staff was 18% and the turnover of medical staff in medical services trust wide was 18% at the time of the inspection.
- The total number of shifts covered by locum medical staff in medical services trust wide, between April 2015 and September 2015, was 1,428. This was for a number of reasons including, vacancies, extra staffing over and above the normal levels and extra ward rounds. Locums were either trust staff working extra shifts or from an agency.

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.

Are medical care services effective?

Good

Care and treatment was provided in line with national and best practice guidelines and medical services participated in the majority of clinical audits where they were eligible to take part.

The sentinel stroke national audit programme (SSNAP) latest audit results rated the trust overall as a grade 'A' which was an improvement from the previous audit results when the trust was rated as a grade 'B'. Since October 2014, the trust had either been ranked first or second regionally in the SSNAP audit. The trust had put in place actions to improve the audit results.

The most recent heart failure and diabetes audits showed the hospital performed better than average for the majority of indicators. However, the service still needed to make improvements to the care and treatment of people who had chronic obstructive pulmonary disease (COPD). Nutrition and fluid intake were mostly recorded correctly.

There was a focus on discharge planning from the moment of admission and there was good multidisciplinary working to support this.

There was evidence of providing services seven days a week. Most staff said they were supported effectively and 89% of staff had received their annual appraisal which was above the trust target.

The trust was not meeting its own target for assisting patients with eating.

Medical care (including older people's care)

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 principals 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.

Evidence-based care and treatment

- The service used national and best practice guidelines to care for and treat patients. The trust monitored compliance with National Institute for Health and Care Excellence (NICE) guidance and were taking steps to improve compliance where further actions had been identified.
- The service participated in all but one of the clinical audits for which it was eligible through the advancing quality programme. In February and March 2015 audits demonstrated the trust were not meeting the appropriate care score target for stoke and chronic obstructive pulmonary disease (COPD).
- There were examples of recent local audits that had been completed on the wards. These included documentation and discharge audits. Action plans were completed following clinical audits to address any areas identified for improvement. Senior staff said they received the results of the audits and learning was shared with them via email.

Pain relief

- Pain relief was managed on an individual basis and was regularly monitored.
- Patients told us that they were asked about their pain and supported to manage it.

Nutrition and hydration

- A coloured tray system was in place to highlight which patients needed assistance with eating and drinking. The mealtime co-ordinators communicated with the catering staff and ensured all patients received a meal. The trust had an internal target to ensure that 75% of patients got assistance with eating when they required it. Information provided by the trust showed that they were not meeting this target. The trust had taken a number of actions including practical measures such as opening sandwich packets for patients and cutting the sandwiches into small triangles and providing soft fruits which were easier to eat.
- There was a food board which listed dietary requirements identified, for example identifying if patients were diabetic, dysphasic, on a low residue diet or needed their food cutting up.
- The majority of patients we spoke with said they were happy with the standard and choice of food available. However a number of patients told us that lunchtime meal were sandwiches and soup only. If patients missed a meal as they were not on the ward at the time, staff were able to order a snack bag for them.

Patient outcomes

- The readmission rates for dermatology at the hospital were similar to the England average.
- The sentinel stroke national audit programme (SSNAP) latest audit results rated the trust overall as a grade 'A' which was an improvement from the previous audit results when the trust was rated as a grade 'B'. Since October 2014, the trust had either been ranked first or second regionally in the SSNAP audit. The trust had actions in place to improve care. These included dedicated stroke beds 'out of beds escalation policy' and weekly meetings to discuss the patient journey for people who'd had a stroke.
- In the 2013 national diabetes inpatient audit (NaDIA) the trust performed better than the England average in 13 of the 21 indicators. The trust performed worse than the England average in foot assessments.
- The Summary Hospital-level Mortality Indicator (SHMI) is a set of data indicators which is used to measure mortality outcomes at trust level across the NHS in England using a standard and transparent methodology. The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated at the hospital. The risk score is the ratio between the actual and expected number of adverse outcomes. A score of 100 would mean that the number of adverse outcomes is as expected compared to England. A score of over 100 means more adverse (worse) outcomes than expected and a score of less than 100 means less adverse (better) outcomes than expected. Between October 2013 and September 2014 the trust score was 97.

Competent staff

Medical care (including older people's care)

- Staff told us they received an annual appraisal. According to trust figures 99% of medical of staff in medical care services across the trust had received their annual appraisal and 79% of nursing staff. The trust target was 85%.
- The trust did not have a clinical supervision policy. Qualified staff told us there were no formal systems for clinical supervision. 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. 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.
- There was a preceptorship programme which supported junior nursing staff. Their competency in undertaking care procedures was assessed by qualified staff.
- The trust was involved in the apprenticeship nursing scheme with the skills for health academy. Cadet nurses were undertaking a national vocational qualification in care. This helped ensure that any future applications for nursing posts were from competent people who had the skills and experience required. The trust had recently become the employer of the year for apprenticeships.
- Staff in bands 1-4 were offered opportunities to undertake appropriate vocational qualifications; however there was no service overview of which staff had gained such qualifications.
- Medical services ensured that healthcare support workers undertook 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.

Multidisciplinary working

- Multidisciplinary team (MDT) working was established on medical wards.
- Ward teams had access to the full range of allied health professionals and 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. •
- A psychiatric liaison service was available within the trust which provided advice and support to staff.
- Nursing staff in the dermatology unit worked alongside outpatient clinic staff to provide a multidisciplinary approach. They also offered outreach support to other wards across the trust that had patients requiring dermatological treatments.

Seven-day services

- Consultants were available during the day Monday to Friday and 9am to 3.30pm at weekends. There was limited medical cover outside these hours with only one junior doctor on duty for all services at Clatterbridge hospital.
- The trust has a workforce and organisational development strategy 2015 – 2018. Two of the objectives were about ensuring that consultant job plans match service demand and support seven day delivery and to review the need for seven day services by clinical area and develop staffing models that match service demand.

Access to information

- 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 trust intranet site which meant all staff had access to them when required.
- On the wards there were files containing minutes of meetings, ward which were available to staff.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff were knowledgeable about the key principles of the Mental Capacity Act (2005) and how these applied to patient care was
- Information provided by the trust showed that only 14% of staff in medical services trust wide had completed mental capacity act level 2 training and 7% had completed level 3 training. Mental capacity act training level 1 was incorporated within level 1 safeguarding training
- Staff had knowledge and understanding of procedures relating to the Deprivation of Liberty Safeguards (DoLs). DoLs are part of the Mental Capacity Act 2005. They aim to make sure that people in hospital are looked after in

a way that does not inappropriately restrict their freedom and are only done when it is in the best interest of the person and there is no other way to look after them. This includes people who may lack capacity.
- There were neuro-psychologists available on the rehabilitation unit who provided advice and support for staff when carrying out capacity assessments.
- Staff were not always following the key principles when using bed rails for patients. The bed rails assessment did not include the recording of consent or best interests' decisions for the use of bed rails. Staff we spoke to at all levels did not know that the use of bed rails is seen as a form of restraint in the national medical council code of practice. The trust policy for behaviour management and the use of restraint does mention that bedrails are a form of mechanical restraint but offers not further guidance.

Are medical care services caring?

Good

Patients told us staff were caring, kind and respected their wishes. They were complimentary about the staff that cared for them. Patients received compassionate care and their privacy and dignity were maintained

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

Compassionate care

- Medical services were delivered by caring and compassionate staff. We observed staff treat patients with dignity and respect.
- We spoke to ten patients throughout our inspection. All patients we spoke with were positive about their care and treatment.
- The trust was performing better than the England average in all 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 all other trusts in all areas of the 2014 CQC inpatient survey.

Understanding and involvement of patients and those close to them

- Patients all had a named nurse and consultant. Patients were aware of this and on the wards we visited; they were displayed on a board above the bed.
- Patients we spoke with said they had received good information about their condition and treatment and felt they were involved in their care planning. Most patients could explain their care plan and patients due to be discharged were aware of the plan.
- Patients said that they felt safe and had received orientation to the ward area on admission.

Emotional support

- Staff felt that they had time to spend with patients when they needed support. They said that emotional support was vital for patients with skin conditions.
- Visiting times met the needs of the relatives we spoke to. Open visiting times were available if patients needed support from their relatives.
- Patients and those close to them told us that clinical staff were approachable and they were able to talk to them if they needed to.
- The rehabilitation centre helped patients and their families seek support and advice from local organisations who provided support for people who had suffered a stroke or had a neurological condition.
- Chaplaincy services were available for patients if required.

Are medical care services responsive?

Good

Medical services took into account the needs of the local people. There were good systems in place at Clatterbridge Hospital 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. There was a clear focus on discharge planning and ward discharge co-ordinators were in place.

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 the falling leaf symbol to

indicate that a patient was at risk of falls. 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.

Service planning and delivery to meet the needs of local people

- The trust was working with health partners in the locality, leading one of the vanguard sites across the country to develop a new healthcare model bringing GPs, community services, mental health and hospital services closer together to re-shape how services are provided. Vanguard means to lead the way in new developments or ideas.
- Patients could be referred from local community health professionals such as GPs or physiotherapists
- The facilities and premises were appropriate for the services that were planned and delivered.

Access and flow

- Between April 2015 and July 2015 bed occupancy across medical services at the trust was consistently above 90%. Evidence shows when bed occupancy rises above 85% it can start to affect the quality of care provided to patients and the orderly running of the hospital.
- Senior staff told us that they had recently employed a member of staff who was skilled in transformation changes and are looking at ways to reduce the bed occupancy across the trust to below 90% but this will take time.
- There was a focus on discharge planning for patients and wards. Staff discussed discharges each day and at the bed management meeting. Discharge letters were sent to general practitioners and the patient also received a copy.
- Length of stay for dermatology for planned admissions was 14.8 days which was longer (worse) than the England average of 4 days.
- The average length of stay for rehabilitation services at the hospital was 92.6 days which was longer (worse) than the England average of 23.5 days. This was attributed to issues relating to accessing care packages and the complex needs of the patients who accessed the service.
- The trust were working with community services to increase the number of transitional beds from 40 to 70 whilst patients wait for their preferred care home. Staff said that from October 2015 there will be a fortnightly discharge planning group to look at best practice around discharges. This group will include community colleagues and social services.
- Meetings about bed availability were held three times a day to determine priorities, capacity and demand for all specialities. These were attended by both senior management staff and senior clinical staff.
- There was a multidisciplinary integrated discharge team to support the discharge of patients across the trust. This team worked seven days a week. The team had trialled criteria led discharges and also piloted designated discharge co-ordinators to individual wards. Staff told us that both projects had been evaluated but they were not aware of the outcome even though they had been involved in the projects.

Meeting people's individual needs

- The trust used a yellow circle symbol to indicate that a patient 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
- There was a specialist nurse for older people, who was the clinical lead for dementia who provided support for staff and a central point for queries. The trust also had access to a psychiatric liaison team who saw and assessed appropriate patients with a cognitive impairment.
- The hospital had implemented the 'forget-me-not' sticker scheme. This was a discreet flower symbol used as visual reminder to staff that patients were living with dementia or were confused. This was to ensure that patients received appropriate care, reducing the stress for the patient and increasing safety.
- The service has a dementia strategy covering four years from 2014 to 2018. It included thirty separate actions covering Joint Advisory Group (JAG) training, clinical leadership, support for carers, assessment and care planning, and a dementia-friendly environment.
- Translation services and interpreters were available to support patients whose first language was not English. Staff confirmed they knew how to access these services.
- Care plans we saw were not always personalised to identify individual needs but did contain the necessary information to ensure that patients were not at risk.

Medical care (including older people's care)

- Leaflets were available for patients about services and the care they were receiving. Staff knew how to access copies in an accessible format, for people living with dementia or learning disabilities, and in braille for patients who had a visual impairment.
- There was a nurse specialist for diabetes who offered specialist advice to staff caring for people with this condition.
- Hoists to accommodate patients of different sizes were available for use in assisted bathrooms which also had an adjustable bath.
- There was a therapy area in the rehabilitation unit with stairs and assessment equipment. This was used to assess patient mobility and how they would manage at home.
- The unit also had a furnished flat available within the clinical area to help assess a patient's capability to manage prior to discharge home. An individual patient could live there and relatives could visit and assist in their care.
- Staff had a team approach to dealing with patients with complex needs

Learning from complaints and concerns

- Patients and those close to them knew how to raise concerns or make a complaint. The trust encouraged people who used services, those close to them or their representatives to provide feedback about their care.
- There were leaflets available on the wards which explained the complaints procedure and the Patient Advice and Liaison Service (PALS)
- Learning from individual complaints was disseminated via team meetings and wards displayed the compliments they received on information boards.
- A PALS report for the trust, which included medical services, showed a number of concerns raised going back to 2014 with the outcome not yet recorded. The report showed no evidence of analysis of trends or learning.

Are medical care services well-led?

Requires improvement

All staff knew the trust vision but were unaware of the strategy for medical services. There was a clear governance structure but there was limited evidence of learning discussed at key meetings and although a significant amount of data was captured this was not always consistently reported on and used effectively to inform clinical practice.

There was a risk register but some risks had been on since 2012 with actions still to be completed. This meant that risks might not be managed in a timely way.

Medication errors were discussed at the clinical governance meeting although it was unclear what learning had taken place. Actions to address the trends identified from 2012/13 incidents were only just being formally discussed in March 2015.

Multidisciplinary team meetings were not held on regular basis on all wards which meant that important information was not shared formally or discussed by all members of the care team.

The majority of staff said they felt supported and said that morale in medical services had improved over the past six months. Staff on the Dermatology Unit said the matron was supportive regarding staffing issues on the ward, and the director of nursing had visited the ward listening to issues and supporting staff.

Vision and strategy for this service

- The trust's vision was summarised as the PROUD approach of care, which stood for patient, respect, ownership, unity, dedication. Staff were aware of the vision and they were displayed on the notice boards.
- The trust's strategic objectives were based on the vision and these objectives cascaded down to service and individual objectives for staff.
- Medical services had a five-year strategy for 2014 – 2019. This included objectives such as ensuring all wards deliver a friends and family test score of 90% and a reduction in the number of hospital acquired infections. It also outlined how the delivery of the 6C's would be implemented. The 6C's are core values for staff and they are caring, compassion, communication, courage, competence and commitment. Whilst the strategy outlined the plans there was no clear underpinning action plan with specific timeframes and responsibility. Staff we spoke to were aware of the trust strategy but not aware of the strategy in medical services.

Medical care (including older people's care)

- NHS staff survey results for 2014 showed that 69% of staff said they had clear planned goals and objectives. The response rate for the trust was 46% which was above the England average but below the response rate in 2013 of 60%.

Governance, risk management and quality measurement

- The risk register highlighted risks across medical services and actions were in place to address concerns for example failure to meet National Institute of Care Excellence (NICE) guidelines. However, from the information provided by the trust we were not assured that risks were being managed appropriately as there were risks on the register since 2012 with actions still being completed and the actions did not always have target dates for completion even though risks were being reviewed on a regular basis.
- Medication errors were discussed at the clinical governance meeting although it was unclear what learning had taken place. Actions to address the trends identified from 2012/13 incidents were only just being formally discussed in March 2015.
- Senior staff knew that there was a risk register and ward managers were able to tell us what the key risks were for their area of responsibility.
- There was a clear governance reporting structure in medical services and the main divisional management performance meeting was held on a monthly basis. As part of the meeting there was a review of the risk register, incident, infection, audits, complaints and feedback from other meetings. However, actions were identified but it was not clear who the lead was for the action and the date the action was to have been completed. There was limited learning discussed at the meetings with the emphasis being on timeframes and numbers.
- Multidisciplinary team meetings were not held regularly on each medical ward. There was evidence that regular team meetings took place on the dermatology ward and these were minuted and cascaded to staff via email.

Leadership of service

- Staff reported having a named link to the trust's board. Staff could explain the leadership structure within the trust and the executive team were accessible to staff.
- Staff on the dermatology unit said the matron was supportive regarding staffing issues on the ward, and the director of nursing had visited the ward listening to issues and supporting staff.
- 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 there had been an improvement in staff morale in the last 12 months.
- We observed good working relationships within all teams and staff said there was a positive culture around challenging decisions by other staff.
- The latest staff friends and family test results for 2014-15, show that 69% of staff would recommend the organisation as a place to be treated. 51% of staff would recommend the organisation as a place to work. There were 208 responses from a total of 5810 staff to these two questions.

Public engagement

- The dermatology ward ran a patient led action learning group, where concerns could be raised and discussed and new ideas put forward.
- This hospital participated in the NHS friends and family test giving people who used services the opportunity to provide feedback about care and treatment. 98% of patients would recommend services at the hospital to friends or a relative.

Staff engagement

- The trust recognised the achievements of staff at an annual celebration event, the 'proud awards'. The dermatology ward won team of the year for 2014 and have been nominated for awards this year.
- The trust held regular 'listening into action' sessions for staff to engage with senior executive staff to discuss any issues or ideas. Medical services also held 'matron surgeries' for staff to talk to the matrons about any issues
- Staff participated in the 2014 staff survey. This included how staff felt about the organisation and their personal development. 60% off staff at the trust felt the training and development they had undertaken had helped them to deliver a better patient experience and 64% felt it had helped them to do the job more effectively. 59%

felt that they were valued by managers. This was lower than the national average of 63%. The response rate was 46%, slightly higher than the national average of 42%.

Innovation, improvement and sustainability

- An analysis of the 2014 staff survey results showed 64% of staff in medical services who responded, felt they were able to make suggestions to improve the work of their team/department. This was worse than the national average of 74%
- The survey also showed that 64% of staff said they had frequent opportunities to show initiative in their role. 42% of staff said they were involved in deciding on changes to improve services for patients. This was worse than the national average of 53%.
- There were several plans for improvements in the near future but staff were unable to give timescales. For example medical services had plans to increase therapy staff at weekends on the rehabilitation unit and for a weekend discharge team to be available.

Surgery

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

Information about the service

We visited Clatterbridge Hospital as part of our announced inspection on 16 to 18 September 2015. Clatterbridge hospital carries out a range of planned surgical services including: urology, ophthalmology, orthopaedics and general surgery. There are two surgical wards and five theatres that carry out elective procedures including day case procedures.

Data provided showed that 10,130 patients were admitted for surgical care between January 2014 and December 2014 at Clatterbridge Hospital. Of those, 81% were for elective (planned) surgery.

As part of the inspection we visited the main theatre areas, including the recovery area and observed parts of two operations. We visited both inpatient surgical wards and the day case unit.

We spoke with five patients, observed care and treatment and tracked two patients care from their admission to surgery. We reviewed seven care records and spoke with a range of staff of different grades and specialities including nurses, doctors, ward managers and matrons.

Summary of findings

We found that Clatterbridge hospital was delivering good surgical services to patients but some areas required improvement.

Medicines were well managed and appropriately stored. Patient records were clear, legible and up to date.

There were low rates of avoidable harm including infections and pressure ulcers. Staff completed risk assessments fully and implemented measures to minimise risk to patients.

Regular auditing of care and treatment was undertaken on regular basis. Patients were treated with kindness, dignity and compassion and their relatives were involved in their care and treatment.

The service was responsive to patients needs and planned services while taking into account the needs of the local population. There were no issues found in relation to access and flow. The service managed complaints well and we saw evidence that learning from complaints took place. We saw examples of outstanding responsive practices including the repurposing of a clinical area into a flat to prepare patients and their families for their discharge.

Surgical services were well led at a local level. However, staff told us they felt they were often 'forgotten' by senior managers. Staff were not clear what the trusts vision was and were not able to tell us how they contributed to it in their daily, working lives. Local ward

Surgery

managers and matrons were visible and known to staff. However staff told us they rarely saw senior managers above matron level and felt disconnected with the trust board.

There was evidence that the service strived to continually improve through public and staff engagement.

However, there were some areas for improvement:

Staff did not receive training on how to use the incident reporting system and as a result told us that they did not always report incidents.

Medical staffing was sufficient to meet patient need during the day time but not out of hours. Staff told us that they had access to advice from medical staff at Arrowe Park Hospital. However, there was only one doctor to cover the whole hospital during out of hour's periods and this doctor was of a medical, not surgical speciality. To compound this, there were also concerns about how a patient whose health was deteriorating would be transferred to the acute hospital site as there were no protocols in place to support this. We were told of an example where a patient waited longer than they should have to be transferred after suffering problems with their heart after surgery.

The environment and equipment were visibly clean and equipment was well maintained. However, there were two unsecured doors which led directly from ward areas which presented a risk to patients who may leave the ward or from visitors entering undetected.

Are surgery services safe?

Requires improvement

Incident reporting varied across surgical services. Staff did not receive training on how to use the incident reporting system and told us they did not always feel comfortable or confident in using the incident reporting system as a result. When incidents were reported, feedback was not consistently given. However, we saw evidence that the service had responded and learned from adverse incidents.

Medical staffing was not sufficient out of hours. Staff told us that they had access to advice from medical staff at Arrowe Park Hospital. However, there was only one doctor to cover the whole hospital outside of normal working hours and this doctor was of a medical, not surgical speciality. To compound this, there were also concerns about how a patient whose health was deteriorating would be transferred to the acute hospital site as there were no protocols in place to support this. We were told of an example where a patient waited longer than they should have to be transferred after suffering problems with their heart after surgery.

The environment was visibly clean and equipment was well maintained. However, there were two unsecured doors which led directly from ward areas which presented a risk to patients who may leave the ward or from visitors entering undetected.

We found that most staff had not undertaken paediatric life support training.

The service collected and displayed safety thermometer data. The rates of avoidable harm were within national averages.

Staff were aware of the trusts major incident policy and were able to show us a folder which contained details on what staff were to do in the event of a major incident.

The majority of staff had completed their mandatory training and were aware of how to raise and manage safeguarding issues.

The environment and equipment were visibly clean and equipment was well maintained, with the exception of one tourniquet machine in the theatre area which was found to be rusty.

Surgery

Medicines were well managed and appropriately stored. Patient records were clear, legible and up to date.

Incidents

- Staff understanding in relation to incident reporting within surgical services varied.
- There was an electronic incident reporting system in place which was available to all staff. When staff did report incidents, managers reviewed them and took appropriate responsive actions. Staff told us they did not receive feedback from incidents that they had raised but did receive general themes and lessons learned from incidents.
- Staff were aware of the types of incident they should report and were able to give us examples such as pressure ulcers and patient falls.
- The trust did not stipulate that training on how to use the incident reporting system was mandatory. Staff told us that they had not received training on how to use the incident reporting system and three staff told us that they did not feel comfortable or confident in using the incident reporting system as a result.
- There were three never events reported in surgical services between January 2014 and March 2015 which had occurred at Arrowe Park Hospital. Never events are serious, wholly preventable patient safety incidents that should not occur if the available preventative measures are in place. In response to these incidents, the trust commissioned an independent review. The learning from these incidents had been shared with staff at Clatterbridge Hospital.
- Staff reported 376 incidents across the trust within surgical services between February 2015 and June 2015.
- Managers shared lessons learned from incidents with frontline staff through newsletters, communications on notice boards and staff meetings.

Safety thermometer

- The NHS safety thermometer is a national improvement tool for measuring, monitoring and analysing avoidable harm to patients and 'harm free' care. Performance against the four possible harms; falls, pressure ulcers, catheter acquired urinary tract infections (CAUTI) and blood clots (venous thromboembolism or VTE), was monitored on a monthly basis.
- Surgical services recorded and monitored data in line with this initiative. Ward areas displayed the information for staff and members of the public to view.
- Safety thermometer information between June 2014 and June 2015 showed that surgical services performed within the expected range for falls with harm, catheter urinary tract infections and pressure ulcers. The data also showed there had been an overall improvement in the rate of pressure ulcers and catheter urinary tract infections since June 2014 and the rates of falls had remained similar for the same period.

Mandatory training

- Mandatory training was provided in two 'blocks'. Block B was a rolling 18 month programme and included training on areas such as infection control. Block A training was provided on a three year rolling programme and this covered subjects including safeguarding and manual handling.
- Data provided by the trust showed that 93.5% of staff in surgical services had received their block A mandatory training, which was slightly lower than the trust's target of 95%. Data showed that 72.5% of staff had received their block B training which was lower than the trust's target of 95%.
- Staff told us that they were encouraged to attend mandatory training and that their managers reminded them when their mandatory training was due for renewal.

Safeguarding

- The trust had safeguarding policies and procedures in place and there was an internal safeguarding team based at Arrowe Park hospital who could provide guidance and support to staff in all areas. Staff were aware of how to refer a safeguarding issue to protect adults and children from suspected abuse.
- Training data provided by the trust in relation to safeguarding showed that 72% of staff in surgical services had completed level 1 safeguarding training and 73% had completed level 2. Both of these were below the trust target of 95%.
- Staff told us that they did receive feedback from safeguarding concerns and referrals they raised. This was cascaded from the trust safeguarding team to frontline staff through their line managers.

Cleanliness, infection control and hygiene

Surgery

- Surgical services effectively managed cleanliness, infection control and hygiene. Rates of infections were low and staff followed measures to protect patients from infections.
- There had been no cases of methicillin resistant staphylococcus aureus (MRSA) bacteraemia infections or clostridium difficile infections identified between March 2015 and August 2015.
- The ward and theatre areas we inspected were visibly clean and well maintained.
- Staff were aware of current infection prevention and control guidelines, and were able to give us examples of how they would apply these principles.
- Cleaning schedules were in place, with allocated responsibilities for cleaning the environment and decontaminating equipment.
- There was adequate access to hand washing sinks and hand gels.
- Staff were observed using personal protective equipment, such as gloves and aprons and changing this equipment between patient contacts. We saw staff washing their hands using the appropriate techniques and all staff followed the 'bare below the elbow' guidance. Staff followed procedures for gowning and scrubbing in the theatre areas.
- The service undertook early screening for infections including MRSA during patient admissions and preoperative assessments. This meant that staff could identify and isolate patients early to help prevent the spread of infections.

Environment and equipment

- Equipment on the wards and in theatre areas was generally visibly clean, and well maintained.
- Staff in the theatre and ward areas told us they had access to the equipment and instruments they needed to care for patients.
- Records indicated that staff carried out regular checks on key pieces of equipment. Emergency resuscitation equipment was in place and records indicated that it had been checked daily, with a more detailed check carried out weekly as per the hospital policy.
- There were adequate arrangements in place for the handling, storage and disposal of clinical waste, including sharps.
- We found two unsecured doors in the ward areas, which led on to a high balcony and out to a staircase from this balcony leading to the car park. The steep staircase and balcony could potentially pose a risk of falls for patients. In addition, it was also possible that members of the public could enter the hospital undetected.

Medicines

- Medicines, including medical gases were securely stored and records indicated that the relevant stock checks were completed and recorded.
- We observed nurses undertaking medication rounds. They conducted appropriate checks when administering medication including checking the patient's identity and allergy status. Staff ensured patients took their medication and did not leave medication unattended.
- Fridges used to store medicines were locked in all areas.
- The temperatures of the fridges were within expected ranges and records indicated that staff checked and recorded the temperatures on a daily basis.
- Controlled drugs were stored securely in line with legislation and records indicated that staff carried out checks on a daily basis to ensure that medicines were reconciled correctly.
- Medical staff were aware of the trust's policy for prescribing antimicrobial medicines and had access to a formulary which guided them in prescribing the correct doses. Appropriate antimicrobial prescribing helps prevent patients developing certain infections associated with antibiotic use.
- We reviewed two medication charts and medical staff had completed all sections on both charts fully. The prescribing was clear and legible.
- Staff received alerts about medication through emails and written communications in ward and theatre areas. Staff were required to sign to state that they had read and understood the alerts.
- Matrons and ward managers reviewed incident data regularly to ensure any medication incidents were investigated in a timely way.
- Discharge medications and prescriptions were managed well.

Records

- We reviewed seven care records and found that individual care records were clear, legible and up to date. They contained detailed patient information, pre-operative assessments and progress records.

- The service and trust used electronic, computer based patient records. All nursing and medical staff within surgical services could access these records from laptop computers and tablet devices. This enabled remote monitoring of patient information for staff groups. In the event that nursing staff had a concern about a patient's condition, medical staff could review the patient's records and vital signs from any area in the hospital and provide advice before they arrived on the ward.
- We observed matrons checking the quality of records in the ward areas and highlighting any areas of concern with staff.

Assessing and responding to patient risk

- The trust did not have a standard process of procedure in place in the event that a patient deteriorated and required transfer to an acute hospital. Staff said they would telephone 999 for an emergency ambulance. We were told of an example where a patient waited longer than they should have to be transferred after suffering problems with their heart after surgery.
- Staff knew how to highlight and escalate key risks that could affect patient safety, such as staffing and delays in obtaining beds for patients in theatre. Ward managers, matrons and senior managers in surgical services were visible and involved with addressing these risks on a daily basis.
- On admission to the surgical wards and before surgery, staff carried out risk assessments to identify patients at risk of specific harm such as venous thromboembolism (VTE), pressure ulcers, risk of falls and risk of infection. If staff identified patients susceptible to these risks, they placed patients on the relevant care pathway and treatment plans.
- An early warning score (EWS) system was in use in all areas of surgical services. The EWS system was used to monitor a patient's vital signs and identify patients at risk of deterioration. Staff carried out monitoring in response to patients' individual needs to identify any changes in their condition quickly. We saw examples of staff seeking appropriate help when a patient's condition deteriorated.
- We observed parts of two operations and saw the theatre teams undertaking the 'five steps to safer surgery' procedures, including the use of the World Health Organization (WHO) checklist. The WHO checklist is an international tool developed to help prevent the risk of avoidable harm and errors before during and after surgery. Theatre staff completed safety checks before, during and after surgery and displayed a good understanding of the 'five steps to safer surgery' procedures. The WHO checklist had also been adapted for different theatre areas including ophthalmology theatres. We reviewed four WHO surgical checklists and these were fully completed.
- Two matrons told us that they had adopted a two-stage audit of compliance with the WHO checklist. Stage one was to review the records and stage two involved the auditor watching the WHO checklist and five steps to safer surgery being used live in the theatres. The results of this audit showed that compliance was consistently 99% and above.

Nurse staffing

- The staffing and skill mix on surgical ward areas and in theatre areas was sufficient, with some periods of reduced staffing in areas because of last minute sickness and unexpected events. Where there were periods of reduced staffing, ward managers and matron had implemented measures to reduce the risks associated with this. These measures included the use of bank and agency staff and ward staff undertaking extra shifts.
- We reviewed three months of rotas for the surgical ward and theatre areas which showed that levels were within recommended guidelines for most shifts. On the shifts where the staffing figures fell below recommended guidelines; this was due to short term and last minute absence. Managers had responded appropriately to try to address these staffing deficits.
- There was evidence that managers planned staffing while taking into account the skill mix and competencies of the staff on duty on the surgical wards, with the exception of staff who dealt with children. An example of this was a lack of staff trained in paediatric life support. This training was not mandatory for staff, despite them working with children who had the potential to become clinically unstable following anaesthetic. Only nine members of staff out of 148 staff across surgical services had received this training. If a paediatric emergency occurred during a shift when these staff were not on duty; the staff would not be trained to deliver resuscitation.
- Each clinical area openly displayed the expected and actual staffing levels on a notice board and staff

updated them on a daily basis. The staffing numbers displayed on the boards were correct at the time of the inspection and reflected the actual staffing numbers in all areas.
- The vacancy rate for nurses in surgical services across the trust was below 3% for the five month period prior to the inspection. At the time of the inspection the vacancy rate for nurses across surgical services trust-wide was 2.4%.

Medical staffing

- There were sufficient numbers of suitably qualified medical staff within surgical services during the daytime hours. Junior and middle grade doctors told us that they were well supported by their seniors and consultants and were able to access senior advice and support, as they needed. However, there was only one junior or middle grade doctor on duty during the night and at weekends. This doctor was a medical doctor and not a surgical doctor, and may not be able to offer specialist surgical care and advice as a result. There were no surgical doctors on site at the hospital after 8pm.
- There was no anaesthetic or critical care support on site after 8pm. If a patient suffered a collapse or became critically unwell, the staff at the hospital would have to call an ambulance.
- The medical skill mix was sufficient when compared with the England average. Consultants made up 45% of the medical workforce across the trust which was higher than the England average of 41%. The number of junior doctors within surgical services across the trust was 16% which was higher than the England average of 12%. However, there were less middle grade doctors and registrars at 38% when compared with the England average of 48%.
- We observed one medical handover which was comprehensive and well structured. Medical staff were informed of important issues or patients who were at risk of deteriorating.
- Junior doctors told us that they were well supported by their seniors and were able to access senior advice and support, as they needed.

Major incident awareness and training

- The trust had a major incident policy in place which was available on the trust intranet site. Staff were able to tell us how they would access it and showed a good understanding of the policy and processes relating to major incidents.
- In two clinical areas, we saw that a folder was placed in a prominent position which contained detailed information for staff to follow in the event of a major incident being declared.

Are surgery services effective?

Good

Surgical services provided care and treatment that followed evidence based practice and national clinical guidelines including those from the National Institute for Health and Care Excellence (NICE) and Royal College of Surgeons.

Surgical services participated in local clinical audits. Policies and procedures reflected national guidelines and best practice. Staff managed patients' nutritional and hydration needs well in all areas,

Patients received care and treatment from competent staff who worked well as part of a multidisciplinary team. Staff sought appropriate consent from patients before delivering treatment and care.

Evidence based care and treatment

- Patients received care and treatment in line with evidence based practice and national guidelines. Clinical audits included monitoring compliance with National Institute for Health and Care Excellence (NICE) and Royal Colleges' guidelines.
- Staff on the surgical wards used care and recovery pathways and plans, in line with national guidance. We reviewed seven patient care plans and saw that these were fully completed in all cases and staff updated them appropriately.
- Policies and procedures reflected current national guidelines and were easily accessible via the trust's intranet site.
- Staff completed venous thrombo-embolism (VTE) assessments for patients where appropriate and discussed options with them to reduce the risk of developing VTE following surgery.

Surgery

Nutrition and hydration

- Staff managed the nutrition and hydration needs of patient's well, both pre and post operatively. Patients were given information in the form of leaflets about their surgery and told how long they would need to fast pre-operatively.
- On the surgical wards, a coloured tray system was in place so that staff could easily identify patients who required assistance with eating and drinking at mealtimes. Staff also placed symbols on the wards' patient information boards to identify patients who required assistance with eating and drinking and patients who required a specialised diet.
- In all the records we reviewed, a nutritional risk assessment had been completed and updated regularly. This helped identify patients at risk of malnutrition and adapt to any ongoing nutritional or hydration needs.
- Staff consistently completed charts used to record patients' fluid input and output and where appropriate staff escalated any concerns.
- Patients told us that staff offered them a variety of food and drink and did not highlight any concerns about the food and drink provided.

Pain relief

- Staff assessed patients pre-operatively for their preferred post-operative pain relief. Staff used pain assessment charts to monitor pain symptoms at regular intervals.
- There was a team specialising in the management of pain available to support staff in the surgical wards and theatres.
- Patient records we reviewed showed that staff gave patients appropriate pain relief when required, which was also confirmed by the patients we spoke to.

Patient outcomes

- Surgical services monitored patient outcomes. Outcomes were measured through internal audits including the World Health Organization (WHO) checklist audit and through participation in national audits including the national hip fracture audit. Outcomes for patients receiving treatment in the service were mostly better than the England average.
- Hospital episode statistics from January 2014 to November 2014 data showed the average length of stay for elective and non-elective patients across all specialties was similar to the England average. This means that patients stayed in hospital on average the same length of time as would be expected and as compared to other areas of England.

Competent staff

- Newly appointed staff had an induction and senior staff assessed their competency before they were permitted to work unsupervised. Agency and locum staff also had inductions before starting work.
- Senior managers managed poor performance effectively and were able to tell us about examples of how they managed poor performance in previous situations.
- Data provided by the service showed 96% of medical staff, 77% of nursing staff and 80% of all other staff working in surgical services had completed their annual appraisals during the year (April 2014 to March 2015) against a trust target of 85%. Appraisals were ongoing and staff told us they routinely received supervision and annual appraisals.
- Medical staff told us they received routine clinical supervision and appraisal and had no concerns relating to revalidation. In addition, they were positive about on-the-job learning and development opportunities and told us they were supported well by line managers.
- All nursing staff apart from one nurse told us that they felt that their managers did not offer them opportunities to develop in their role. They told us that they were not routinely offered any training or development that they felt would be beneficial to their role over and above their mandatory requirements.

Multi-disciplinary working and coordinated care pathways

- There was effective daily communication between multidisciplinary teams within the surgical wards and theatres. Staff handover meetings were carried out on a daily basis to ensure all staff had up-to-date information about risks.
- The ward staff told us they had a good relationship with consultants and ward-based doctors.
- There were routine team meetings that involved staff from the different specialties. Patient records showed there was routine input from nursing and medical staff and allied health professionals.

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

Seven day services

- Elective surgery was carried out five days per week. If patients required surgery during out of hours periods they would have to be transferred to Arrowe Park Hospital.
- One junior or middle grade doctors provided out of hours medical care to patients on the surgical wards. Nursing staff told us they felt well supported outside normal working hours. There was also advice available by telephone from Arrowe Park Hospital for the doctor to access.
- Microbiology, imaging (e.g. x-rays and scans), physiotherapy and pharmacy support was available outside of normal working hours.
- Medical staff told us that they had adequate access to urgent imaging outside of normal working hours. This meant that patients could have scans and x-ray's urgently out of hours if required.

Access to information

- The information needed for staff to deliver effective care and treatment was readily available in a timely and accessible way.
- Staff in surgical services used electronic, computer based patient records. All staff could access these records from laptop computers and tablet devices. This enabled remote monitoring of patient information for staff groups. This enabled the them to highlight and explore any issues from any location in the hospital.
- The records we looked at were complete, up to date and easy to follow. They contained detailed patient information from admission and surgery through to discharge. This meant staff could access all the information needed about the patient at any time.
- Medical staff produced discharge summaries from the electronic patient system and sent them to the patient's GP in a timely way. This meant that the patient's GP would be aware of their treatment in hospital and could arrange any follow up appointments they might need. A copy of the discharge summary was also provided to the patient on discharge.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- Staff sought appropriate consent from patients prior to undertaking any treatment or procedures.
- Staff had the appropriate skills and knowledge to seek consent from patients. Staff were able to tell us clearly about how they sought informed verbal and written consent before providing care or treatment. All patient records we looked at indicated that staff had sought and obtained verbal or written consent before treatment was delivered.
- Staff understood the legal requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.
- If a patient lacked the capacity to make their own decisions, staff made decisions about care and treatment in the best interests of the patient and involved the patient's representatives and other healthcare professionals appropriately. Staff were able to give us recent examples of how they had considered these issues when delivering patient care.
- Staff had awareness of what practices could be deemed as restraint and displayed an understanding of the deprivation of liberty safeguards and their application.
- A trust-wide safeguarding team based at Arrowe Park hospital provided support and guidance for staff in relation to any issues regarding mental capacity assessments and deprivation of liberties safeguards.

Are surgery services caring?

Outstanding ☆

Staff respected and valued patients as individuals and empowered them as partners in their care. Feedback from patients and their relatives was consistently positive and there were numerous complimentary letters that outlined how staff went above and beyond their duty.

Results from the NHS Friends and Family Test were consistently positive and better than the England average. Staff of all grades and disciplines treated patients with kindness, dignity and respect at all times.

Staff provided care to patients while maintaining their privacy, dignity and confidentiality. Patients were overwhelmingly positive about the level of care and compassion provided by staff and told us that they were fully involved in decisions and kept informed about their

plans of care. Staff were flexible in their approach to caring for patients to ensure their relatives could be as involved as much as possible and encouraged patients and their relatives to be partners in their care.

We observed staff interacting with patients on a one to one basis and displaying a caring attitude which went above and beyond what was expected.

Staff were observed to go out of their way to meet patient's preferences and we observed strong relationships between staff, patients and their relatives. Their commitment to offering high quality care and support to patients was evident throughout the inspection.

Staff worked together effectively as a multidisciplinary team to provide reassurance and support to patients when they were anxious. This included all staff such as porters, reception staff, nursing staff and medical staff worked together to provide patients with the best possible care.

Compassionate care

- Staff treated patient with kindness, dignity, respect and compassion. Staff took time to interact with patients in a considerate and compassionate manner.
- The areas we visited were compliant with same-sex accommodation guidelines. Patient's dignity was respected. We observed that curtains were closed around patient bed areas when staff were providing personal care. There were private areas available where staff could speak to patients privately if required, in order to maintain confidentiality.
- We spoke with five patients, who gave us exceptionally positive feedback about how staff treated and interacted with them. They told us that staff went out of their way to ensure that they meet their needs.
- A patient told us about an example where on a previous admission, their relatives were involved in an accident on the way to collect them from the ward. The patient had a fear of ambulances, so staff helped them to contact different relatives to find transport. In addition, the patient told us that staff stayed a number of hours after their shift to provide support and arranged a hot meal.
- The NHS Friends and Family Test (FFT) is a satisfaction survey that measures patients' satisfaction with the healthcare they have received. The results between March 2014 and February 2015 showed that all areas in surgical services consistently scored above (better than) the England average, indicating that patients were positive about recommending the hospital's wards to friends and family. One ward area received feedback for nine out of 11 months that showed 100% of patients would recommend the hospital to their friends and family.

Understanding and involvement of patients and those close to them

- Staff respected patients' rights to make choices about their care and communicated with patients in a way they could understand. We observed staff taking time to answer question and offer explanations to patients.
- Patients and their families told us that staff kept them informed about their treatment and care. They spoke positively about the information staff gave to them verbally and in the form of written materials, such as information leaflets specific to their condition and treatment.
- Patients told us the medical staff fully explained the treatment options to them and allowed them to make informed decisions.
- Pre-operative assessments took place and took into account individual preferences. We observed staff using the 'this is me' document during pre-operative assessments. Staff completed this document with patients and their families to understand the wishes and needs of patients living with a cognitive impairment, such as dementia.

Emotional support

- Staff demonstrated that they understood the importance of providing patients and their families with emotional support.
- We saw staff providing reassurance to patients when they were anxious. This reassurance was provided by the multidisciplinary team working together. One example was when a patient's relative highlighted that a patient was feeling very anxious. Support was provided by a receptionist and a health care support worker who arranged for an advanced nurse practitioner and the surgeon to speak to the patient before they went into theatre to provide further support and reassurance.
- Patients told us that staff supported them with their emotional needs.

Surgery

- We observed that the team throughout the surgical services and also other services at the hospital worked together to ensure that patients had the best possible patient journey.
- All staff were overwhelmingly kind in their approach to patients. Their commitment to offering high quality care and support to patients was evident throughout the inspection. All staff including porters, reception staff, nursing staff and medical staff asked patients how they were and offered them reassurance.
- We reviewed a complimentary letter from a patient's relative which outlined that staff continued to support the relative of a patient who had attended a surgical ward and had sadly passed away. This letter outlined that staff went out of their way to signpost the relative to appropriate support agencies. The relative also wrote that the ward manager had telephoned them a number of times after the patient's death to provide support.

Are surgery services responsive?

Good

Surgical services were responsive to the needs of patients. They were well organised and had provisions in place to meet the needs of the local population. One example of this was the repurposing of a clinical area into a mock dwelling. This was designed to help prepare patients for discharge to their own home and bridge the gap between acute patient care and community rehabilitation. Patients could 'move' into the dwelling with their relatives for short periods before discharge.

Staff kept patients well informed of their treatment and care. Information was readily available for patients in a variety of formats, which could be adapted to individual needs.

The length of time patients stayed in hospital was mostly the same as the England average with some exceptions. In these exceptions, senior managers were able to tell us what they were doing to improve this.

Complaints were well managed and we saw evidence of learning from complaints.

Planning and delivering services which meet people's needs

- Surgical services were planned and delivered to meet the needs of patients and we found that the service used data about the local population to inform service planning.
- Regular meetings were held to assess whether the service needed to change or adapt to new information about the local population.
- The directorate manager for surgical services also told us how the senior management team had noted an increase in the number of patients who could have day case surgery. Surgical services had therefore increased their capacity to provide day case surgery to meet this demand at the Clatterbridge site.

Meeting individual needs

- Information leaflets about services and treatments were readily available in all areas. Staff told us they could provide leaflets in different languages or other formats, such as braille, if requested. They could access an interpreter for patients' whose first language was not English and were able to show us how they would do this. They also had access to language line which is a telephone translation facility.
- Staff received mandatory training in the care of patients living with dementia. Each ward area had a dementia link nurse in place. Staff could also contact a trust-wide safeguarding team for advice and support in treating with patients living with dementia or a learning disability.
- Staff used a 'this is me' document for patients admitted to the hospital with dementia. Patients or their representatives completed this document and included key information such as the patient's likes and dislikes. This document was also completed during the pre-operative stage of a patients care to ensure any reasonable adjustments which were needed were put in place.
- A reasonable adjustment pathway was in place for patients living with a disability and in use in all theatre areas. This pathway alerted staff to any reasonable adjustments that they needed to make. We saw evidence that this pathway had been used in patient records.
- We saw evidence of staff planning care for patients who identified as transgender in a way that would meet their needs. This planning included specifying what preferred name patients would like to be called and the gender

they identified with. Staff told us they also gave them the option to be treated in a side room for privacy or in the main bay areas. Where possible, staff accommodated these preferences.

- A mock domestic dwelling was available for patients to use when preparing for discharge. Staff told us this had been developed to improve the number of patients who were readmitted after being discharged. The dwelling had a fully functioning living area with space to prepare meals and use the bathroom. This helped patients prepare for the challenges they would face when they were discharged home. Staff told us that patients could report which tasks they found difficult while staying in the dwelling and staff could arrange appropriate aids and services in response to these needs.
- Accessibility to all facilities and areas was good.
- An interpreter service was available for patients whose first language was not English.
- We observed examples of staff supporting patients to maximise their independence. One example of this was pre-operative education for patients undergoing joint replacement surgery. As part of this pre-operative education program, staff were able to identify patients who required additional support in the post-operative phase of their treatment and ensure it was in place at the time of their post-operative discharge. This meant patients were able to be discharged as soon as possible after their operations and maintain their independence.

Access and flow

- Patients were admitted for surgical treatment and care through the pre-planned surgery route,
- The admission, transfer or discharge of patients from the surgical wards was well managed in all areas.
- Patient records showed discharge planning took place at an early stage and there was multidisciplinary input (e.g. from physiotherapists and social workers). Staff completed a discharge checklist, which covered areas such as medication and communication. Discharge letters written by the doctors included all the relevant clinical information relating to the patient's stay at the hospital.
- The associate director for scheduled care told us performance against waiting time standards was routinely monitored and improvements were achieved through better planning and routine multidisciplinary meetings.
- Patients told us they had easy access to surgical services and had not experienced delays in accessing treatment.
- The average length of time that patients stayed in hospital after having surgical treatment was around the same as the England average. In some specialities the length of time patients stayed in hospital after surgical treatment was longer than the England average; notably in the urology and trauma and orthopaedic specialities. Senior managers told us they were working to reduce the length of time patients stayed in hospital following surgical treatment. One of the ways they were trying to do this was through the introduction of specialised treatment pathways and pre-operative preparation programmes for patients. The service hoped that by preparing patients as much as possible before planned surgery, this would help facilitate their discharge after surgery.

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 including the number of complaints and any comments for improvement.
- The trust recorded complaints on the trust-wide system. The local ward managers and matrons were responsible for investigating complaints in their areas. Ward managers told us that on some occasions investigations would be undertaken by staff external to the ward to ensure a level of independence in the investigation.
- Data showed there had been 26 complaints raised across surgical services between July 2014 and July 2015. The highest proportion of complaints were regarding communication with staff members. All patients we spoke with told us they had no concerns regarding communication from staff.
- We reviewed one complaint record and saw it was appropriately documented and had been responded to in a timely manner.
- Staff told us managers discussed information about complaints during staff meetings to facilitate learning.

Senior managers within the service told us information and key lessons learned from complaints were included in monthly newsletters to staff. We saw evidence of this in minutes of meetings and previous newsletters.

Are surgery services well-led?

Good

Surgical services were well led at local line manager and matron level. The trusts vision was embedded throughout the division. Staff were not clear what the trust vision was and were not able to tell us how they contributed to it in their daily, working lives. There were robust governance frameworks within the service and managers were clear about their roles and responsibilities.

Risks were appropriately identified, monitored and there was evidence of action taken where appropriate. There was clear leadership throughout the service and staff spoke positively about their line managers. Staff told us that senior managers were not visible and they felt they were 'forgotten' by the trust board and senior managers.

Staff told us the culture within the service had improved in particular in theatre areas as a result of an independent review as a result of a never event incident at Arrowe Park Hospital.

There was evidence of efforts on the part of senior managers and leaders to continually improve the service through public and staff engagement. There were areas of strong innovation to facilitate improvement, with evidence that senior managers had assessed the sustainability of these measures.

Vision and strategy for this service

- The trust had a vision which is based around the PROUD values; patient, respect, ownership, unity and dedication. This vision was displayed prominently around the hospital on posters. All staff we spoke with were not aware of the vision and were not able to articulate the vision and values for the trust.

Governance, risk management and quality measurement

- There was a robust governance framework within surgical services. Senior managers were clear on their roles in relation to governance and they identified, understood and appropriately managed quality, performance and risk.
- There were risk registers in place for all areas of surgical services and there was a clear alignment of risks recorded and what staff told us was concerning them. Managers regularly reviewed, updated and escalated the risks on these registers where appropriate. There were action plans in place to address the identified risks. There was a system in place that allowed managers to escalate risks to trust board level through governance meetings.
- Audit and monitoring of key processes took place across the ward and theatre areas to monitor performance against objectives. Senior managers monitored information relating to performance against key quality, safety and performance objectives and they cascaded this to ward and theatre managers through performance dashboards and meetings.
- There was a regular clinical governance meeting held within surgical services and we saw minutes from this meeting.

Leadership of this services

- The leadership within surgical services reflected the vision and values set out by the trust. Staff spoke positively about local leaders within the services. Local leaders were visible, respected and competent in their roles.
- There were clearly defined and visible local leadership roles across surgical services. Staff told us that their line mangers visible and approachable but that they felt 'forgotten' by the senior managers and trust board. Matrons for surgical services and the theatre manager were visible during our visit. Staff did not know who the clinical director and associate director of nursing were. They told us that they did not frequently visit the clinical areas.
- Staff particularly spoke positively of the ward managers, matron and theatre manager. Matrons for surgical services and the theatre manager were visible during our visit.
- Medical staff told us their senior clinicians supported them well and they had access to senior clinicians when they required.

Surgery

Culture within this services

- Most staff we spoke with told us they felt respected and valued. Three nursing staff out of 8 in the theatre areas told us that there had been improvements to how they felt about working in the services, but that there needed to be more support from senior managers.
- All staff told us they would feel secure raising a concern or issue with their managers.

. **Public engagement**

- Staff told us they routinely engaged with patients and their relatives to gain feedback from them. Information on number of incidents, complaints and the results of the NHS Friends and Family Test were displayed on notice boards in the ward and theatre areas.
- Surgical services participated in the NHS friends and family test, which gives people the opportunity to provide feedback about care and treatment they received.

Staff engagement

- Staff told us they received support and regular communication from their line managers.
- The services and trust also engaged with staff via email, newsletters attached to payslips and through other general information and correspondence displayed on notice boards in staff rooms.

Innovation, improvement and sustainability

- Staff and managers were continually striving to improve the care and treatment patients received.
- Staff told us they were able to suggest improvements to managers and they considered and implemented them where possible. One example of this was the repurposing of a clinical area into a mock dwelling. This was designed to help prepare patients for discharge to their own home and bridge the gap between acute patient care and community rehabilitation.
- Patients could 'move' into the dwelling with their relatives for short periods before discharge. This helped staff identify whether any further measures were needed before patients were discharged. It also empowered patients to maintain their independence and improve their confidence prior to discharge. Staff told us that this had been introduced partly due to issues which were raised around patients discharge home when they felt they weren't ready.
- Leaders were working to continually improve services. We saw evidence of this in the form of robust plans relating to improvements that assessed and ensured sustainability while ensuring patients were at the centre of the decisions made.

Outpatients and diagnostic imaging

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

Information about the service

A range of outpatient and diagnostic services are provided by Wirral University Teaching Hospital NHS Foundation Trust at Arrowe Park Hospital and Clatterbridge Hospital. A number of outpatient appointments are also offered at community locations.

The outpatients and diagnostic imaging departments at Clatterbridge Hospital are located on the ground level. The hospital offers a variety of outpatient services for a full range of specialities, including dermatology, podiatry, cardiac, plastics, phlebotomy, x-ray, and the Wirral Breast Centre. Magnetic Resonance Imaging (MRI) scanning appointments were available but delivered by an external provider.

In the twelve months prior to our inspection there were 430,391 outpatient appointments across the trust with 92,433 taking place at Clatterbridge Hospital.

We visited Clatterbridge Hospital on 17 September 2015 and inspected a number of outpatient and diagnostic services including: dermatology, phlebotomy, physiotherapy, plastics, podiatry, cardiac, radiology, bone densitometry and breast screening services. We spoke with eight patients and 31 staff including nursing and administration staff, doctors and radiographers. We received comments from people who contacted us about their experiences. We also reviewed the trust's performance data and looked at individual care records.

Summary of findings

There were significant staff vacancies across the whole trust in the diagnostic and imaging services.

The outpatients service across the whole trust did not achieve the national target for people waiting for treatment in July 2015 and August 2015. In addition, the trust consistently did not meet their own internal timescale targets for reporting on urgent diagnostic results during April 2015 to August 2015.

Clinical governance measures were in place for radiology. However, there had been no radiation safety committee meeting since September 2012 and it is a statutory requirement that radiation protection meetings take place at least annually.

We observed plans in radiology that were developed for some areas to address sustainability and to improve services but there was a lack of communication on these plans to clinical staff

Staff shortages had been identified and placed on the risk register. However, progress was slow to resolve the issue.

The outpatient and diagnostic imaging departments were visibly clean, although the outpatient departments were variable in their facilities in terms of space and seating arrangements.

Outpatients and diagnostic imaging

There was a clear process for reporting and investigating incidents and staff told us that they received feedback for the outcomes of the incidents which suggests the hospital has the ability to learn from such incidents.

Data provided by the trust as a whole showed that they had achieved 99% for the availability of records for outpatient appointments. On the rare occasion when records were not available staff prepared a temporary file for patients that included the most recent diagnostic results and essential patient details. This enabled the consultation to go ahead which meant that the patient did not have to reschedule their appointment.

Mandatory training was well attended for staff working in outpatients and diagnostic imaging across the whole trust. There were appropriate protocols for safeguarding adults and children in place and staff were aware of their role and responsibilities in relation to safeguarding.

Are outpatient and diagnostic imaging services safe?

Requires improvement

There were significant staff vacancies across the whole trust in the diagnostic and imaging services with a vacancy rate of 9.9% reported for diagnostic radiographers. The data provided could not be split specifically to Clatterbridge Hospital and whilst there were fewer staff on this site, the staff rotated across both hospital sites.

Emergency equipment was available throughout outpatients and diagnostic imaging departments however in some areas there was a lack of evidence to confirm the equipment was safety checked on a daily basis in adherence to trust policy.

Cleanliness and hygiene was of a good standard throughout most of the areas we visited and most staff followed good practice guidance in relation to the control and prevention of infection. However, there was some inconsistencies in relation to procedures to ensure equipment and areas were cleaned.

The radiology department had equipment that exceeded the ten year life span recommended although there was evidence of regular quality assurance and maintenance of the equipment and staff did not highlight any issues in regards to service delivery.

There was a clear process for reporting and investigating incidents and learning from incidents took place.

Safeguarding and mandatory training were well attended. Staff were aware of their role in safeguarding, a reporting process was in place and staff knew how to escalate concerns.

The trust had paper based medical records that were readily available during clinic consultations. A contingency plan was in place to ensure information was available at consultation should the medical file be unavailable.

Incidents

- Specific information for Clatterbridge Hospital was not available however, data from across the trust showed there were 38 radiation errors and near misses recorded 6 April 2015 to 3 September 2015. A near miss is an

unplanned event that did not result in injury, illness or damage but had the potential to do so. The trust uses a pause and check process which aims to ensure that the right person gets the right x-ray on the right part of the body. The recording of these near misses would suggest that the pause and check process was being used and working.

- All staff we spoke with at Clatterbridge Hospital knew how to report incidents, we saw evidence that incidents were reported, and staff told us they received feedback and learning from incidents both as a referrer and in team meetings.

Cleanliness, infection control and hygiene

- Staff complied with the trusts policies and guidance on the use of personal protective equipment and adhered to "bare below the elbow" guidelines. Areas we visited were visibly clean. Hand gel was readily available in all the clinical areas and we observed staff using the hand gel.
- The cleaning schedules we observed were checked and completed. We observed 'I am clean' stickers on equipment which identifies the equipment had been cleaned in between patient use. However, this was not consistent across the hospital; stickers were observed in the dermatology department but were not seen in physiotherapy.
- Patient-led assessments of the care environment (PLACE) audits for 2013 and 2014 scored higher than the national average for cleanliness across the trust, specific data for Clatterbridge Hospital was not available.
- Infection control training was attended by staff as part of their mandatory training. Data provided by the trust identified that 97.8% of staff across all outpatients and diagnostics had completed the training, which was higher than the trust target of 95% but the information was not disaggregated to show the figures specifically for Clatterbridge staff.
- Policies and procedures for the prevention and control of infection were in place. Staff understood them and could describe their role in managing and preventing the spread of infection

Environment and equipment

- Following a review of radiology equipment across the trust as a whole, 66% of equipment was identified as being older than the lifespan recommended by the Royal College of Radiologists. The recommended lifespan of general imaging equipment is ten years. Evidence was provided of regular quality assurance and maintenance of diagnostic imaging equipment. At the time of our inspection staff reported no current issues with equipment breakdowns at Clatterbridge Hospital.
- Clear signage and safety warning lights were in place in the x-ray department to warn people about potential radiation exposure.
- Resuscitation trolleys were in place in the outpatients and diagnostic imaging department. However, in physiotherapy and the inpatient x-ray room the checklists were not always completed and may suggest that not all the trolleys were checked daily. We observed that resuscitation trolleys not being checked daily was a risk identified on the trust wide risk register in March 2015.
- Portable appliance testing (PAT) was inconsistent in outpatients and diagnostic imaging. Equipment observed in plastics clinic and physiotherapy were PAT tested and in date however, the suction machine in the breast centre had no PAT testing sticker.
- There was access to toilets and water fountains in most waiting areas and although there were no drinks facilities in the main x-ray waiting area, there were facilities nearby.
- Some waiting areas in outpatient clinics were small and cramped with limited space for patients who may have restricted mobility and need wheelchair access. The bone densitometry scanning unit was situated across the hospital from general x-ray and was used to measure bone density in conditions such as osteoporosis. Doors into the waiting area were noted to be very heavy and staff advised that money had previously been allocated to replace them however this had not happened. Patients attending for a scan may have mobility issues and may find operating the heavy doors difficult however; we did not observe any patients operating the doors at the time of our inspection.

Medicines

- Local anaesthetic medication was observed stored in a locked room in the breast centre. There were no medicines stored in the outpatient x-ray rooms.
- Medicines were stored appropriately. Temperature records were complete and contained minimum and maximum temperatures to alert staff when they were not within the required range.

Outpatients and diagnostic imaging

- There were no controlled drugs or IV fluids held in the outpatient areas.

Records

- The outpatient department used a combination of paper medical records and an electronic system where diagnostic imaging, pathology and microbiology results were stored.
- An audit of case note availability in 2014 showed that medical records were available in 99% of consultations across the whole trust in outpatients. There were occasions when records were not available for an appointment. In such cases, staff prepared a temporary file for the patient that included correspondence and diagnostic test results so that their appointment could go ahead. This meant that the patient did not have to reschedule their appointment and the temporary file was merged with the main file once it was located.
-

Safeguarding

- Staff were aware of their roles and responsibilities in relation to safeguarding and could describe what types of concerns they would report and how they would raise matters of concern appropriately. Trust wide policies and procedures were available on the intranet and staff were able to demonstrate how to access them.
- Safety procedures were observed in radiology and policies and checklists were clearly visible. Staff in the radiology department were observed obtaining name, address and date of birth of patients on arrival which relates to the 'know your patient' initiative as well as a requirement of the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2000. Staff were observed wearing dosimeters that detect exposure to ionising radiation, this was being monitored by the trust to safeguard staff.
- Training statistics provided by the trust for all outpatients and diagnostics showed that 96.5% of staff had completed level 2 safeguarding children and adults training and 97.2% of staff had completed level 1. Training figures for Clatterbridge Hospital alone were not available.

Mandatory training

- Staff stated they were able to access mandatory training through on-line courses as well as face-to-face training.
- Mandatory training was delivered on a rolling 18 month programme (Block B) covering areas such as infection control and medicines management and a 3 year rolling programme (Block A) incorporating moving and handling, risk management and fire safety. At the time of our inspection training statistics for outpatient, diagnostic, and imaging staff across the whole trust showed 95.7% were compliant with Block B and 97.8% with Block A compared to the trust target of 95%. Staff were alerted by their managers when training was due and staff we spoke to said they were encouraged to attend

Assessing and responding to patient risk

- The trust had identified radiation protection supervisors and we observed these displayed on a list in each department. We observed signs in the radiology department to prevent people entering areas that would place them at risk of radiation exposure.
- There was a clear process in place in outpatients and diagnostic imaging departments to check the identity of the patient by using name, address, and date of birth. We observed staff obtaining this information from patients that attended for appointments.
- Resuscitation equipment was available in the outpatient and diagnostic areas however; if patients become generally unwell or required urgent medical attention they were transported to Arrowe Park Hospital by ambulance as Clatterbridge Hospital had no accident and emergency service.

Nursing staffing

- Across the trust there had been vacancies in outpatients for clinical support workers (CSWs) since March 2015 and three vacancies remained at the time of our inspection. However, recruitment was in progress. In dermatology outpatients, nurse vacancies were reported but recruitment was in progress. Nursing staff and CSWs in outpatients worked across Clatterbridge Hospital and Arrowe Park Hospital sites to cover as required.
- Nursing staff in the breast centre rotated from the surgical unit to surgical outpatients and the breast centre had four breast care specialist nurses and two advanced nurse practitioners to support patients.
- Sickness absence figures for nursing in outpatients and diagnostics was only available across the trust and not for Clatterbridge Hospital specifically. The trust had a

target of 4% staff sickness. However, in the outpatient department the sickness rate for nursing staff was 12.9% in August 2015 and had been consistently high since March 2015, peaking at 16.7% in May 2015. There had been a 29.9% turnover rate across outpatients for the whole trust from March 2015 to August 2015.

Medical staffing

- Medical staff arranged outpatient clinics directly with the outpatient department to meet the needs of their specialty.
- Locums had been employed to reduce waiting lists and those we spoke to had received a comprehensive trust induction. This ensures locum staff had knowledge of trust procedures and access to medical records to provide safe care to patients.

Allied Health professionals

- Information from the trust indicated a vacancy rate of 57.4 whole time equivalents (WTE) for all staff in diagnostic and imaging services across the trust as of August 2015. This equated to a 8.46% vacancy rate however, recruitment was ongoing. The vacancy rate for diagnostic radiographers in x-ray specifically was 4.23 WTE which equated to a 9.9% vacancy rate.

Major incident awareness and training

- The trust had a major incident policy in place and the staff we spoke with were aware of the policies and knew where to access them.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

Patients attending outpatients and diagnostic imaging department received care and treatment that was evidenced based and followed national guidance.

Staff worked together in a multi-disciplinary environment to meet patients' needs. Staff received training and additional development opportunities were available to assist staff to remain competent to deliver safe and effective care within their roles and responsibilities.

Information relating to a patient's health and treatment was available from relevant sources before a clinic appointment. After the appointment the information was shared with the patient's GP and relevant professionals to assure continuity of care for the patient.

Evidence-based care and treatment

- Care and treatment within the outpatient and diagnostic imaging department was delivered in line with evidence-based practice. Policies and procedures, assessment tools and pathways followed recognisable and approved guidelines such as the National Institute for Health and Care Excellence (NICE). In the breast centre we saw evidence of regular quality assurance and pathways such as 'right woman right results' which ensures the correct patient receives the correct diagnosis.
- Evidence from the trust relating to audits of compliance with Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER) indicated that the last published audits were dated 2012, and 2013. However, the trust provided evidence that audits were taking place in 2015.
- The physiotherapy department were members of the North West Musculoskeletal Group. The physiotherapists had introduced the "Start back" programme which incorporates the NICE pathway for spinal pain.
- We reviewed five patient records in dermatology which were legible and up to date. We found all the records had a plan of treatment and where invasive treatment was required, consent was documented. This ensured patients had continuity of care and had agreed with decisions regarding their treatment.

Pain relief

- During our inspection we did not observe the administration of pain relief and one manager informed us that pain relief was not administered by staff in the radiology department.

Patient outcomes

- Discrepancy meetings were held in radiology. The purpose of the meetings was to facilitate collective learning from radiology discrepancies and errors and thereby improve patient outcomes and safety. We saw evidence that the meetings had taken place from 2013 to 2015, the discrepancy findings and outcomes were identified.

Outpatients and diagnostic imaging

- The breast centre participated in the National Cancer Patient Experience survey and patient questionnaires were sent to patients three times a year to assist in improving breast services. Patient workshops were held and feedback was provided to the centre.
- The spinal rehabilitation programme was evaluated by approved patient satisfaction tools and recent evaluation from patients had identified an improvement in their functional ability.

Competent staff

- Staff identified their learning needs through the trusts appraisal process and 92.7% of staff across the trust in outpatients and diagnostic imaging had completed an appraisal within the previous twelve months. This is higher than the trust target of 88%. Information for Clatterbridge Hospital staff only was not available.
- Staff reported that additional opportunities were available for development in the breast centre with examples provided of both internal and external opportunities. One team member had recently qualified as an assistant nurse practitioner and another team member had attended a university course.
- Staff in the breast centre audited the images they were involved with every three months to identify trends and promote continuous improvement of practice.
- In dermatology clinic all trained staff completed a dermatology course which was taught by the manager of the dermatology service.

Multidisciplinary working

- The diagnostic imaging and outpatients departments we visited were staffed by a range of professionals working together as a multi-disciplinary team to provide a comprehensive service to patients.
- 'The 'one stop' clinics within the breast centre ensured that patients could attend for one appointment and see a range of specialists for investigations and consultation and so prevented the need for patients to return for several appointments. Multidisciplinary meetings take place weekly and 'away days' are held to update staff and promote continuing professional development.
- The dermatology department did outreach sessions in the community for example, providing education sessions to health visitors regarding emollient therapy.
- Letters were sent out from the outpatients department to patient's GPs to provide a summary of the consultation and any relevant treatment management plans.

Seven-day services

- Radiology cover at Clatterbridge Hospital was provided 365 days a year. However, outside the core hours of Monday to Friday 8.30am-5.00pm, the radiologists were available off site and accessed through an on call system.
- The breast centre provided services Monday to Friday 8.30am-5.00pm however, staff told us that this can be extended as needed to meet the centres two week referral to treatment target.
- There were no regular outpatient clinics offered at weekends but additional clinics were scheduled on occasion at weekends and evenings due to waiting list pressures.

Access to information

- Staff had access to previous diagnostic imaging records and test results which could help avoid unnecessary repeat investigations and provides continuity of care for patients.
- The radiology used a system called the Picture Archiving and Communications (PACS) system which is a nationally recognised system used to report and store patient images. The system was used across the trust and within a Cheshire and Merseyside consortium; this system allows local and regional access to images.
- Staff were able to access information such as policies and procedures from the trust's intranet and staff could demonstrate this during our inspection.
- The breast centre provided a wide range of current national cancer care leaflets for patients. Patient leaflets were available through the physiotherapy service we observed leaflets had been reviewed and were noted to be in date.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff in outpatients and diagnostic imaging departments worked on the principle of implied consent. This is when a patient acts in a way that is consistent with them understanding and complying with the request of the clinician and removes the need

for consent to be given in writing. Five sets of records were reviewed in dermatology and consent was documented in all cases where invasive treatment was required.
- Staff in physiotherapy advised that they do not undertake mental capacity assessments, if required they would access the mental capacity team that was available on the wards. Staff were given a leaflet that included the Mental Capacity Act as part of safeguarding e-learning to use as reference.

Are outpatient and diagnostic imaging services caring?

Good

Outpatient and diagnostic imaging services were delivered by caring, committed and compassionate staff, who treated people with dignity and respect. We observed how staff interacted with patients and found them to be polite, friendly and helpful.

Staff involved patients and those close to them in all aspects of their care and treatment. Care provided took an holistic view of patients' needs and feedback from patients was overwhelmingly positive about the care they had received. Staff worked with patients to empower and support them and attention to emotional needs was prioritised.

Compassionate care

- As part of our inspection we observed patients being treated with dignity and respect. This was supported by the patient-led assessments of the care environment (PLACE) audit for 2013 and 2014 which showed that the trust achieved higher than the national average for treating people with dignity and respect.
- Patients spoke positively about the care provided by staff. Some of the comments we received during our inspection were; "staff always introduced themselves", "the service is marvellous" and "staff are very polite". Patients in the breast centre also told us their "experience couldn't be better" and they felt "very lucky to have this service".
- Staff told us that there was always a nurse available to chaperone, we observed the policy and there were clear notices displayed on the walls of the breast centre informing patients of this service if they wanted to use it.
- We observed a group of patients receiving physiotherapy education and support. During the session we observed clear instructions from staff to patients, and there was a good friendly rapport. The session was delivered with a caring attitude and good support was provided in a relaxed atmosphere.

Understanding and involvement of patients and those close to them

- Patients in the breast centre told us the information leaflet they received with their hospital letter was "very informative" and "staff explain everything".
- Friends and Family forms were available in all the areas we visited with boxes for patients to submit feedback. Trust data showed that at May 2015, 99% of patients would recommend the breast service to their friends or family.
- There was information in the clinic areas about how to access interpreters and staff were aware of the process. Staff told us that interpreters could be booked in advance of the clinic appointment.
- We observed clinical support workers introducing themselves to patients at the start of their appointments and explaining what they were going to do.

Emotional support

- Patients from the breast centre were supported by breast care specialist nurses and could attend the HOPE course which was a group-based, self-management support course.
- Patients told us they could contact the specialist breast care nurse anytime and they always responded.
- For patients attending the breast unit psychological support was available at a nearby trust. This assisted patients to deal with the emotional effects of their diagnosis and treatment.
- The breast centre had the 'lavender room', a quiet, private room away from the main treatment area where patients could receive difficult information.
- We observed strong patient support and emotional care during a dermatology consultation.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services responsive?

Requires improvement

The outpatients' services across the whole trust did not achieve the national target for people waiting for treatment in July 2015 and August 2015. The trust consistently did not meet their own internal timescale targets for reporting on diagnostic imaging results during April 2015 to August 2015 however, patients were waiting less than six weeks for radiology appointments.

There was a large number of outpatient clinic appointments cancelled across the whole trust due to the process in place for rebooking appointments. Managers had plans to implement a partial booking system to reduce cancellation of appointments and to offer patients more choice. This had been introduced in some areas but IT problems had been encountered and it was not in place for all clinics at the time of our inspection.

Did not attend (DNA) rates were higher than the national average and increased significantly when physiotherapy outpatients information was included. A high number of DNAs was due to processes in place in relation to booking appointments and the trust were implementing a new partial booking system at the time of our inspection which is intended to reduce the number of DNAs and improve clinic utilisation.

Services were planned to meet patient's needs, and patient's individual needs were accommodated. Complaints were dealt with at service level where able and information how to raise a complaint was readily available across the outpatients and diagnostic imaging services. Complaints were mostly managed within the trust timeframe.

Service planning and delivery to meet the needs of local people

- Staff from the breast centre worked across the surgical and surgical outpatients department and clinic staff visited patients on the ward to ensure continuity of care.
- The length of appointments in the screening area of the breast centre was flexible with longer appointments available for symptomatic patients.
- Additional diagnostic services were available at St Catherine's Community Hospital and Victoria Central Hospital.
- Dermatology delivered "skin club" study days for health professionals in the community to educate and support staff to deliver services closer to patients' homes.
- Staff in back pain rehabilitation clinic were trained in cognitive behaviour therapy to support patients with their pain management.

Access and flow

- Diagnostic appointments were planned and arranged to meet both the needs of the patients and national referral to treatment targets. Additional clinics were scheduled as waiting list initiatives to improve access to clinics for patients in a timely manner.
- National targets to achieve 95% for patients on non-admitted pathways were not achieved for July 2015 and August 2015 with the lowest being 93.5% in August 2015. However, the trust did meet the target across the trust as a whole from April 2015 to June 2015. Non-admitted pathways covers those patients whose treatment started during the month and did not involve admission to hospital.
- In the period April 2014 - March 2015 the trust met the target for 93% for patients to be seen by a specialist within two weeks of an urgent referral for concerns about cancer.
- From April 2015 to April 2015, the trust performed worse than the England average for the percentage of people waiting less than 31 days from diagnosis to first definitive treatment. However, for the same period, the trust performed better than the England average for the percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment.
- The national target for referral to non-urgent radiology diagnostic tests to be undertaken is six weeks. This target was consistently met across the whole trust between September 2014 and August 2015 and the trust's performance was better than the England average.
- In the period May 2015 to August 2015 over 90% of routine radiological tests such as plain film x-rays were reported in the required timeframe. However, in the magnetic resonance imaging (MRI) department, routine reporting times were significantly lower falling to 24% in July 2015.

Outpatients and diagnostic imaging

- The trust had an internal target to report 98% of urgent radiology tests within a defined timescale from referral. The timescale was different for each and was determined by the type of radiology test required. In the period April 2015 to August 2015 the trusts internal reporting target was not achieved for x-ray and ultrasound scans. The radiology manager advised that a staffing review was in progress across diagnostic services.
- The 'did not attend' (DNA) rates were lower than the national average for January 2014 to Apr 2015 across the whole trust for outpatient appointments. However the external figures did not include physiotherapy. When physiotherapy figures were included the DNA rate increased from 5.9% to 9% at January 2015. Staff told us that there were a high number of DNAs due to the nature of the patient's condition; in particular, the back pain clinic. There was a plan in place to introduce a partial booking system with the aim of reducing DNAs and improving clinic slot utilisation. The partial booking system should allow patients more choice to access care and treatment at a time to suit them.
- Medical staff in the breast centre ran clinics concurrently with screening clinics to enable a 'one stop' service allowing patients to attend for investigations, biopsies and consultations in one appointment if required. This reduced the need for patients to return for multiple appointments and reduced waiting time for diagnostic results.
- Patients were kept informed of any delays when attending outpatient clinics, the breast centre or for diagnostic imaging.

Meeting people's individual needs

- Staff described how people in vulnerable circumstances were accommodated in the department so they were seen as soon as possible to reduce any anxiety for the patient. The service had facilities to accommodate bariatric (obese) patients within the physiotherapy and radiology departments which included bariatric beds, radiology machines and gowns.
- Access to interpreting services could be arranged by telephone or if staff were alerted to a patients requirements translators could be booked in advance however we did not see this system in use during our inspection.
- The breast centre held prosthetic clinics twice weekly along with tattooing services for patients post-surgery. This services was intended to support patients post-surgery to improve self-esteem and body image.
- Staff reported receiving in-house dementia training which provided staff with additional knowledge and skills to care and support patients with dementia who attended the departments.

Learning from complaints and concerns

- Trust wide clinical governance meetings were held in radiology and there was evidence that complaints were discussed and reviewed in meeting minutes.
- Initial complaints were dealt with by the clinic managers who resolved them locally where possible. During the period April 2014 to March 2015 there were 15 complaints for the clinical support division which included radiology, laboratory medicine, physiotherapy and occupational therapy. Of these complaints, 14 were closed within the trust's specified timeframe. There was evidence of duty of candour and feedback to staff was identified with the outcomes of the complaints. Lessons learnt from complaints was feedback to staff during planned or ad hoc meetings or via emails from the service leads.

Are outpatient and diagnostic imaging services well-led?

Requires improvement

The leadership and governance arrangements did not always support the delivery of high quality care.

Clinical governance measures were in place for radiology however, there had been no radiation safety committee meeting since September 2012. It is a statutory requirement that radiation protection meetings take place annually.

We observed plans in radiology that were developed for some areas to address sustainability and to improve services but there was a lack of communication on these plans to clinical staff. The sustainable delivery of quality care was put at risk by the financial challenge

Staff shortages had been identified and placed on the risk register. However, progress was slow to resolve the issue.

Outpatients and diagnostic imaging

Staff felt supported by their local managers however said they rarely saw any members of the trust board in their departments.

Teams worked well locally and we saw evidence that information was shared regarding key issues such as the outcome of incident investigations.

Managers in some areas were developing innovative practice to improve patient outcomes and experience and develop staff.

The trusts values were displayed throughout the hospital. Staff were aware of the trust values and staff were awarded and recognised for demonstrating the values within their work

Vision and strategy for this service

- The trust's vision was summarised as the PROUD approach of care, which stood for patient, respect, ownership, unity, dedication. Staff were aware of the vision and they were displayed on the notice boards.
- All staff we spoke to were aware of the trusts vision and values. We saw evidence of the trust values being considered in the annual appraisal process.
- The trusts vision and values were displayed throughout the departments.
- The dermatology team had been nominated for one of the trust's PROUD awards.

Governance, risk management and quality measurement

- Radiology departments should have a radiation safety committee which meets at least annually. The principle function of this committee is to ensure that clinical radiation procedures and supporting activities in the trust are undertaken in compliance with ionising and non-ionising radiation legislation. We saw evidence that the last formal meeting was held in September 2012. We viewed the trusts risk register for July 2015 and this was not identified as a risk however, the radiology manager advised us that the committee was set to meet in October 2015.
- Clinical governance meetings were held in the radiology department across the trust to review risks, incidents and complaints and to identify trends.
- The outpatients and diagnostic service departments recorded risks on the trusts central and departmental risk registers. There was one risk recorded on the department risk register at July 2015. The risk identified related to patients not being able to get through on the telephone to book an appointment. This had been on the register since May 2012 and had a review date identified for August 2015. We observed action plans with timeframes on the risk register and changes that had been completed to date.
- We saw that staffing shortages in haematology had been on the risk register since 2013 and a shortage of sonographers had been on the register since 2012 however, there was a national shortage of sonographers that was having an negative impact on recruitment.
- Information was shared with staff via team meetings, trust bulletins, and emails from service leads.

Leadership of service

- Despite management being based on the Arrowe Park Hospital site, staff reported that managers were accessible. Most staff felt supported by their local managers however, stated that the executive team were not visible.
- Monthly team meetings were held in the dermatology clinic to ensure effective communication with staff.
- Managers had a good knowledge of performance in their areas of responsibility and they understood the risks and challenges to their service.
- Staff reported that they were aware of weekly question and answer sessions with the Chief Executive online but staff we spoke with did not say they had used this system to communicate with the Chief Executive.
- Some staff described a comprehensive induction process on commencing employment with the trust. In physiotherapy a structured support network was in place and all assessments and treatment plans were peer reviewed. There was an internal mentor who meets with staff each week.

Culture within the service

- There was evidence of good team working and high morale in the areas we visited. Staff were committed and proud of their work.
- One member of staff in the breast centre described her colleagues as "a lovely bunch of people", another in radiology stated that it's "not just about coming to work".
- Divisional directors said they were most proud of the staff and their responsiveness to other services and how they cope with competing demands.

Outpatients and diagnostic imaging

Public engagement

- Staff were keen to engage patients and the public to improve the patient experience. In physiotherapy there were pre and post treatment audits in place.
- Dermatology had a "working together" patient group to raise skin awareness and they had recently sent a survey to GPs to gain their ideas on potential areas for development.
- The breast centre participated in the National Cancer Patient Experience survey and patient questionnaires were sent to patients three times a year to assist in improving breast services. Patient workshops were held and feedback was provided to the centre. The breast centre also had an active patient support group. This was evidenced in the meeting minutes we reviewed relating to this group.

Staff engagement

- Listening in to action meetings were just beginning in the radiology department to engage with staff.
- Staff reported that weekly emails were received from the Chief Executive and that ideas and suggestions could be voiced.
- Staff participate in the friends and family survey.

Innovation, improvement and sustainability

- A pain management programme was provided for patients struggling with back pain. Psychological and emotional input was offered in conjunction with physiotherapy to treat both physical and mental symptoms. An audit of the service was observed and patients had identified improvements in pain management and quality of life.
- The dermatology clinic were developing their nurses to provide surgical interventions which should provide promotional opportunities within the service in addition to a reduction in patient waiting times.

Outstanding practice and areas for improvement

Outstanding practice

- We observed staff interacting with patients on a one to one basis in surgical areas and displaying a caring attitude which went beyond what was expected. Staff encouraged patients and their relatives to be partners in their care. Staff were observed to go above and beyond to meet patients preferences. We observed strong relationships between staff, patients and their relatives.
- Patients' needs and preferences were central to the planning and provision of services at Clatterbridge Hospital. One example of this was the repurposing of a clinical area into a mock dwelling. This was designed to help prepare patients for discharge to their own home and bridge the gap between acute patient care and community rehabilitation. Patients could 'move' into the dwelling with their relatives for short periods before discharge. This helped staff identify whether any further measures were needed before patients were discharged. It also empowered patients to maintain their independence and improve their confidence prior to discharge. Staff told us that this had been introduced partly due to issues which were raised around patients discharge home when they felt they weren't ready.
- The sentinel stroke national audit programme (SSNAP) latest audit results rated the trust overall as a grade 'A' which was an improvement from the previous audit results when the trust was rated as a grade 'B'. Since October 2014 the trust had either been ranked first or second regionally in the SSNAP audit.

Areas for improvement

Action the hospital MUST take to improve

Medical care (including older people)

- The trust must ensure that robust information is collected and analysed to support improvements in clinical and operational practice.
- The trust must deploy sufficient staff with the appropriate skills on the Clatterbridge rehabilitation unit at night.
- The trust must ensure there is adequate medical cover out of hours for the hospital.
- The trust must ensure there is a clear operational protocol for the transfer of patients who deteriorate on the Clatterbridge Hospital site.

Surgery

- The trust must ensure that all staff involved with the care and treatment of children receive adequate life support training.
- The trust must ensure there is sufficient medical cover out of hours for the hospital.
- The trust must ensure there is a clear operational protocol for the transfer of patients who deteriorate on the Clatterbridge Hospital site.
- The trust must ensure that the doors which lead to high balconies on the ward areas are suitably secured.

Outpatients and diagnostic imaging

- The trust must take action to reduce the delay in referral to reporting times of urgent diagnostic investigations.
- The trust must resume radiation safety committee meetings and hold them at least annually.
- The trust must take steps to fill vacancies to ensure compliance against their current staffing establishment.

Action the hospital SHOULD take to improve

Medical care (including older people)

- The trust should ensure that all patients consent to the use of bedrails and if they lack capacity to consent, the principles of the Mental Capacity Act (2005) are adhered to. Practice should be supported by clear policies, procedures and training.

Outstanding practice and areas for improvement

- The trust should ensure that records are kept secure at all times so that they are only accessed and amended by authorised people.
- The trust should ensure that actions to improve standards of medicines management are identified and addressed in a timely way.

- 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.

Surgery

- The trust should ensure that senior managers are visible at the Clatterbridge Hospital on a regular basis and that staff at the site are engaged with the overall trust strategy and vision.

Outpatients and diagnostic imaging

- The trust should ensure all resuscitation trolleys are checked within the defined timescales and that documentation is completed to confirm it has been done.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 15: Premises and equipment **How the regulation was not being met:** Access to and exits from a ward were not appropriately secure. This is because the security arrangements presented a risk that patients may leave and visitors may enter unnoticed. HSCA 2008 (Regulated Activities) Regulations 2014, Regulation 15 (1) (b).

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 12: Safe care and treatment **How the regulation was not being met:**

This section is primarily information for the provider

Requirement notices

Care and treatment did not include arrangements to respond appropriately and in good time to people's changing needs. The provider did not have arrangements to take appropriate action if there was a clinical or medical emergency.

This is because there wasn't a standard process or procedure in place in the event that a patient deteriorated and required transfer to an acute hospital.

In addition, there were lengthy delays in the reporting of urgent diagnostic test results.

HSCA 2008 (Regulated Activities) Regulations 2014, Regulation 12 (1) (2) (a) (b)

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 17: Good Governance **How the regulation was not being met:** Systems and processes were not always operated effectively to ensure that the risks relating to the health, safety and welfare of service users and others were assessed, monitored and mitigated in a timely way. This is because all departments had a risk register but the risks were not always managed and mitigated in a timely way. In addition, radiation safety committee meetings were not being held at least annually. HSCA 2008 (Regulated Activities) Regulations 2014, Regulation 17(2)(b)

This section is primarily information for the provider

Requirement notices

How the regulation was not being met:

Records were not always secure.

This is because record trolleys were left unlocked on the clatterbridge rehabilitation centre.

HSCA 2008 (Regulated Activities) Regulations 2014, Regulation 17(2) (c).

How the regulation was not being met:

The provider did not always assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services)

The provider did not seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity

The provider did not evaluate and improve in respect of the processing of information.

This is because the trust did not collect and analyse all available information in medical care to support improvements in clinical and operational practice.

HSCA 2008 (Regulated Activities) Regulations 2014, Regulation 17(2)(a)(e)(f)

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 18 HSCA (RA) Regulations 2014 Staffing
Surgical procedures	

This section is primarily information for the provider

Requirement notices

Treatment of disease, disorder or injury

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 18: Staffing

How the regulation was not being met:

There were not always sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed to meet the needs of the patients.

This is because there were shortages of nurses and medical staff in the hospital, particularly in medical care services and radiology.

In addition, there was an insufficient number of staff in theatre recovery with training in paediatric life support despite caring for children.

HSCA 2008 (Regulated Activities) Regulations 2014, Regulation 18 (1) (2) (a)