Care Quality Commission

Warrington and Halton Hospitals NHS Foundation Trust

Warrington Hospital

Quality Report

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

Ratings

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

Summary of findings

Summary of findings

Letter from the Chief Inspector of Hospitals

Warrington Hospital is one of three locations providing care as part of Warrington and Halton Hospitals NHS Foundation Trust. It provides a full range of hospital services including emergency care critical care, general medicine including elderly care, general surgery, orthopaedics, anaesthetics, a level 2 neonatal unit, paediatrics and maternity services. The trust also provides services from Halton General Hospital (including the Cheshire and Merseyside Treatment Centre) and genito-urinary medicine services from Bath Street Health and Wellbeing Centre.

Warrington and Halton Hospital NHS Foundation Trust provides services across the towns of Warrington, Runcorn (where Halton General Hospital is based), Widnes and the surrounding areas. It provides access to care for over 500,000 patients.

We carried out this inspection as part of our comprehensive inspection programme.

We carried out an announced inspection of Warrington Hospital between 27 and 29 January 2015. In addition an unannounced inspection was carried out between 5pm and 8.30pm on 11 February 2015. As part of the unannounced visit we looked at the management of medical admissions out of hours.

Overall we rated Warrington Hospital as 'requires improvement'. We have judged the service as 'good' for caring and effective. However improvements were needed to ensure that services were safe, responsive to people's needs and well-led.

Our key findings were as follows:

Access and patient flow

- Due to the increasing numbers of emergency admissions, there was continual pressure on the availability of beds at the hospital. Bed occupancy in the trust overall exceeded the England average throughout 2014, with bed occupancy levels within the medical division in excess of 100%. This meant that some patients were not always placed in the area best suited to their needs. As a result, the management of patient access and flow across the hospital was of concern and remained a significant challenge for managers.
- There were also pressures placed on bed capacity by the number of delayed discharges, which meant people were in hospital longer than they needed to be. In critical care, staff told us that there were times when, due to bed pressures within the rest of the hospital, pressure was applied to take more patients than they had the staffing levels to manage. As a result, there were times when patients' needs outweighed the staffing numbers and skill mix.
- We also identified concerns relating to the management and utilisation of the theatre recovery 'stabilisation bay'. The standard operating protocol in place for the stabilisation bay stated that up to two patients could be admitted for a maximum of four hours. However, there were instances when more than two patients were admitted to the bay and they often stayed longer than four hours. In some cases patients were cared for in the stabilisation bay for up to two days. The stabilisation bay was also an unsuitable environment for caring for inpatients. There was no privacy, no facilities for relatives and at times children would be in the same area as adults. Furthermore nurses working in the bay were recovery nurses supported by operating department practitioners. This meant that they didn't always have the competencies needed for managing critical care patients in the longer term.

Cleanliness and infection prevention and control

- The trust had six cases of MRSA in the period from April 2013 to September 2014. (The target is zero).
- The trust's Clostridium difficile (C.diff) infection rate had mainly been worse than (higher than) the England average since September 2013.
- Each MRSA and C. diff incident was investigated to identify the root cause. Action plans had been developed to prevent recurrence.

Summary of findings

- However, staff were aware of and applied infection prevention and control guidelines.
- We observed good practices in relation to hand hygiene, 'bare below the elbow' guidance and the appropriate use of personal protective equipment, such as gloves and aprons, while delivering care.
- Patients received care in a clean, hygienic and suitably maintained environment.
- Appropriate equipment was in good supply and was clean and well maintained.

Medical staffing

- Medical treatment was delivered by skilled and committed medical staff.
- However, there were not always enough medical staff to provide timely treatment and review of patients, particularly out of hours.
- There were a high number of vacancies in some areas, particularly the emergency department and medical care.
- Existing vacancies and shortfalls were covered by locum, bank or agency staff when required. All agency and locum staff had to undertake a local induction before they were allowed to work in the trust.
- British Association of Perinatal Medicine recommendations for Local Neonatal Unit (LNU) out-of-hours Tier 1 medical cover were not adhered to. Trainee doctors told us they had raised this as a serious concern, but it was not clear what action had been taken as a result. Neonatal nurses also told us that they had concerns related to the level of medical cover at night and weekends.

Nursing staff

- Care and treatment was delivered by committed staff. However nurse staffing levels, although improved, remained a challenge in some key areas. Vacancies and staff absences were covered by bank staff, overtime and agency staff. Although the wards and departments were suitably staffed at the time of our inspection, covering staffing shortfalls in this way is not a long-term sustainable position. This was acknowledged by the hospital management team who were making continuing efforts to recruit staff both nationally and internationally.
- Although we found staffing levels were adequate at the time of our inspection, there was no flexibility in numbers to cope with increased capacity and demand, or short notice sickness and absence.

Mandatory training

- Mandatory training attendance varied across the divisions, but on the whole was below the set target of 85% .

Mortality rates

- Mortality and morbidity meetings were held weekly at divisional level and were attended by representatives from all teams within the relevant divisions. As part of these meetings, attendees reviewed the notes for every patient who had died in the hospital within the previous week. Any learning identified was shared and applied.

Nutrition and hydration

- Patients had a choice of nutritious food and an ample supply of drinks during their stay in hospital. Patients with specialist needs in relation to eating and drinking were supported by dieticians and the speech and language therapy team.
- There was a coloured jug system in place to identify and support patients who needed assistance with eating and drinking.
- Support was given in a sensitive and discreet way.

Medicines management

- Medicines were provided, stored and administered safely and securely.
- Anticipatory prescribing in end of life care was embedded in line with best practice. This meant that pain relief and other medication could be provided in a timely way when a patient's condition changed.

Summary of findings

Areas of outstanding practice included:

- In 2014, the bereavement service for women and their partners who had lost a baby won the national Butterfly Award for “best hospital bereavement service”.
- The hospital had a purpose built and highly effective ward for patients living with dementia which was well equipped and staffed. Patients with dementia were assessed and admitted to the ward based on the severity of their dementia.
- The hospital ran a "Hello, my name is...would you like a drink?" campaign to raise awareness within the service of issues surrounding hydrating patients, the importance of accurately filling in fluid balance charts and the prevention and treatment of patients with Acute Kidney Injury.

However, we found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 [now Health and Social Care Act 2008 (Regulated Activities) Regulations 2014] and the trust needs to make improvements in these areas.

Importantly, the trust must:

- Ensure that medical staffing is sufficient to provide appropriate and timely treatment and review of patients at all times, including out of hours.
- Ensure that medical staffing is appropriate at all times, including medical trainees, long-term locums, middle-grade doctors and consultants.
- Ensure that nursing and midwifery staffing levels and skill mix are appropriate, particularly in medical care services and maternity.
- Improve the levels of mandatory training compliance.
- Improve the rate of appraisals completion.
- Improve patient flow throughout the hospital to ensure patients are cared for on the appropriate ward for their needs and reduce the number of patient bed moves, particularly in the medical division.
- Ensure the protocols for the use of the stabilisation bay are followed to ensure patients do not stay there longer than four hours, and that no more than two patients are in the bay at any one time.

In addition the trust should:

In urgent and emergency services:

- Ensure staff complete the Malnutrition Universal Screening Tool (MUST) for all patients who require one.
- Ensure all staff in the department have time to take their allocated breaks.
- Look to improve compliance with the Department of Health target to treat 95% of patients within four hours.

In medical care services:

- Improve processes in place for providing feedback and learning from incidents and complaints.
- Review systems in place to ensure essential equipment is replaced in a timely manner.
- Aim to improve access to seven day services for all disciplines across the medical division.
- Improve processes in place to ensure risks within the division are clearly communicated to nursing staff. Review the admission process for the GP Acute Medical Unit to ensure patients are appropriately referred to the service.

In critical care services:

- Take action to reduce the number of delayed discharges.

Summary of findings

- Ensure medical records are fully and appropriately completed, in particular the second daily consultant reviews and regular entries by the parent medical team.

In maternity and gynaecology services:

- Ensure there is a clear vision and strategy for both midwifery and gynaecology services that is clearly communicated with staff.
- Improve local leadership in maternity services to ensure a cohesive approach to care delivery between medical and nursing staff.
- Continue to improve staff engagement.
- Continue to embed and promote the care of low risk women in line with NICE guidelines.

In end of life care services:

- The increase in referral rates year on year presented a challenge for the service and the provider should ensure that the specialist palliative care team has the appropriate staffing levels and skill mix to meet the demands on the service.
- Review its access to specialist medical advice over 24 hours in line with national guidance for end of life care.
- Review accommodation at ward level to ensure that patients at the end of their lives can be nursed in appropriate rooms that afford privacy for the patient and families.
- Ensure smooth transition of leadership within the palliative care team.

In outpatients and diagnostic imaging services:

- Take action to ensure that waiting times for outpatient clinics are improved.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Good	There were systems in place for reporting and managing incidents. Staff were familiar with the system and used it appropriately to record incidents. There was a risk-aware culture in the department and evidence of learning from incidents to avoid recurrence. Patients received care in a clean and suitably maintained environment. There was a good supply of clean and well maintained equipment. Medicines and records were managed effectively and safely. Staff were aware of the safeguarding policy and escalated concerns regarding abuse or neglect appropriately. Staffing levels were sufficient to meet patients' needs and processes were in place to ensure resource and capacity risks were managed. However, the department had a high number of nursing staff vacancies and high sickness rates. These were covered by bank staff overtime and agency staff; however this position was not sustainable in the longer term. There were efficient and well managed processes in place for handovers. Treatment and care was provided in line with national guidance and evidence based practice. Patients were assessed for pain relief as they entered the emergency department. There was effective collaboration and communication among all members of the multidisciplinary team. Staff understood the legal requirements of the Mental Capacity Act 2005 and had access to link workers such as the safeguarding lead to support good practice in this regard. Staff treated patients with dignity, compassion and respect at all times. Patients spoke positively about the care and treatment they had received. Staff provided patients and their families with emotional support and comforted patients who were anxious. Performance against the national A&E target set by the Department of Health target to admit or discharge 95% of patients within four hours of arrival was poor. At the time of the inspection, the emergency department had only met this target once since April 2014. During routine operating hours, the department could cope with the patient

Summary of findings

flow. However, when patients could not be appropriately placed in the hospital, this negatively affected the patient flow. This was a constant challenge in the department and in the hospital as a whole.
The organisation's vision and strategy had been cascaded to all staff. There was clearly defined and visible leadership and staff and staff felt there was an open and supportive culture. Staff were engaged, enthusiastic and proud of the work they did.

Medical care **Requires improvement**

There were high numbers of consultant vacancies across the medical division. There were processes in place which were followed to ensure the condition of patients was monitored to identify any potential deterioration. However, emergency medical cover out of hours was provided by junior medical staff who did not always feel they had the skills and experience to deal with the severity of the patients' conditions. Nurse staffing levels on some wards were below established numbers and high levels of bank and agency staff were necessary to provide safe and effective care for patients.
There were systems in place for reporting incidents but feedback to staff was variable, particularly to junior doctors. Levels of mandatory training completion were below set targets of 85% for clinical staff across all disciplines. There was limited evidence of learning from complaints. Pressures on the availability of beds resulted in patients regularly being cared for on wards outside of their speciality, or being moved around the hospital during their stay. Patients in elective general medicine, cardiology and non-elective cardiology were regularly in hospital for longer than they needed to be. In all other areas the average length of stay was either in line with or better than the national average.
National guidelines were used to treat patients. Outcomes for patients were as good as, or better than the England average for most medical conditions. Patient care and treatment was delivered by a multi-disciplinary care team, although seven day working was not in place throughout the medical division. Services were delivered by caring and compassionate staff. We

observed that staff treated patients with dignity and respect. Care was planned and delivered in a way that took into account the wishes of the patients.
The trust had a vision and strategy for the organisation with clear aims and objectives that had been cascaded across the medical division. Risks and performance within the medical division were discussed regularly at both ward and divisional level, although the systems in place to communicate risks and changes in practice to frontline nursing staff were not robust.

Surgery

Good

Patient safety was monitored and incidents were investigated to assist learning and improve care. Patients received care in safe, clean and suitably maintained premises. There was a good supply of suitable, clean and well maintained equipment. Medicines were stored and administered safely and securely. Patient records were completed appropriately. The staffing levels and skills mix was sufficient to meet patients' needs and staff assessed and responded to patients' risks appropriately.
Staff received mandatory training in order to provide safe and effective care. However, levels of mandatory training attendance within the division were variable, with some areas falling well below the trust target of 85%.
The surgical services provided care and treatment that followed national clinical guidelines and staff used care pathways effectively. Surgical services performed in line with similar sized hospitals and with the England average for most safety and clinical performance measures. Where these standards had not been achieved, actions had been taken and this had led to improvements in compliance.
Patients received care and treatment by trained, competent staff that worked well as part of a multidisciplinary team. Patients spoke positively about their care and treatment. They were treated with dignity and compassion.
The majority of patients were admitted, transferred or discharged in timely manner. The surgical services achieved the 18 week referral to treatment standards for most specialties and there had been

recent improvements in performance where these standards had not previously been achieved, such as for trauma and orthopaedics. A number of inpatient beds in the surgical wards were occupied by patients receiving medical care (medical outliers). This meant that operations were sometimes cancelled due to the lack of beds available for surgical patients. The hospital was working to address this by reviewing the way surgical beds were allocated to patients. The majority of patients whose operation was cancelled for non-medical reasons were treated within 28 days.

There was clearly visible leadership within the surgical services. Staff were positive about the culture and support available. The management team understood the key risks and challenges to the service and the actions in place to address them.

Critical care **Requires improvement**

There were significant numbers of delayed discharges from critical care. During 2014, 27% of patients experienced delays in discharge of more than 24 hours. The occupancy figures collated by NHS England showed that the bed occupancy for December 2014 was 100%. However data provided by the trust indicated that occupancy overall for the month of December 2014 was 80%. Staff told us there were times, due to access and flow issues within the rest of the hospital, when pressure was applied to take more patients than they had the staffing levels to cope with. As a result, staff felt that on these occasions the acuity level of the patients on the unit outweighed the staffing numbers and skill mix.

In addition, we identified concerns relating to the management and utilisation of the theatre recovery 'stabilisation bay'. The standard operating protocol in place for the stabilisation bay stated that up to two patients could be admitted for a maximum of four hours. There were instances when more than two patients were admitted to the bay and they stayed in excess of four hours although it was not clear how often the stabilisation bay had operated outside of the standard operating protocol. We found examples of cases where patients were cared

for in the stabilisation bay for up to two days. The stabilisation bay did not provide a suitable environment for caring for patients in the medium term.
Nursing documentation contained appropriate assessments. In medical records however, second daily consultant reviews were not always recorded. In addition, routine entries from the parent medical team were not present. We saw that in most cases people's care needs were assessed, planned and delivered in a manner that protected their rights and maintained their dignity.
Patients and their relatives were treated with understanding, compassion, dignity and respect. The team was good at involving patients, family and friends in all aspects of their care and treatment.
Care was delivered in line with evidence- based, best practice guidance. The results from ICNARC showed that patient outcomes and mortality were within the expected ranges when compared with similar units nationally. There were clear systems in place and a transparent culture towards reporting, investigating and learning from incidents. There was good access to seven day services including out-of-hours intensivist support and pharmacy, physiotherapy and imaging services.

Maternity and gynaecology — **Requires improvement**

Patients were at risk of avoidable harm as a result of the number of midwives being frequently below the safe staffing levels set by the trust. Staff were not up to date with essential training and regular safety checks on emergency equipment were not carried out appropriately and in a timely manner.
There was a lack of action for improvement where data showed this was necessary. Access to the maternity services and the flow of patients through the departments was impeded by lack of adequate staff and insufficient capacity to meet the demand.
The leadership of the service was reactive and staff were not clear on the future strategy for maternity services.
There had been some improvements since our last inspection in June 2014, in the assessment of patients and the care of those women who were assessed as being low risk. However systems were still new and there remained a risk averse culture

among some staff. Progress had also been made towards collaborative working between midwifery and medical staff although further improvements were required.
Staff were caring, kind and patient and were committed to providing good care to patients.

Services for children and young people

Good

Evidence based care and treatment was delivered in line with best practice guidance. Good multidisciplinary team working was evident. There were suitable processes in place to ensure consent was obtained appropriately. Family centred care was the prevailing philosophy in children and young people's services. Parents were generally enthusiastic about the care their children received from the medical and nursing staff. We observed positive, compassionate interactions between staff and patients and their families.
Staff had a clear vision of how to develop and improve the service. The trust had developed a paediatric service strategy 2013-2016 plan. There were clear aspirations to develop the service, with each action allocated to a specific member of staff. We also found clear examples of areas within the service that were being developed. For example, the service was working closely with commissioners to develop and expand the paediatric acute response team (PART) and define the future pathway for paediatric community services. The service was also in the process of developing a community respiratory service.
However, the risk register identified that staff shortages in the neonatal unit may lead to closure of the unit. This would result in babies being transferred to other units in the Cheshire and Merseyside area. The service had responded to this and were meeting British Association of Perinatal Medicine (BAPM) 2014 standards at the time of our inspection. However, BAPM recommendations for Local Neonatal Unit (LNU) out-of-hours Tier 1 medical cover were not adhered to. Trainee doctors told us they had raised this as a serious concern. Neonatal nurses also told us that they had serious concerns related to the level of medical cover at night and weekends. Following our inspection the service undertook a review of the tier one support provided on the neonatal unit. The investigation

found that whilst there had been no concerns identified in relation to patient safety or quality of care, the service should look at developing the nursing staff further to include an advanced neonatal nurse practitioner and enhanced practitioner team.

End of life care

Good

There were sufficient numbers of trained clinical, nursing and support staff with an appropriate skill mix to ensure that patients receiving end of life care were well cared for in all the settings we visited. However, there was no access to specialist palliative medical support out of hours. Medicines were prescribed, stored and administered appropriately. Access to syringe drivers for people needing continuous pain relief was available.

The trust was introducing the “amber care bundle” and had appointed a designated member of staff who worked with the palliative care team to facilitate implementation across the trust. Where DNACPR (Do Not Attempt Cardio Pulmonary Resuscitation) forms were in place, we found that patients were involved in the discussion about their decision or there was a capacity assessment recorded in their medical notes.

However, we found that patients at the end of their lives could not always be assured of a single room to ensure their privacy. The management of risk was in place at a divisional level but further work was required to ensure that staff at all levels of the organisation were aware of the service risks and had access to feedback from governance systems.

Outpatients and diagnostic imaging

Requires improvement

There were systems for reporting actual and near-miss incidents across the hospital. Staff told us they understood what to report and were able to show us how they would report an incident through the electronic reporting system. However some staff told us that they did not always report incidents on the system as they did not have time and would rather resolve the issue such as the availability of a complete record for a patient.

Data provided by the trust showed that they had achieved over 97% availability of records for outpatient appointments. However there were occasions in the audiology and fracture clinics at Warrington Hospital when complete patient records were not available for an appointment. In such

cases staff prepared a temporary file for patients that included the most recent diagnostic and test results coupled with essential patient information so that the patient's appointment could go ahead. Staff acknowledged that this was not ideal; however it meant the patient did not have to reschedule their appointment. Going forward, there was a plan in place to implement an electronic records system throughout the service in 2015. A key risk for the service was the poor clinic efficiency due to the increase in waiting lists and clinics being arranged at short notice. We did not see a clear plan in place to ensure that the risk was managed effectively.

Staff were aware of the trust's vision and values but were unclear as to the future strategy for outpatient and diagnostic imaging services.

Staff followed good practice guidance in relation to the control and prevention of infection .Records showed that regular hand hygiene audits were undertaken which demonstrated high compliance rates throughout the outpatient areas. There were systems in place for reporting safeguarding concerns. Staff were clearly able to explain their role in safeguarding and how they would escalate concerns in this regard.

Requires improvement

Warrington Hospital

Detailed findings

Services we looked at

Urgent & emergency services; Medical care (including older people's care); Surgery; Critical care; Maternity and Gynaecology; Services for children and young people; End of life care; Outpatients & Diagnostic Imaging

Contents

Detailed findings

Background to Warrington Hospital

Warrington Hospital provides a full range of hospital services including emergency care critical care, general medicine including elderly care, general surgery, orthopaedics, anaesthetics, a level 2 neonatal unit, paediatrics and maternity services. The trust also provides services from Halton General Hospital (including the Cheshire and Merseyside Treatment Centre) and genito-urinary medicine services from Bath Street Health and Wellbeing Centre.

Warrington and Halton Hospital NHS Foundation Trust provides services across the towns of Warrington, Runcorn (where Halton General Hospital is based), Widnes and the surrounding areas. It provides access to care for over 500,000 patients. In total the trust has 591 beds.

We carried out this inspection as part of our comprehensive inspection programme.

Our inspection team

Our inspection team was led by:

Chair: Andy Welch, Medical Director & Consultant ENT Surgeon, Newcastle NHS Foundation Trust

Head of Hospital Inspections: Ann Ford, Care Quality Commission

The team included an inspection manager, nine CQC inspectors, two experts by experience and a variety of specialist advisors including consultant medical staff, senior nurses, allied health professionals and governance experts.

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, we reviewed a range of information we held about Warrington and Halton Hospitals NHS Foundation Trust and asked other organisations to share what they knew about the hospital. These included local 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 in Halton and in Warrington on 26 January 2015 when people shared their views and experiences of Warrington Hospital. Some people also shared their experiences by email or telephone.

The announced inspection of Warrington Hospital took place from 27 to 29 January 2015. We held focus groups and drop-in sessions with a range of staff in the hospital, including nurses, trainee doctors, consultants, midwives, student nurses, administrative and clerical staff, physiotherapists, occupational therapists, pharmacists, domestic staff and porters. We also spoke with staff individually as requested.

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

We also undertook an unannounced inspection between 5pm and 8.30pm on 11 February 2015. During the unannounced inspection we looked at the management of medical admissions out of hours.

Detailed findings

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

Facts and data about Warrington Hospital

Warrington Hospital is one of three locations providing care as part of Warrington and Halton Hospitals NHS Foundation Trust. In total, the trust has 591 beds. In 2013/14 there were 46,165 inpatient admissions, 421,240 outpatient attendances and 84,536 emergency department attendances.

Warrington and Halton Hospital NHS Foundation Trust provides services across the towns of Warrington, Runcorn (where Halton General Hospital is based), Widnes and the surrounding areas. It provides access to care for over 500,000 patients. The trust employs 3,389 members of staff. The total revenue for the trust was £212.7 million while the full cost was £215.6 million. This meant the trust had a deficit of £2.9 million.

The health of people across Warrington and Halton varies, but outcomes for people tend to be worse than the national average, particularly in the Halton area. Life expectancy for men and women in both areas is worse than the national average. There is also a higher number of hospital stays due to self-harm and alcohol related harm in both areas, compared to the national average.

Detailed findings

Our ratings for this hospital

Our ratings for this hospital are:

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

Urgent and emergency services

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

Information about the service

Urgent and emergency services were provided across two sites that form part of Warrington and Halton Hospitals NHS Foundation Trust. The emergency department at Warrington Hospital consisted of an accident and emergency department (A&E) that was open 24 hours a day, seven days a week, providing urgent and emergency care and treatment for children and adults across Warrington and Halton, and a clinical decisions unit (CDU).

Urgent and emergency services provided by Warrington and Halton Hospitals NHS Foundation Trust saw approximately 100,783 patients between April 2013 and March 2014. Approximately 22% of patients were admitted to hospital.

There are 13 bays in the major injuries area of the adults' A&E department. Five of those bays are for resuscitation, with one designated for significant trauma and one for children and young people. There are seven bays in the minor injuries area and a lounge area for patients awaiting discharge. The paediatric area consists of three cubicles and five open beds. There is ample room in the waiting areas and there are specific areas for parents to breastfeed their children.

Patients who require diagnosis, observation, treatment and rehabilitation, but are not expected to need an overnight stay, attend the CDU. The CDU consists of nine beds and five chairs for patients who are mobile. Patients who attend the unit can be discharged with an appointment to return for further assessment.

As part of our inspection we visited the emergency department during our announced inspection on 27–29 January and as part of our unannounced inspection on 11 February 2015. We spoke with patients and relatives, observed care and treatment and looked at care records. We also spoke with a range of staff at different grades including the associate divisional director of unscheduled care, the associate director of nursing for unscheduled care, the clinical lead, the assistant matron for A&E, the interim A&E manager, consultants, associate specialists, emergency nurse practitioners, nurses, the senior sister coordinator, the safety and risk link nurse, the departmental assistant, the ambulance liaison officer (who was employed by another organisation), healthcare assistants, domestics and receptionist staff. We received comments from our listening events and from people who contacted us to tell us about their experiences, and we reviewed performance information about the trust.

Urgent and emergency services

Summary of findings

There were systems in place for reporting and managing incidents. Staff were familiar with the system and used it appropriately to record incidents. There was a risk-aware culture in the department and evidence of learning from incidents to avoid recurrence. Patients received care in a clean and suitably maintained environment. There was a good supply of clean and well maintained equipment. Medicines and records were managed effectively and safely. Staff were aware of the safeguarding policy and escalated concerns regarding abuse or neglect appropriately. Staffing levels were sufficient to meet patients' needs and processes were in place to ensure resource and capacity risks were managed. However, the department had a high number of nursing staff vacancies and high sickness rates. These were covered by bank staff overtime and agency staff; however this position was not sustainable in the longer term.

There were efficient and well managed processes in place for handovers.

Treatment and care was provided in line with national guidance and evidence based practice. Patients were assessed for pain relief as they entered the emergency department. There was effective collaboration and communication among all members of the multidisciplinary team. Staff understood the legal requirements of the Mental Capacity Act 2005 and had access to link workers such as the safeguarding lead to support good practice in this regard.

Staff treated patients with dignity, compassion and respect at all times. Patients spoke positively about the care and treatment they had received. Staff provided patients and their families with emotional support and comforted patients who were anxious.

Performance against the national A&E target set by the Department of Health target to admit or discharge 95% of patients within four hours of arrival was poor. At the time of the inspection, the emergency department had only met this target once since April 2014. During routine operating hours, the department could cope with the patient flow. However, when patients could not be appropriately placed in the hospital this negatively affected the patient flow. This was a constant challenge in the department and in the hospital as a whole.

The organisation's vision and strategy had been cascaded to all staff. There was clearly defined and visible leadership and staff and staff felt there was an open and supportive culture. Staff were engaged, enthusiastic and proud of the work they did.

Urgent and emergency services

Are urgent and emergency services safe?

Good

There were systems in place for reporting and managing incidents. Staff were familiar with the system and used it appropriately to record incidents. There was a risk-aware culture in the department and evidence of learning from incidents to avoid reoccurrence. Patients received care in a clean and suitably maintained environment. There was a good supply of clean and well maintained equipment.

Medicines and records were managed effectively and safely. Staff were aware of the safeguarding policy and escalated concerns regarding abuse or neglect appropriately. Staffing levels were sufficient to meet patients' needs and processes were in place to ensure resource and capacity risks were managed. However, the department had a high number of nursing staff vacancies and high sickness rates. These were covered by bank staff overtime and agency staff; however this position was not sustainable in the longer term.

There were efficient and well managed processes in place for handovers. The trust had an up-to-date major incident plan that listed key risks that potentially could affect the provision of care and treatment. However, records showed that not all staff had received appropriate mandatory training in line with the trust target (85%).

Incidents

- Staff were confident about reporting incidents, near misses and poor practice.
- Incidents were raised via the electronic incident reporting system, by completing paper incident reporting forms or by leaving a message with an automated telephone system which was picked up by the governance team and entered into the electronic incident reporting system. A policy was in place to support this approach.
- Trust data showed there were 1007 incidents reported in relation to urgent and emergency services from January 2014 to December 2014. The majority of these were raised in relation to patients attending the department with pressure ulcers that had been acquired in the community.
- Following that the main reasons for incidents reported were in relation to blood specimen collection errors and incorrectly labelled specimens. As a result of these incidents, staff in the emergency department had received additional training in collecting and labelling specimens.
- In 2013/14 two incidents had been reported via the Strategic Executive Information System (STEIS), one in relation to a child death and one in relation to an allegation of assault against a healthcare professional. The associate director of governance told us the child death was reported for information only as no incident had occurred at the trust. We reviewed the incident report for the allegation of assault which showed that a multidisciplinary team undertook the investigation and developed an action plan (that included staff training), which was monitored. A policy was also in place for dealing with aggressive and abusive patients.
- Staff were able to describe recent incidents and clearly outlined actions that had been taken as a result of incident investigations to prevent reoccurrence.
- Learning from incidents was shared across the department via noticeboards, newsletters and safety huddles at handovers.

Cleanliness, infection control and hygiene

- The emergency department and the clinical decisions unit (CDU) were both clean, well maintained and in a good state of repair. Staff were aware of current infection prevention and control guidelines and we observed good practices such as hand washing facilities and hand gel being available throughout the departments. Staff followed hand hygiene and 'bare below the elbow' guidance and staff wore personal protective equipment, such as gloves and aprons, while delivering care.
- Data showed that healthcare-associated infections MRSA and Clostridium difficile (C.diff) rates for the trust were within expected limits. There were no cases of C.diff attributed to the A&E department from April 2014 to December 2014.
- The policy was to screen all patients admitted to a ward area from A&E for MRSA. The electronic patient administration system made a note and tracked all patients with any infectious conditions so staff could be alerted.

Environment and equipment

Urgent and emergency services

- The emergency department was well maintained with appropriate security measures in place for the protection of patients, staff and visitors.
- The admission route was set up so that patients conveyed by ambulance and those at high risk were seen and triaged immediately. High risk patients were visible from the nursing stations for observation and timely intervention. There was clear segregation for adults and children that attended the department.
- There was a specific x-ray service situated within the department for easy access.
- There was a secure room that was used to assess patients with mental health needs. This was not a Section 136 room (a designated place of safety) under the Mental Health Act (1983). Patients who required a designated Section 136 room would be conveyed to a nearby hospital with suitable facilities to provide good care.
- The resuscitation area had five cubicles with one designated for significant trauma and one for children. The cubicles were all well-equipped for adult and paediatric patients.
- There was equipment in place for specific procedures that may only be carried out several times a year. Staff confirmed all items of equipment were readily available and any faulty equipment was either repaired or replaced promptly.
- Adequate equipment was available in all areas including appropriate equipment for children. Equipment was appropriately checked and decontaminated regularly with checklists in use for daily, weekly and monthly checks of equipment in the resuscitation trolleys and within the cubicles.
- Staff were made aware of alerts that had been issues by the National Patient Safety Agency (NPSA) and warnings had been shared with staff such as potential equipment sabotage.

Medicines

- Policies were available for the management of medication and posters were displayed reminding staff to check protocols if changes were made to patients regular medication.
- Medicines throughout the emergency department were stored correctly and safely in locked cupboards or fridges and temperatures were recorded where necessary.
- Nurses had controlled access to these locked areas that provided an audit trail of who had accessed the areas.
- When issuing medication for patients to take home, the prescriptions and drugs dispensed were checked by two nurses in accordance with good practice.
- Staff from the pharmacy department were responsible for maintaining minimum stock levels and checking medication expiry dates.
- We checked the storage and balance of controlled drugs in the emergency department and found the stock balances were correct.
- When controlled drugs where dispensed, the controlled drugs registers had been signed by two members of staff and the volume of any drugs for disposal was recorded accurately.

Records

- Patient records were kept securely, easy to locate and we were able to access the notes we required when conducting our patient record reviews.
- The emergency department had developed its own patient clinical assessment record that included the patient's personal details, previous admissions, alerts for allergies, observations charts as well as triggers for chest pain and asthma. There were separate clinical assessment records for adults and children.
- We looked at patient records across the department and were able to follow and track patient care and treatment easily. Observations were well recorded and were in keeping with the individual needs of the patient.
- We found that the Malnutrition Universal Screening Tool (MUST), a five-step screening tool to identify adults who are malnourished (or at risk of), was not always recorded as outlined in the observation trigger tool in use in the CDU. This meant that patients who stayed in the CDU for a number of days may not receive the correct diet to meet their nutritional needs.

Safeguarding

- Policies were in place that outlined the trust's processes for safeguarding adults and children.
- A safeguarding link nurse and a health visitor for children worked with specific teams to ensure patients were not at increased risk of neglect or abuse.
- The electronic patient record system alerted staff to any safeguarding issues and it was mandatory for staff to

complete a safeguarding trigger in the clinical assessment record for all children who attended A&E. Social services could be contacted by phone and there was a health visitor on site if needed.
- Staff confirmed they knew how to escalate concerns, who to contact and were aware of the services provided.
- Records showed that 74% of medical and 73% of nursing staff had undertaken safeguarding adults training and 71% of medical and 87% of nursing staff had undertaken safeguarding children training.

Mandatory training

- Medical and nursing staff confirmed they had received an induction specific to their role when they had begun work in the department. We viewed local induction checklists which included departmental safety instructions, orientation and policies and procedures. These had been signed by the staff and their supervisors.
- Staff received mandatory training in areas such as infection prevention and control, moving and handling and safeguarding children and vulnerable adults.
- Staff within the emergency department also received role specific mandatory training such as medicines management, Advanced Paediatric Life Support (APLS), Trauma Nursing Core Course (TNCC), Advanced and Immediate and Paediatric Immediate Life Support (ALS, ILS and PILS). However, completion of this training was variable, 94% of nursing staff had completed adult advanced life support only 60% had completed advanced paediatric life support.
- There was a lead for education within the department and staff were responsible for maintaining their own training. The trust target was to have 85% of staff having received mandatory training. Data provided by the trust showed this target was not always met. For example only 68% of medical and 35% of nursing staff had undertaken equality & diversity training, 75% of medical and 26% of nursing staff had undertaken moving and handling training.
- Mandatory training was delivered on a rolling programme and the matron and clinical lead told us they were confident the trust mandatory training compliance target would be achieved by year end (March 2015). All non-compliant staff had been identified and lists had been sent to their line manager for remedial action to be taken.
- The paediatric staff received simulation training for emergency situations. Paediatric nursing staff received training via the paediatric department and not from within the emergency department Staff felt that this approach did not allow them to interact with their colleagues and emphasis was focused on general paediatrics not emergency paediatrics.

Assessing and responding to patient risk

- All patients with minor injuries who presented to the emergency department themselves (self-referral) were booked in via the receptionist and then triaged by a nurse who asked routine questions using a recognised triage system to determine the nature of the ailment. Patients who were conveyed by an ambulance were seen immediately by a nurse via a separate entrance.
- An appropriately qualified nurse performed triaged patients depending on the severity of their ailment and streamed patients to the appropriate route such as the minor or major injuries areas.
- Patients 16 years and younger were referred to the children's A&E department where they could wait in a dedicated area before being triaged. All staff in the children's A&E performed triage. This included appropriately trained healthcare assistants who completed the triage and had it checked by a trained nurse.
- The electronic admissions system automatically alerted staff if any patients had attended the hospital and the A&E department previously and whether they were assigned to any specialist team in the hospital, for example the oncology team, so staff in A&E could seek appropriate care for the patient.
- A GP out-of-hours service was also based in the same area and provided support during busy periods to patients in A&E who met their treatment criteria.
- On admission, patients at high risk were placed on care pathways to ensure they received the right level of care. An Early Warning Score tool (An EWS is a system that scores vital signs and is used as a tool for identifying patients who are deteriorating clinically) was part of the patient record with clear directions for escalation printed on the reverse of the observation charts. Staff were aware of the appropriate actions to take if a patient's condition deteriorated.
- If there were no cubicles in the A&E area or if there was a long wait, the nurses in triage would carry out initial

observations and request initial blood tests and x-rays so patients were not delayed, and results were available when they were reviewed by a consultant for a more efficient diagnosis.
- There was an escalation policy in place and bed management meetings took place regularly with involvement of senior staff, matrons and emergency co-ordinators to address and escalate risks that could impact on patient safety, such as low staffing and bed capacity issues.
- An A&E consultant performed a ward round daily in the CDU. We observed medical and surgical outliers in the CDU during our inspection. 'Outliers' is a term used to identify patients who have been placed on a ward that is not in line with their specialty requirement. For example respiratory or gastroenterology. This usually occurs when beds on the relevant wards are not available
- Any outlying patients staying in the CDU who were not being treated as part of the A&E pathways were seen by their own specialty consultants.
- We observed the department during a busy period (due to adverse weather conditions) and saw that trollies were placed in the corridor area as capacity in the department was full. The patients waiting on the trolleys received appropriate care and attention however patients waiting and being treated in this way was far from ideal.

Nursing staffing

- Nursing staff of differing grades were assigned to each of the patient areas within the department. Teams consisting of a band 7 lead, a band 6 nurse and a number of band 5 nurses had been setup to cover the various areas for consistency and for support in training and workload management.
- The nursing establishment was derived from the use of a recognised staffing acuity tool and incorporated National Institute for Health and Care Excellence (NICE) guidance. The last assessment of staffing acuity levels had been carried out in November 2014.
- There was one nurse to every four cubicles and two nurses to every patient in cardiac arrest and trauma. The assistant matron confirmed the current staffing levels met the criteria but not when the department was busy.
- We observed the numbers of nursing staff during the inspection to be adequate for the flow of patients but sometimes during busy periods or periods of increased demand there was limited flexibility in staffing numbers to cope with additional patients, particularly when patients were placed in the corridor areas when there were no cubicles available.
- There was also a play specialist in the paediatric A&E who worked with children as they were waiting for treatment or for distraction therapy as they were being treated.
- The assistant matron explained that in-house data looked at peaks in attendances and was used to inform staffing numbers, but patient acuity wasn't taken into account.
- There were six vacancies for band 5 nurses in the department and efforts were being made to recruit to these posts.
- Sickness was at 9% in January 2014, staff had plans in place to reduce sickness rates to 3% by April 2014. However some long term staff sickness from September 2014 meant that sickness had increased again to 7.5% in December 2014.
- Cover for staff leave or sickness was provided by bank staff made up of the existing nursing team or by agency nurses who helped provide cover at short notice. Where agency staff were used, the organisation carried out checks to ensure they had the right level of training to deliver emergency care.
- Staff in the department told us they regularly couldn't take their allocated breaks and often had to work through their lunchtime due to pressures within the department.

Medical staffing

- The proportion of consultants at 18% and registrars at 25% was worse than the England average of 23% and 39% respectively. However, the ratio of middle grade doctors was 36% which was better than the England average of 13%. The ratio of junior doctors at 23% was comparable to the England average of 25%.
- All staff worked various shifts over a 24-hour period to cover rotas and to be on call during out-of-hours and weekends.
- Medical staffing in the emergency department consisted of nine consultants (two of whom were part time) and two associate specialists. Consultant cover during the week was available from 7am to 11pm on weekdays. At

weekends there was consultant cover from 7am to 3pm on Saturdays and 3pm to 11pm on Sundays. Outside of these hours, there was an on-call rota where consultants could be contacted at any time.

- There were five registrars and 10 student doctors on placement. . The department had funding for five additional middle grade speciality doctors but they had been unable to recruit to these posts. There was at least one middle career doctor and a junior staff member on duty at all times.
- The clinical lead told us there was a stable middle grade and consultant level workforce but that maintaining steady staffing was a challenge and the aim was to develop new staffing models that would be sustainable.
- Existing vacancies and shortfalls were covered by locum, bank or agency staff when required. All agency and locum staff were provided with a local induction before they were allowed to work in the area.
- Staff told us that there were generally sufficient numbers of medical staff with the appropriate skill mix to ensure that patients were safe and received the right level of care. However, when the department was busy, staff took longer to perform assessments on patients.
- The paediatric area was covered by a Foundation year 2 (F2) trainee doctor (Previously known as a senior house officer or SHO) from 9am to midnight and from midnight to 9am the consultant from the adults A&E area would provide the additional cover on an on-call basis. Support was also available from the paediatric department in the hospital.

Handovers

- Each area within the emergency department had their own handovers during shift changes.
- A consultant led "Safety Huddle" took place three times daily and more frequently if required. This included all professionals such as nursing staff, medical staff, the mental health liaison team, the children's health visitor and the hospital alcohol liaison service. This took place around the patient white board and topics discussed included staffing levels, complaints, incidents as well as patient handover related issues such as clinical acuity and medication needs.
- Senior and junior staff attended this to make sure they were all aware of any tasks that were allocated such as blood samples to be taken from patients.
- All the information was then logged in a communication file to ensure those staff not present could also be made aware.
- A system was in use for tracking patients before handover to the ward areas based on clinical prioritisation by the early warning scores (EWS) system.
- We observed handovers of patients from the ambulance staff to the hospital staff. These were discreet, dignified and efficient.

Major incident awareness and training

- Guidance for staff in the event of a major incident was available in the business continuity plan which listed key risks that could affect the provision of care and treatment.
- Security guards patrolled the car park; corridors and public areas such as A&E. Staff in the emergency department could call security for immediate support and would also dial 999 for police assistance if required.
- The department had decontamination facilities and equipment to deal with patients who may be contaminated with chemicals and other hazardous substances.
- The lead consultant told us staff from the trust didn't attend the scene of any major trauma and, if staff were called upon, then staff from North West Ambulance Service (NWAS) would take the lead at the scene on a range of emergency incidents.
- Simulation training in relation to minor incidents was run by a multi-disciplinary team aimed at both the paediatric and adult teams in the department.
- Following an Emergency Preparedness, Resilience and Response (EPRR) audit in September 2014 a number of recommendations were identified in relation to chemical, biological, radiological, nuclear warfare and explosives (CBRNe) training. Lead nurses were identified in the department and they completed a train the trainer course in Nov 2014. This led to a departmental formal CBRNe training course in December 2014 for dry and wet decontamination simulation with a target to have all required staff trained by April 2015.
- As of January 2015 77% of trained staff in the department had received Ebola training in Ebola management and simulation.

Are urgent and emergency services effective?

Urgent and emergency services

(for example, treatment is effective)

Good

Treatment and care was provided in line with national guidance and evidence based practice. Patients were assessed for pain relief as they entered the emergency department. We saw effective collaboration and communication among all members of the multidisciplinary team and services were geared to run seven days a week. There was a designated staff member on each shift responsible for offering drinks and small snacks on a two hourly basis to patients waiting in the department. There were suitable processes in place to obtain patient consent. Staff understood the legal requirements of the Mental Capacity Act 2005 and had access to link workers such as the safeguarding lead to support good practice in this regard.

The department participated in national College of Emergency Medicine (CEM) audits. However, results from the audits were mixed. Data from the 2013 CEM audits for consultant sign off showed that only 18% of patients' diagnoses had been discussed at consultant level and only 24% at senior doctor level. This meant that while the department was performing broadly in line with the national average this was still well below expected standard. There were clear action plans in place as a result of the CEM audits indicating what improvements need to be made as a result.

Evidence-based care and treatment

- The emergency department used a combination of National Institute for Health and Care Excellence (NICE) and College of Emergency Medicine (CEM) guidelines to determine the treatment they provided.
- A range of clinical care pathways had been developed in accordance with recognised guidance for example, trauma, stroke, pneumonia and fractured neck of femur. The department audited compliance with these pathways regularly.
- These pathways were put into action as soon as the patient entered the department, which meant patients were seen and treated effectively by the appropriate staff and that diagnostic tests were carried out and results were reviewed promptly.
- The patient clinical assessment record reflected evidence-based guidance for effective risk assessment and included tools for risk assessing patient risks such as sepsis so that if the patient's condition deteriorated, medical staff could be alerted quickly.
- Guidance was regularly discussed at governance meetings, disseminated and the impact that it would have on staff practice was discussed. Staff were encouraged to undertake a clinical audit to assess how well NICE and other guidelines were adhered to. All of these audits resulted in staff education and changes in practice to improve patient care.

Pain relief

- Patients were assessed for pain relief as they entered the emergency department. A screening process identified any patients who may need pain relief which was given immediately.
- In 2012 the department had participated in the national College of Emergency Medicine audit for renal colic, which assessed the expedience of pain relief. The audits showed that 100% of the audited records had analgesia provided in accordance with local or national guidelines. However,the percentage of patients in severe pain receiving analgesia within 20 minutes, 30 minutes and 1 hour were well below the expected standard. For example, only 14% of patients in severe pain were provided with analgesia within 20 minutes compared to the expected standard of 50%. We requested an action plan to determine what actions the trust were taking in response to the findings but were not provided with one. It was therefore unclear what action had been taken to improve these outcomes since 2012.
- The last College of Emergency Medicine audit for pain in children was conducted in 2012. The trust performed below the college standards. We looked at action plans which stated they would inform all staff who worked in paediatric A&E of the results of audit and highlight importance of good documentation. They also invited feedback about the audit and its results from nursing staff and engaged in dialogue of how to improve standards of care. It was not clear how progress with these action plans was being monitored.

- A review of patient records and patients we spoke with confirmed that they had been offered appropriate pain relief in a timely way.

Nutrition and hydration

- The Trainee Associate Practitioner (TAP) was the designated staff member on each shift responsible for offering drinks and small snacks on a two hourly basis to patients waiting in the department.
- The department had facilities to make drinks and snacks such as toast and cereal. There was a fridge with sandwiches for patients and staff told us they could get food and warm meals from the hospital kitchen if required.
- We saw patients being offered refreshments during our visit. The TAP asked nursing staff if patients (due to the nature of their medical conditions) could have refreshments before offering them.
- The Clinical Decisions Unit (CDU) had a system for patients to choose meals and staff told us they assisted patients to order meals if needed.

Patient outcomes

- There was a consultant lead for audit in the emergency department. The department participated in national College of Emergency Medicine (CEM) audits so they could benchmark their practice and performance against best practice and other emergency departments. Audits included consultant sign off, renal colic, pain relief and fractured neck of femur.
- Data from the CEM audits for consultant sign off showed that only 18% of patients' diagnoses had been discussed at consultant level in 2013 and only 24% at senior doctor level. The England average was 12% of patients' diagnoses discussed at consultant level and 31% at senior doctor level. The CEM standard was for 100% of discharged patients need to be at the very least discussed with a consultant. This meant that while the department was performing broadly in line with the national average this was still well below expected standard.
- Data also showed that 53% of patients' notes had been reviewed in the emergency department after discharge by a consultant and at senior doctor level which appeared to be better than the England average. However, it should be noted that the majority of UK emergency department's had a figure of zero for this measure, because they had no record of having conducted these reviews.
- Unplanned re-admittance rates to A&E within 7 days from January 2013 to May 2014 were above the 5% target set by the Department of Health and were similar to the England average for the same timeframe.
- We requested an action plan to determine what actions the trust were taking in response to the findings but were not provided with one. It was therefore unclear what action had been taken to improve these outcomes.

Competent staff

- Departmental records showed appraisal rates varied between staff types. As of October 2014 only 44% of medical staff and 71% or nursing staff in emergency care had received appraisals for the year 2014 to 2015. An appraisal gives staff an opportunity to discuss their work progress and future aspirations with their manager.
- Staff told us they had received an appraisal or were due to have one. Information provided by the trust identified that the process for 2014 to 2015 had started and was still ongoing.
- The nursing and medical staff were positive about on-the-job learning and development opportunities.
- Medical staff told us clinical supervision was in place and adequate support was available for revalidation.

Multidisciplinary working

- We observed collaboration and communication among all members of the multidisciplinary team (MDT) to support the planning and delivery of patient centred care. Daily MDT meetings, involving the nursing staff, therapists and medical staff as well as social workers and safeguarding leads (where required) ensured the patient's needs were fully explored. This included identification of the patients existing care needs, relevant social / family issues, mental capacity as well as any support needed from other providers on discharge, such as home care support or alcohol rehabilitation.
- The hospital alcohol liaison team was staffed externally and supported the emergency department with patient discharges. There was a specific pathway for people with alcohol withdrawal symptoms. Therapies provided by the hospital alcohol liaison team included linking

potential patients with other professionals, educating staff and patients about alcohol misuse, and also providing drop-in sessions for patients so they could avoid re-admittance to the emergency department.
- The mental health liaison team provided 24 hour support to patients with psychiatric issues and worked with staff in the emergency department. The team had specific pathways, management plans and confidential systems in place to support patients who were mentally unwell.
- The regional ambulance service employed Ambulance Liaison Officers (ALO) to engage with the emergency departments in the hospitals. This role involved the ALO attending A&E departments and taking part in bed management meetings to look at bed capacity in the hospitals. The ALO would make their control desk aware of the outcomes from these meetings which meant that ambulance staff were informed of any potential escalation protocols so they could divert patients to other trusts if needed.

Seven-day services

- The X-ray department, specifically for A&E, was open 24 hours a day, 7 days a week. Specialist investigations such as MRI and CT scans were carried out in the main hospital.
- Pharmacy services were not available 7 days a week, but a pharmacist was available on call out of hours. During working hours, patients attending A&E who required medication were directed to the hospital pharmacy. The department held a stock of frequently used medicines such as antibiotics and painkillers that staff could access out of hours. Stock levels were appropriate and were regularly checked to ensure the supply was adequate for peak times such as weekends and public holidays.

Access to information

- Patients confirmed they had received information about their care and treatment in a manner they understood.
- Information relating to patient safety was displayed on notice boards throughout the department. This provided up-to-date information on performance in areas such as hand hygiene, environment and equipment cleanliness, falls, pressure ulcers and other incidents.
- Staff accessed information such as audit results, lessons learned from incidents, performance indicators, clinical pathways and policies and procedures via the intranet site.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff had the appropriate skills and knowledge to seek consent from patients. Staff explained how they sought verbal and implied informed consent due to the nature of the patients attending the emergency department. Records showed written consent was appropriately sought before providing care or treatment.
- Arrangements were in place to ensure staff understood the requirements of the Mental Capacity Act 2005 and applied these requirements when delivering care. Training in consent, safeguarding vulnerable adults and children, the Mental Capacity Act 2005 and Deprivation of Liberties Safeguards (DoLS) was included as part of mandatory training to all staff. However, mandatory training compliance figures showed that staff attendance wasvariable.
- Staff understood the legal requirements of the Mental Capacity Act 2005 and had access to link workers such as the safeguarding lead to support good practice.
- When a patient lacked capacity, staff sought the support of appropriate professionals so that decisions could be made in the best interests of the patient.

Are urgent and emergency services caring?

Good

Staff treated patients with dignity, compassion and respect at all times. Patients spoke positively about the care and treatment they had received. Staff provided patients and those close to them with emotional support and comforted patients who were anxious or upset

Patients and those close to them were included and involved in decisions about their care and treatment options.

Care and treatment was given taking into account the wishes and preferences of the patient.

Compassionate care

Urgent and emergency services

- All the patients, relatives and representatives we spoke with were positive about the care and treatment provided. However, a number of patients provided negative feedback in relation to long waiting times, particularly during busy hours.
- We observed many examples of compassionate care including staff taking time out to speak to patients and to reassure them. However, during busy times, we noted that there was little interaction with the patients.
- The NHS Friends and Family Test had a low response rate between July 2014 and December 2014, which meant the results may not be a representative view of the population that the emergency department served. The results showed that the majority of patients would recommend the department to their family and friends. The percentage of patients who were likely or extremely likely to recommend the department was in line with or slightly worse than the England average.
- During 2014, CQC sent a questionnaire 850 people who had attended an NHS accident and emergency department (A&E) during January, February or March 2014. Responses were received from 274 patients at Warrington and Halton Hospitals NHS Foundation Trust.The results showed that overall Warrington and Halton Hospitals NHS Foundation Trust performed about the same as other trusts in the majority of areas surveyed including: waiting times, care and treatment, environment and facilities and overall experience. However, the trust performed worse compared with other trusts for standards of privacy at reception.
- A review of the data from the CQC's adult inpatient survey in 2013 showed that 81% of patients felt they were given information about their condition and 83% felt they were afforded sufficient privacy and dignity.

Understanding and involvement of patients and those close to them

- On admission, patients were allocated a named nurse to ensure continuity of care.
- There were positive interactions between staff, patients and their relatives when seeking verbal consent. Patients confirmed their consent had been sought before care and treatment was delivered.
- Patients and those close to them were also involved in the planning for discharge from the department.

Emotional support

- Staff were clear about the importance of providing patients with emotional support. We observed many positive interactions between staff and patients and saw staff providing reassurance and comfort to people who were anxious or worried.
- A relatives' room was available for people who had witnessed traumatic incidents such as a road traffic accident.
- There was a viewing room for deceased patients, which allowed people to spend extra time with their loved ones. A bereavement leaflet and pack was available for people who were bereaved that gave helpful advice and step by step instructions on the services available and how they could be accessed.
- A noticeboard and information leaflets outlined the chaplaincy services available with timings for prayers and services.
- Staff confirmed they could access management support or counselling services after they had assisted with a patient who had been involved in a traumatic or distressing event, such as a fatal road traffic accident, or if they had been subject to a negative experience.
- Nursing and medical staff were included in debriefing sessions after traumatic events.

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

Requires improvement 

The Department of Health target for emergency departments is to admit, transfer or discharge patients within four hours of arrival. In 2014/15, the emergency service had not met the target in each of the three quarters to date. Data for the main A&E at Warrington Hospital showed that the department did not consistently meet the target between April 2014 and December 2014. Total time spent in A&E (average per patient) from November 2013 to May 2014 was worse than the England average. The percentage of emergency admissions via A&E waiting four to 12 hours from the decision to admit and being admitted was comparable to the England average between April 2013 and January 2014 and above (worse) than the England average between January 2014 and September 2014. The target

to achieve 85% of ambulance handover within 15 minutes was only achieved once (March 2014) between January 2014 and December 2014 with an average compliance of 74%.

During routine operating hours, the department could cope with the patient flow. However, when patients could not be appropriately placed in the hospital this negatively affected the patient flow which was a constant challenge in the department and in the hospital as a whole.

Service planning and delivery to meet the needs of local people

- The trust wide escalation policy described how the emergency department would be involved in dealing with a range of foreseen and unforeseen circumstances where there was significant demand for services or if there were resource issues such as lack of staffing.
- Nursing and medical staff were familiar with this policy and were very clear about the importance of the whole hospital, and other agencies working together.
- There was a responsive coordination of senior staff who arranged beds, investigations and scans for patients to ensure the service could better manage patients at busy times. Daily bed management and safe staffing meetings were taking place so that capacity was constantly monitored so that patients could be managed and treated in a timely way.
- There were suitable and segregated waiting areas for both adults and children with sufficient seating arrangements.

Meeting people's individual needs

- A variety of information leaflets were available in the emergency department. These were mostly in English.
- Staff told us they would ask relatives or family members if interpretation was needed but they would not use any relatives or family members to assist patients with consenting procedures during treatment. Interpreter services were available by the use of a telephone service or face-to-face where English was not the patient's first language. However, nursing staff told us they would usually try to find a staff member who spoke the language if possible as it could take over an hour to access a translator via the phone.
- Patients living with dementia were assessed and treated in specific cubicles to promote their safety and staff could monitor them closely.
- Staff asked patients with learning disabilities if they had a completed "passport document" with them. The passport is a document completed by the patient or their representative, which includes key information such as the patient's medical history and their likes or dislikes.
- Where a patient was identified as living with dementia or having learning disabilities, staff could contact a trust-wide specialist link nurse for advice and support.
- We were informed of the process to manage bariatric patients. When the patient was being conveyed, the ambulance staff would usually make this known in advance. Additional staff and appropriate equipment, such as a bariatric trolley, could be provided to support the moving and handling of bariatric patients as required.
- Care plans were in place in the A&E for children with direct access to the emergency department for reoccurring and ongoing conditions such as asthma who attended frequently. The file was conveniently located and all staff were aware of the actions to take if someone known to them attended.

Access and flow

- During routine operating hours, the department could cope with the patient flow. However, when patients could not be appropriately placed in the hospital this negatively affected the patient flow which was a constant challenge in the department and in the hospital as a whole.The Department of Health target for emergency departments is to admit, transfer or discharge patients within four hours of arrival. In 2014/15, the trust as a whole had not met the target in each of the three quarters to date.
- In quarter one, the trust achieved compliance of 94% with the four hour target. In quarter two, the trust's compliance was at 93% and in quarter three, compliance had dipped to 90%. In real terms, this meant that a total of 757 patients waited more than four hours to be admitted, transferred or discharged from the emergency department.
- Despite this, no patients waited for more than 12 hours from the decision to admit to being admitted for all three quarters.
- The Department of Health data is a trust wide combination for Warrington Hospital and Halton Hospital. Data for the main A&E at Warrington Hospital showed that the department did not consistently meet

the target between April 2014 and December 2014. Warrington Hospital only achieved the 95% target on one occasion (June 2014), with the lowest month being recorded as 84% in December 2014.

- During the inspection we saw a number of four hour target breaches occur. The trust was undergoing a busy period due to winter pressures and adverse weather conditions and the trust was in "red status" which meant it was reaching full capacity. We saw three patients who had been in the department for 12 hours and some that had been in the department for around eight hours.
- The A&E achieved 86% compliance on 27 January 2015 with 238 attendances and had 38 breaches, 76.9% compliance on 26 January 2015 with 256 attendances and had 70 breaches, 78.9% 25 January 2015 with 226 attendances and had 55 breaches and 84.5% compliance on 24 January 2015 with 198 attendances and had 37 breaches.
- All individual breaches of the four hour target were investigated and categorised into why they occurred. We looked at the breach report for 28 January which showed the majority were due to patients waiting for a bed in the ward area and patients not being assessed in a timely manner in the department. The report for 27 January also showed a similar pattern. Other reasons for delays were patients not being able to be discharged due to clinical needs or patients who needed psychiatry input. In other weeks we saw patients couldn't be discharged due to needing specialist input or were awaiting transport home.
- The trust had done extensive work to investigate why the 4-hour waiting target was sometimes exceeded. Factors contributing to poor performance included bed occupancy within the hospital, which had been above the England average of 85% between April 2013 and June 2014 for general and acute beds. The shortage of social care and having no designated social worker meant patients couldn't leave the department as they were awaiting further input such as a care home assessment.
- Total time spent in A&E (average per patient) from November 2013 to May 2014 was worse than the England average.
- The percentage of emergency admissions via A&E waiting four to 12 hours from the decision to admit and being admitted was comparable to the England average between April 2013 and January 2014 and above (worse) than the England average between January 2014 and September 2014.
- Data collated nationally by the health and social care information centre (HSCIC) on patients leaving the department without being seen showed that the rate for this trust was worse (higher) than the England average from January 2013 to May 2014 but below the upper target of 5% set by the Department of Health. Data provided by the trust for June 2014 to December 2014 showed the trust were below the 5% target.
- The hospital had a clear escalation policy that described the steps staff would take when demand caused pressure on capacity. Staff were familiar with this policy and were clear about the importance of the whole hospital, and other agencies, working together.
- Staff felt there was a constant pressure to move patients through the department to meet targets.
- The target to achieve 85 % of ambulance handover within 15 minutes was only achieved once (March 2014) in the period between January 2014 and December 2014 with the range being 69% to 86% and an average compliance of 74%. In real terms, there were a total of 2668 occasions when the handover took more than 15 minutes between January 2014 and December 2014 and 74 occasions when the handover took more than 75 minutes for the same period
- Data received from the ambulance liaison officer (ALO) in relation to the 15 minute handover target showed the trust had a low compliance of around 70% (i.e. when it came to handing the patient over from the ambulance to booking them into the trust system within 15 minutes). The ALO told us the actual figure should have been higher but staff were too busy to complete the electronic handover in a timely manner. The ALO told us the compliance was previously higher when the department had an admin person specifically for completing the handover process but funding was withdrawn and compliance had dropped.
- We performed an unannounced inspection on 11 February 2015 at 6:30pm to 7:30pm and saw the department was extremely busy with 30 four hour target breaches and patients waiting in the corridor. The whole department was facing flow issues due to ward closures in the hospital caused by outbreaks of infection. The staff seemed calm and were working in a responsive

manner despite the pressures. The CDU had five medical outliers from other areas who had been in the ward for over 5 days. However, they were being well managed.

- The main issue causing the CDU to have outliers was that there were patients who were medically fit to be discharged but couldn't be due to lack of social care at home.

Learning from complaints and concerns

- There was a trust wide complaints and concerns policy which included information on how people could raise concerns, complaints, comments and compliments. This included contact details for the Patient Experience Team (PET) at the trust and included information around the Patient Advice and Liaison Service (PALS).
- Information was displayed in the department about how patients and their representatives could complain. Nursing, medical and administrative staff understood the process for receiving and handling complaints in the department and told us information about complaints was discussed during routine team meetings to raise staff awareness and to aid future learning.
- Complaints were recorded on a centralised trust-wide system. The emergency department (including A&E, the minor injuries unit at Halton Hospital and the CDU) had received 45 complaints between April 2014 and December 2014. The majority were in relation to the standard of treatment received by the patient.
- The timescales to respond to a complaint varied depending on the severity of the complaint. Complaints rated as low to moderate complaints would be dealt within 15 working days, moderate complaints would be dealt within 30 working days and complaints rated as high or severe would be dealt within 50 working days.
- Complaints were monitored as part of the ward quality indicators. We reviewed three complaints that had been raised and found staff had followed the correct process but the timescales hadn't always been met in ensuring the complaint was closed. We saw that learning requirements had been considered and identified as a result of a complaint.

Are urgent and emergency services well-led?

Good

The trust's priorities, outlined in the "Operational Plan Document for 2014-16", incorporated the trust's vision and included specific strategic objectives applicable to the emergency department. There were clearly defined and visible leadership roles in department. The departments were well led locally by the senior staff on the wards, the clinical leads and the associate director leads. Senior staff in the department provided visible leadership, particularly at times when the department was stretched. The teams were motivated and worked well together, with good communication between all grades of staff. Staff spoke of an open culture where they could raise concerns or issues in relation to patient care or any adverse incidents that occurred and these would be acted on.

The divisional risk register included risks and ratings identified for the emergency department; progress and improvements were monitored through a regular quality committee meeting and fed back at divisional, departmental and at executive level.

Vision and strategy for this service

- The vision at Warrington and Halton Hospitals NHS Foundation Trust was "to be the most clinically and financially successful integrated health care provider in the mid-Mersey region". The three elements to deliver this were "Quality, People and Sustainability" which were visible across the emergency department.
- These were underpinned by a range of improvements in each area such as the "Emergency Care Reform" to better deal with demand on the front end services in terms of extra space and staffing.
- The trust's priorities, outlined in the "Operational Plan Document for 2014-16", incorporated this vision and included specific strategic objectives applicable to the emergency department such as improving emergency flow and looking at the 24/7 model for emergency care by extending current care provision for emergency patients to ensure equity of access to decision making and diagnostic support 24/7.

- Staff were provided with a corporate induction that included the trust's and the service's core values and objectives. Staff had a clear understanding and could articulate what the vision and values meant for their practice.

Governance, risk management and quality measurement

- The unscheduled care divisional integrated governance group was made up of a range of committees such as the information governance and corporate records subcommittee and the infection control subcommittee that fed into the trust board of directors via the governance committee.
- Senior staff were aware of the departmental risks, performance activity, recent serious untoward incidents and other quality indicators.
- The divisional risk register included risks and ratings identified for the emergency department; progress and improvements were monitored through a regular quality committee meeting and fed back at divisional, departmental and at executive level.
- Risks were rated from low to high with the lower risks being managed at ward level and the higher risks being escalated corporately. The risk register was maintained by a safety and risk link nurse and was reviewed at regular governance and board meetings.
- The four main risks on the divisional risk register as of December 2014 were identified as: 4 hour target within A&E, patient capacity and flow through emergency department, nursing staffing and absconding/missing patients. The trust was taking action to try and address these risks and action plans were in place to support the necessary identified actions.
- Day-to-day issues, information around complaints, incidents and audit results were shared on notice boards around the department and also via meetings and safety huddles.
- Routine audit and monitoring of key processes took place across the department to monitor performance against objectives.

Leadership of service

- There were clearly defined and visible leadership roles in department. The departments were well led locally by the senior staff on the wards, the clinical leads and the associate director leads.
- Senior staff in the department provided visible leadership, particularly at times when the department was stretched. The teams were motivated and worked well together, with good communication between all grades of staff.
- Staff felt their efforts were acknowledged and felt managers listened and reacted to their needs.
- Staff told us they felt free to challenge any staff members who were seen to be unsupportive in the effective running of the service.
- There had been some long term vacancies due to people leaving the department and from sickness. The matron was off due to ill health and was being covered by the assistant matron for A&E. This added additional pressure to the role as there was little time for administrative duties.
- There was a vacancy for the A&E manager. An interim A&E manger was in post until the vacancy had been filled. Interviews for suitable candidates were being arranged at the time of our inspection. The discharge manager post was also vacant. This impacted on patients being discharged effectively from A&E.
- Staff in the paediatric emergency department told us felt they forgotten at times and there wasn't clear medical or nursing leadership. The matron had left and had not been replaced and staff weren't always clear about who was responsible of the management of the service.

Culture within the service

- All staff we spoke with, including senior managers told us the overall ethos was centred on the quality of care patients received and meeting targets was secondary.
- Staff spoke of an open culture where they could raise concerns or issues in relation to patient care or any adverse incidents that occurred and these would be acted on. We observed that staff from all specialties worked well together and had mutual respect for each other's contribution.
- Staff told us the morale within the department was mostly good and the teams worked well together. However, at times, when the department reached high patient capacity, staff felt that the morale dropped.

Public and staff engagement

- Staff received communications in a variety of ways such as newsletters, emails, briefing documents and departmental meetings. Staff told us they were made aware when new policies were issued.
- In 2013 staff had participated the NHS staff survey. The results for the trust showed mainly positive responses with 81% of staff were feeling satisfied with the quality of work and patient care they were able to deliver, 91% of staff agreed their role made a difference to patients. Some negative responses included 40% of staff suffered work related stress in the last 12 months and 14% of staff experienced physical violence from patients, relatives or the public in last 12 months.
- The safety and risk link nurse had carried out risk assessments in relation to staff wellbeing and workload which had been rated as a medium risk within the department. Appropriate actions had been assigned to reduce stress and staff were being surveyed regularly to gain feedback.
- The department included 'What are you saying' information on notice boards, which listed improvements made by the trust in response to queries raised by patients.

Innovation, improvement and sustainability

- The winter plan 2014 -2015 included challenges such as pressure on emergency services throughout the year leading to reduced performance and the possibility of severe weather which leads to increased A&E attendances, admissions and transport and staffing problems.
- The trust received additional financial resource to enable them to manage the winter pressures. The emergency department received £800,000 and the Urgent Care Centre £240,000.
- The assistant matron for A&E told us the number of patients didn't differ over this period but the type of patient and the nature of ailments differed such as more elderly patients presented due to falling. The additional resource was going into increase the timeliness of treatment for patients with mental health issues and to fund additional emergency nurse practitioners in the triage area.
- The trust participated in a "Perfect Week" exercise in conjunction with the Emergency Care Intensive Support Team (ECIST) during May 2014. The results included the trust status changing from red to green and over 85% of patients having a senior medical review every week day by 2pm. However, the A&E target to achieve zero four hour target breaches was not met as breaches ranged from 6 up to 40 in the week. The conclusion noted the achievements were delivered while also dealing with a period of intense pressure on the emergency department and high levels of emergency admissions at the start of the week.

Medical care (including older people's care)

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

Information about the service

The medical care services at Warrington Hospital are managed by the division of medicine and urgent care services and provide care and treatment for a wide range of medical specialities including acute medicine, gastroenterology, respiratory medicine, cardiology, elderly care and stroke care. There were 18,900 admissions to medical care services at Warrington Hospital in 2013/14, of which 74% were emergency admissions.

We visited wards A1, A2 and A3 (acute medical assessment area), A7 (respiratory, A8 (general medicine), B12 (general medicine including the 'forget me not' unit for dementia care) and B14 (general medicine), C21 (cardiology) and C22 (gastroenterology), the coronary care unit and cardiac catheterisation laboratory, the winter ward and the discharge lounge over the course of our inspection. The acute stroke unit was located on B14.

We observed care, looked at records for 12 people and spoke with 15 patients, seven relatives and 39 staff across all disciplines, including doctors, nurses and health care professionals. We also spoke with members of the divisional management team.

Summary of findings

There were high numbers of consultant vacancies across the medical division. There were processes in place which were followed to ensure the condition of patients was monitored to identify any potential deterioration. However, emergency medical cover out of hours was provided by junior medical staff who did not always feel they had the skills and experience to deal with the severity of the patients' conditions. Nurse staffing levels on some wards were below established numbers and high levels of bank and agency staff were necessary to provide safe and effective care for patients.

There were systems in place for reporting incidents but feedback to staff was variable, particularly to junior doctors. Levels of mandatory training completion were below set targets of 85% for clinical staff across all disciplines. There was limited evidence of learning from complaints. Pressures on the availability of beds resulted in patients regularly being cared for on wards outside of their speciality, or being moved around the hospital during their stay. Patients in elective general medicine, cardiology and non-elective cardiology were regularly in hospital for longer than they needed to be. In all other areas the average length of stay was either in line with or better than the national average.

National guidelines were used to treat patients. Outcomes for patients were as good as, or better than the England average for most medical conditions. Patient care and treatment was delivered by a multi-disciplinary care team, although seven day

Medical care (including older people's care)

working was not in place throughout the medical division. Services were delivered by caring and compassionate staff. We observed that staff treated patients with dignity and respect. Care was planned and delivered in a way that took into account the wishes of the patients.

The trust had a vision and strategy for the organisation with clear aims and objectives that had been cascaded across the medical division. Risks and performance within the medical division were discussed regularly at both ward and divisional level, although the systems in place to communicate risks and changes in practice to frontline nursing staff were not robust.

Are medical care services safe?

Requires improvement

There were systems in place for reporting incidents.There was evidence of feedback and learning from reported incidents being shared and applied to improve practice and prevent recurrence. However, feedback to staff, particularly to junior doctors, was variable.

Levels of mandatory training completion were below set targets of 85% for clinical staff across all disciplines. There were high numbers of consultant vacancies across the medical division. There were processes in place which were followed to ensure the condition of patients was monitored to identify any potential deterioration. Emergency medical cover out of hours was provided by junior medical staff who did not always feel they had the skills and experience to deal with the severity of the patients' conditions. In some instances, the night handovers were not always well managed and we observed some confusion over who was responsible for leading the handover.

Nurse staffing levels on some wards were below established numbers and high levels of bank and agency staff were necessary to provide safe and effective care for patients.

Incidents

- There were robust systems in place for reporting incidents and 'near misses' within the medical division. Staff had received training and were confident in the use of the incident report system but did not always report incidents, particularly incidents in relation to understaffing or inappropriate skill mix. Staff told us this was because they didn't feel that any action would be taken.
- There was evidence of feedback and learning from reported incidents being shared and applied to improve practice and prevent recurrence. However, feedback to staff, particularly junior doctors, was variable.
- Mortality and morbidity meetings were held regularly and were usually attended by matrons from within the medical division. These meetings discussed any deaths that had occurred within the medical directorate and any identified learning.

- Staff across all disciplines were aware of their responsibilities regarding the recently introduced Duty of Candour legislation.

Safety thermometer

- The medical directorate was managing patient risks such as falls, pressure ulcers, bloods clots, and catheter urinary infections, which are highlighted by the NHS Safety Thermometer assessment tool. The NHS Safety Thermometer is a tool designed to be used by frontline healthcare professionals to measure a snapshot of these harms once a month. The trust monitored these indicators and displayed information on the ward performance boards.
- The safety thermometer indicated that the rates of pressure ulcers and falls had both increased since May 2014, However, data provided by the service showed that there had been a sustained reduction in hospital acquired pressure ulcers and rates remained low overall. Rates of catheter urinary infections had shown an overall trend of improvement since July 2013.

Cleanliness, infection control and hygiene

- The wards we inspected were clean. There were cleaning schedules in place and levels of cleanliness were audited regularly.
- The hospital infection rates for Clostridium difficile (C.diff) and Methicillin Resistant Staphylococcus Aureus (MRSA) infections, including the wards within the medical division, had been above the England average since May 2013.
- Staff were aware of current infection prevention and control guidelines. We observed staff following good hand hygiene practice on all of the wards we visited.
- Hand towel and soap dispensers were adequately stocked. There was a sufficient number of hand wash sinks and hand gels. Access to the sinks in both the male and female areas of the winter ward was blocked by patient lockers. We discussed this with staff who told us they used sinks in other areas of the ward. This increased the risk of spreading infection within the winter ward.
- There was a programme of audit carried out by infection control specialist nurses. We saw results of these audits and the feedback and actions given to ward staff.
- There were suitable arrangements for the safe disposal of waste. Used linen that presented an infection risk was segregated and managed appropriately. Clinical and domestic waste was segregated in colour-coded bags and managed safely. Sharps such as needles and blades were disposed of in approved receptacles.

Environment and equipment

- Staff on all wards told us that equipment was readily available and any faulty equipment was either replaced or repaired promptly.
- There was no planned programme for funding replacement of some essential equipment, such as telemetry and cardiac monitors. Some of this equipment had been replaced and the remainder was nearing the end of its useful life. Staff were required to apply for funding for the replacement of this equipment.
- We checked the resuscitation equipment on all of the wards we visited and found this had been checked daily by a designated nurse.
- The condition of the flooring within the stroke unit was poor, due to water leaks which had left it broken and uneven in places and the general environment was in need of refurbishment.

Medicines

- The hospital used a comprehensive prescription and medication administration record chart for patients that facilitated the safe administration of medicines. Medicines interventions by a pharmacist were recorded on the prescription charts to help guide staff in the safe administration of medicines.
- We looked at the prescription and medicine administration records for seven patients on three wards. We saw appropriate arrangements were in place for recording the administration of medicines. These records were clear and fully completed.
- Controlled drugs were stored and managed appropriately.

Records

- As part of our inspection we reviewed twelve sets of patient records. Overall, nursing care records were comprehensive, current and easy to navigate and contained all the information required to support the delivery of safe care. There were instances however, where nursing records were not always consistently completed. For example, fluid balance charts and personal care round records were not completed on every occasion.

- Medical and allied health professional records documentation was accurate, legible, signed and dated, easy to follow and gave a clear plan and record of the patient's care and treatment.
- Nursing documentation contained a range of risk assessments covering the major risks for patients. The standardised risk assessments covered risks such as tissue damage, risks of falls and use of bed rails. These had been updated when required.

Safeguarding

- There was a system in place for raising safeguarding concerns. Staff were aware of the process and could explain what was meant by abuse and neglect. This process was supported by staff training.
- Safeguarding training formed part of the mandatory training programme but training rates were less than the trust target of 85%. Training records showed that 61% of trained nursing staff and 40% of medical staff within the medical division had completed level 1 adult safeguarding training.

Mandatory training

- Levels of mandatory training within the medical division were variable for clinical staff across all disciplines, with almost all areas falling well below the trust target of 85%.
- Ward managers informed us that nurse staffing levels had been insufficient to enable staff to be released for mandatory training.

Assessing and responding to patient risk

- The National Early Warning Score (NEWS) was used for acutely ill patients. NEWS is a scoring system that identifies patients at risk of deterioration or needing urgent review. We found that NEWS scores were consistently and accurately completed.
- We found that the response provided by medical staff and/or the team of highly skilled advanced nurse practitioners known as the 'MET' (Medical Emergency Team), to a patient whose condition was deteriorating was timely and effective. Nursing and medical staff spoke positively of support this team provided in the care of very sick patients.
- The medical division had on-site access to the services of a critical care unit when required.

Nursing staffing

- Nursing staffing levels had been reviewed throughout the medical division during 2014 and were due to be reviewed again. Staffing levels had been assessed using a validated acuity tool. There were minimum staffing levels set for wards throughout the medical division. Required and actual staffing numbers were displayed on every ward we visited. Where shortfalls were identified, these were filled by bank and agency staff, when available. Occasionally a healthcare assistant would be deployed if trained staff were unavailable.
- There were high nurse vacancy rates on some wards. Ward A1 (the medical assessment unit) had 20 trained nurse vacancies in December 2014, which represented approximately 25% of the nursing workforce for this ward. Nursing staff had been re-deployed to A1 from other wards and the trust had actively recruited new nursing staff. Although five band 2 healthcare assistants had been appointed recently, the ward manager told us there would be 12 vacancies for trained nurses at the end of March 2015. Recruitment to fill these posts was ongoing.
- Information provided by the trust indicated that between January and September 2014, approximately 20% of nursing shifts within the medical division had been filled by bank or agency staff.
- During the week of our inspection, 17 of the 21 nurses on the duty rota for the winter ward were bank or agency staff. Shifts had been filled with regular bank and agency staff, where possible to minimise risk and promote continuity.
- However, the skills and experience of temporary staff varied and it was not always possible to use the same staff.
- Although the telemetry system within the hospital had the capacity to monitor up to 16 patients, only eight could be monitored due to shortages of telemetry trained nurses to observe the recordings and take appropriate action where necessary. Telemetry is a system of electronically recording patients' vital signs and transmitting them to a central point for monitoring. There was frequently a waiting list of patients, who were assessed and prioritised according their clinical need. During the weekend prior to our inspection there were five patients on the waiting list for telemetry.

Medical care (including older people's care)

- Nursing handovers took place at the start of each shift on all the medical wards. Staffing for the shift was discussed as well as any high-risk patients or potential issues. Handovers were detailed and staff on duty were familiar with the needs of patients in their care.

Medical staffing

- Consultants in the medical division accounted for 28% of the medical workforce, well below the England average of 33%. Trainee doctors accounted for 24% compared with the England average of 23%. There were 11 consultant vacancies within the medical division at the time of our inspection. Five of these vacancies were in elderly medicine.
- There were 12 locum consultants employed within the medical division at the time of our inspection. The use of medical locums in the medical division, across all grades, varied between 13% and 27% between January and September 2014.
- Medical handovers were paper based and were described by the junior doctors as "worrying" and "unstructured". In some instances, the night handovers were not always well managed and we observed some confusion over who was responsible for leading the handover.
- Junior medical staff told us they felt their workload, outside of normal working hours, was difficult to manage. Sickness absence levels were not well communicated to the junior medical staff and even when fully staffed, the medical cover was considered to be stretched. Emergency medical cover out of hours was provided by junior medical staff who did not always feel they had the skills and experience to deal with the severity of the patients' conditions. There were two foundation year 1 (F1 – trainee doctors) grade doctors on duty to deal with the ongoing treatment reviews of patients recently admitted (following initial consultant review) and any poorly patients throughout the hospital whose condition needed a review. There was a consultant present on site until 9pm Monday to Friday and available on call outside of these hours. A registrar was also available on site 24 hours a day to provide support.
- F1 doctors also carried the medical emergency team (MET) bleep out of hours.The MET F1 doctor's role was to attend as 1st responder for training purposes, with the advanced nurse practitioner who had undertaken specific training to support the 1st responder.
- All the F1 grade doctors we spoke with told us they did not always feel able to manage both the numbers and the severity of the condition of some of these patients.

Major incident awareness and training

- Plans were in place to deal with the additional pressures on beds and staffing within the trust during the winter period. The effectiveness of these plans was reviewed regularly in line with changing demands on the service provided.
- Strike action by public sector workers had been planned to take place during our inspection. Although the strike did not take place, ward managers were able to discuss contingency plans in place to minimise the impact of the strike on patients.

Are medical care services effective?

Good

National guidelines were used to treat patients. Outcomes for patients were as good as, or better than the England average for most medical conditions. SSNAP data and additional audit data related to the management of stoke patients was reviewed regularly and actions were taken to improve the care provided. There were specific care pathways for certain conditions in order to standardise and improve the care for patients. For example, care pathways were used for the care of patients with dementia and stroke.

Patient care and treatment was delivered by a multi-disciplinary care team, although seven day working was not in place throughout the medical division. Patients were asked for their consent to procedures appropriately and correctly. The Mental Capacity Act 2005 was adhered to appropriately and the Deprivation of Liberty Safeguards (DoLS) were applied, when necessary.

Medication records demonstrated that patients were prescribed suitable analgesia and that it was administered as needed. People were provided with a choice of suitable and nutritious food and drink and we observed hot and cold drinks available throughout the day.

Evidence-based care and treatment

- Staff used a combination of National Institute for Health and Care Excellence (NICE), and Royal Colleges' guidelines to determine the treatment they provided. Local policies were written in line with this and had been updated periodically, as required.
- Clinical guidelines for most conditions were available and accessible via the trust intranet, with the exception of guidelines for some conditions, such as acute coronary syndrome, which were only available using the IT systems in the emergency department.
- There were specific care pathways for certain conditions in order to standardise and improve the care for patients. For example, care pathways were used for the care of patients with dementia and stroke.
- There was a planned programme of specific local audits across each speciality within the medical division in addition to more general, division wide audits, such as infection control. These included documentation audits and the accuracy and timeliness of discharges.
- Patients on the medical assessment unit were reviewed by a consultant once each day.

Pain relief

- Patients told us they received timely and effective pain relief.
- Medication records demonstrated that patients were prescribed suitable analgesia and that it was administered as needed.

Nutrition and hydration

- Appropriate nutritional assessments had been undertaken and were well documented in all the care records we reviewed.
- People were provided with a choice of suitable and nutritious food and drink and we observed hot and cold drinks available throughout the day.
- Staff were able to tell us how they addressed peoples' religious and cultural needs regarding food. We saw that, where possible, there was a period over mealtimes when all activities on the wards stopped, if it was safe for them to do so. This meant that staff were available to help serve food and assistance was given to those patients who needed help.

Patient outcomes

- An analysis of data submitted by the trust for April to June 2014 as part of the Sentinel Stroke National Audit Programme (SSNAP) showed that the trust's stroke services attained an overall score of 'C' on a scale of A to E, with A being the best. However, comparison of thrombolysis rates with other stroke centres are unreliable as thrombolysis is not provided at this hospital out of normal working hours. SSNAP is a programme of work that aims to improve the quality of stroke care by auditing stroke services against evidence-based standards.
- SSNAP data and additional audit data related to the management of stoke patients was reviewed regularly and actions were taken to improve the care provided to stroke patients.
- An analysis of data from the Heart Failure Audit 2012/13 showed the hospital was performing above the England average in all areas measured.
- Data submitted by the trust to the Myocardial Ischaemia National Audit Project (MINAP) was limited as many of the emergency procedures were carried out at a nearby specialist hospital. However, all the data submitted was above the England average.
- An analysis of the National Diabetes Inpatient Audit 2013 showed that the hospital was performing above the England average in 14 of the 21 indicators.
- Standardised relative re-admission rates for non-elective general and respiratory medicine were better than the England average, but the re-admission rates for cardiology were 14% above the England average. Standardised relative re-admission rates for elective respiratory medicine and cardiology were better than the England average, but the re-admission rates for gastroenterology were 26% above the England average.
- The lung cancer audit 2014, reporting on all of 2013, showed the trust performed slightly better than the England and Wales average for the number of cases discussed at multidisciplinary meetings (100% compared with the average of 99%). However, it also showed that the trust performed slightly worse than the England and Wales average for the percentage of patients having a CT scan before bronchoscopy (88.6% compared with the average of 89.6%) and the percentage of patients receiving surgery in all cases (11% compared with the average of 15%).
- Patients in elective general medicine, cardiology and non-elective cardiology were regularly in hospital for longer than they needed to be. In all other areas the average length of stay was either in line with or better than the national average.

Medical care (including older people's care)

Competent staff

- There was a system in place within the medical division to ensure that staff were registered with the General Medical Council and the Nursing and Midwifery Council and maintained active registration entitling them to practice.
- Nursing and medical appraisal rates across the medical division were low. Information requested from the trust showed that up to October 2014, 48% of medical staff and 66% of nursing staff within the medical division had received an appraisal during the last year. The 2013 NHS staff survey showed that the trust performed better than the England average for staff reporting that their appraisal was well structured.
- The General Medical Council's decisions regarding revalidation of doctors at this trust was in line with other trusts throughout England.

Multidisciplinary working

- Multidisciplinary teams (MDTs) worked well together to ensure coordinated care for patients. From our observations and discussions with members of the multi-disciplinary team, we saw that staff across all disciplines genuinely respected and valued the work of other members of the team.
- Teams met at various times throughout the day, both formally and informally, to review patient care and plan for discharge. MDT decisions were recorded and care and treatment plans amended to include changes.
- Access to psychiatric input was reported by both nursing and medical staff as good. An initial assessment by a psychiatric nurse would trigger a timely psychiatric review where appropriate.
- The early supported discharge team for stroke patients worked very with at this trust and had resulted in a reduced length of stay and an improved patient experience for these people.
- Thrombolysis services for stroke patients were provided by a local trust outside of normal working hours.

Seven-day services

- There was good access to medicines out of hours through an emergency medicines cupboard. There was an on-call service provided by the pharmacy team.
- Medical specialties had a consultant presence seven days per week. We saw that acutely ill patients received a daily consultant review.
- Most of the wards within the medical division did not have routine input from allied health professionals out of hours. There were arrangements for patients to be assessed by a therapist at the weekend to facilitate discharge, but routine ongoing treatment was not provided.
- The stroke team were introducing seven day working for some allied health professionals during the week of our inspection.
- Emergency imaging services were available out of hours.

Access to information

- Access to information was good for patients and their families. We saw examples of comprehensive information for patients regarding the management of their health conditions.
- All the information needed to deliver care and treatment was available to the relevant staff. However, there were several electronic and paper based systems in place for managing patient information. This was time consuming for staff who sometimes needed to access several systems in order to access information or record care.
- Some of the electronic systems in use were outdated and in need of replacement. We were informed that a review of these systems had taken place and plans were in place to update them later in 2015.
- Access to passwords for the trust information system for temporary staff, particularly locum doctors, was good.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients were asked for their consent to procedures appropriately and correctly. The Mental Capacity Act 2005 was adhered to appropriately and the Deprivation of Liberty Safeguards (DoLS) were applied, when necessary.
- We saw staff obtaining verbal consent when helping patients with personal care.

Are medical care services caring?

Good

Medical care services were caring. Services were delivered by caring and compassionate staff. Staff treated patients

with dignity and respect. Care was planned and delivered in a way that took into account the wishes of the patients. Patients told us that if they did not understand any aspects of their care that the medical, nursing or allied health professional staff would explain to them in a way that they could understand.

The average response rate for the Friends and Family test within the medical division between April 2013 and July 2014 was 34%, which was better than the England. Wards within the medical division scored better than the England average in the test, with 75% of patients reporting they would be likely or extremely likely to recommend these ward to friends and family.

Compassionate care

- Medical services were delivered by caring and compassionate staff. We observed that staff treated patients with dignity and respect. All the people we spoke with were positive about their care and treatment.
- The average response rate for the Friends and Family test within the medical division between April 2013 and July 2014 was 34%, which was better than the England average of 30%. Wards within the medical division scored better than the England average, with 75% of patients reporting they would be likely or extremely likely to recommend these ward to friends and family.

Understanding and involvement of patients and those close to them

- Patients and relatives felt involved in their care.
- They had frequent opportunities to speak with the consultant and other members of the multi-disciplinary team looking after them about their treatment goals. This enabled patients to make decisions about and be involved in their care.
- Patients told us that if they did not understand any aspects of their care that the medical, nursing or allied health professional staff would explain to them in a way that they could understand.

Emotional support

- The stroke unit had good links with a national charity providing practical and emotional care and support for stroke patients. Representatives from this charity attended the MDT meetings and provided important psychological input into the short and longer term recovery of stroke patients.
- The chaplaincy service offered patients and their relatives or carers a range of advice on spiritual matters. They had access to representatives of most religions.

Are medical care services responsive?

Requires improvement

Bed occupancy in the trust overall exceeded the England average throughout 2014, with bed occupancy levels within the medical division in excess of 100%. This meant there were often more medical patients than available beds within the hospital. Pressures on the availability of beds resulted in patients regularly being cared for on wards outside of their speciality, or being moved around the hospital during their stay. Bed management meetings were held throughout the day. Matrons from the medical division attended these meetings and gave an assurance that all medical patients not being cared for on the most appropriate ward for their condition had received a daily medical review. However, despite these assurances, in three of the cases we followed up this was not the case.

The discharge lounge was a small area at the entrance to the winter ward which functioned as a 'holding area' for patients rather than an effective discharge lounge. There was no clear distinction between where the discharge lounge finished and the winter ward began, which was confusing for patients in both the ward and the discharge lounge. There was no space for patients in wheelchairs or on trolleys without blocking access to the winter ward. The lounge was staffed by one nurse, frequently a band 4 nurse. As a result administration of medicines usually required assistance from the registered nurses working on the winter ward.

There was limited evidence of learning from complaints.

Services were provided to meet the needs of individual patients, particularly those in more vulnerable circumstances, for example patients with dementia or a learning disability. There was good use of "This is me" documentation throughout the division to aid communication. The hospital had a purpose built and

highly effective ward for patients with a diagnosis of dementia which was well equipped and staffed. Patients with dementia were assessed and admitted to the ward based on the severity of their dementia.

Service planning and delivery to meet the needs of local people

- There were good links with commissioners and other providers, including the voluntary sector, during the planning and delivery of services.
- Access to the GP acute medical unit was not controlled by clinicians. Staff told us this meant that patients were sometimes admitted when there was a more appropriate place for them to receive treatment. We spoke with the newly appointed nursing lead for the medical division, who informed us that this process was currently under review and was likely to change as a result of the findings.

Access and flow

- There were 18,900 admissions to medical care services at Warrington Hospital in 2013/14. General medicine accounted for 68% of these admissions.
- Bed occupancy in the trust overall exceeded the England average throughout 2014, with bed occupancy levels within the medical division in excess of 100%. This meant there were often more medical patients than available beds within the hospital. During our inspection there were between 20 and 30 medical patients each day who were being cared for on a ward outside of their speciality. This was despite the trust opening the winter ward to meet the increased demand during the winter months.
- Patient flow throughout the hospital was responsive to the number of patients in the emergency department waiting for beds. Medical patients were transferred from the emergency department to any available bed within the hospital once all the medical wards were full. This system had an adverse effect on some surgical and orthopaedic patients admitted in an emergency, who could not be cared for on the most appropriate ward for their condition due to these beds being filled with medical patients.
- Several wards within and outside of the medical division had designated beds for medical patients, and there was a designated medical team to treat and review these patients. This system generally worked well. We reviewed the records of 10 medical patients on three of these wards and found they were generally cared for by staff with the appropriate skills and experience and reviewed by medical staff in a timely way.
- Bed management meetings were held throughout the day. Matrons from the medical division attended these meetings and gave an assurance that all medical patients not being cared for on the most appropriate ward for their condition had received a daily medical review. However, despite these assurances, in three of the cases we followed up this was not the case.
- Patients who had been transferred to a neighbouring trust for treatment, such as thrombolysis, were not always able to return to Warrington hospital as soon as they were medically fit due to a shortage of beds. This meant that families had to travel longer distances to visit them. The trust which provided thrombolysis services to Warrington patients out of normal working hours is located 9 miles from Warrington Hospital.
- Nursing staff on several wards within the medical division told us that discharges were delayed due to the availability trainee doctors to write the prescriptions for take home medicines.
- 28% of patients (3,432 people) within the medical division were moved at least once during their hospital stay between April and October 2014, while 1% (88 people) were moved a least 4 times.
- The referral to treatment times for patients admitted within the medical division were very good, with all areas performing better than the England average.
- The discharge lounge was a small area at the entrance to the winter ward which functioned more as a 'holding area' for patients than an effective discharge lounge. There was no clear distinction between where the discharge lounge finished and the winter ward began, which was confusing for patients in both the ward and the discharge lounge. There was no space for patients in wheelchairs or on trolleys without blocking access to the winter ward. The lounge was staffed by one nurse, frequently a band 4 nurse, and had few facilities, most of which were winter ward facilities used by the discharge lounge patients. Administration of medicines usually required assistance from the registered nurses working on the winter ward.

Meeting people's individual needs

- As part of our inspection we spoke with two people who had a learning disability and members of their families.

We found that adjustments had been made to enable families to remain with these people, which was appreciated by the families who had been closely involved in their care.

- "This is me" documentation was used where appropriate throughout the medical division for people who could not communicate effectively with staff due to, for example, a learning disability or dementia.
- The hospital had a purpose built and highly effective ward for patients living with dementia which was well equipped and staffed. Patients with dementia were assessed and admitted to the ward based on the severity of their dementia.
- We looked at how patients with dementia were cared for on other wards within the medical division and found that both the care delivered and the relevant documentation was good throughout.
- For patients whose first language was not English, staff could access a language interpreter if required.
- The hospital ran a "Hello, my name is...would you like a drink?" campaign to raise awareness within the service of issues surrounding hydrating patients, the importance of accurately filling in fluid balance charts and the prevention and treatment of patients with Acute Kidney Injury.
- There was no television provided by the trust in the winter ward. The ward manager informed us that one television had been donated and would be in use within the ward as soon as the relevant safety checks had been completed.

Learning from complaints and concerns

- Complaints were handled in line with trust policy. Staff would signpost patients to the Patient Advice and Liaison Service team if they were unable to deal with concerns directly. Patients would be advised to make a formal complaint if their concerns remained.
- There was information displayed throughout the medical wards and hospital corridors on how to complain. We spoke with patients and relatives who knew how to raise concerns, make complaints and provide comments, should they wish to do so.
- There was very limited evidence of learning from complaints. Staff we spoke with throughout the medical division could not give us examples of feedback from complaints or any action that had taken place to improve the service provided.

Are medical care services well-led?

Good

The trust had a vision and strategy for the organisation with clear aims and objectives that had been cascaded across the medical division. Each specialty within the medical division had a strategy. These strategies were detailed and had been developed with input from the multi-disciplinary team. Awareness of the stroke strategy was particularly good throughout members of the stroke team at all levels. We saw several examples of good leadership by individual members of medical and nursing staff throughout the medical division that were positive role models for staff.

Risks and performance within the medical division were discussed regularly at both ward and divisional level, although the systems in place to communicate risks and changes in practice to frontline nursing staff were not robust.

Vision and strategy for this service

- The trust had a vision and strategy for the organisation with clear aims and objectives that had been cascaded across the medical division. Most staff had some awareness of these, although awareness by the medical staff was lower than that of other clinicians.
- Each specialty within the medical division had a strategy. These strategies were detailed and had been developed with input from the multi-disciplinary team. Awareness of the stroke strategy was particularly good throughout members of the stroke team at all levels.

Governance, risk management and quality measurement

- Risks within the medical division were discussed regularly at both ward and divisional level, and escalated up where necessary.
- The medical division had quality dashboard for each service and ward areas. This showed performances against quality and performance targets and these were presented monthly at the clinical governance meetings.
- The system in place to communicate risks and changes in practice to nursing staff was not robust. All the ward managers we spoke with told us they relied on verbal dissemination of information during staff handovers

and safety briefings. These were not always detailed or written which meant it was difficult to keep track of which staff had received the information, particularly when they were on holiday or sick leave.

Leadership of service

- There was several examples of good leadership by individual members of medical and nursing staff throughout the medical division that were positive role models for staff.
- Staff told us their immediate line managers were accessible and approachable. They told us that some members of the executive team, particularly the chief executive, were very visible around the trust. They spoke positively about the time the chief executive spent within the wards and departments working with frontline staff. However some staff members, particularly the junior frontline staff, did not feel that the executive team appreciated the day to day operational challenges involved in delivering direct care and treatment to patients, particularly those without a clinical background.

Culture within the service

- Most staff spoke enthusiastically about their work. They described how they enjoyed their work, and how proud they were to work at the trust.
- There was a culture within the medical division whereby staff focused on the welfare of patients throughout the division rather than their own speciality. An example of this was ward managers supporting the transfer of one member of their permanent nursing staff to A1 ward temporarily to provide better care to patients until more staff were recruited.

Public and staff engagement

- Data from the NHS staff survey 2013 showed that the percentage of responses relating to staff engagement was better than the England average.
- Staff from the stroke team actively participated with patient engagement initiatives run by the voluntary sector designed to improve the patient experience.

Innovation, improvement and sustainability

- Members of the stroke team had developed a tool which enabled them to more accurately predict the care required for stroke patients during their recovery. This meant staff could be deployed within the team to provide the optimum levels of care by the right clinicians, at the right time for patients. The team were exploring the validation of this tool at the time of our inspection.

Surgery

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

Information about the service

Warrington hospital carries out a range of surgical services including: urology, ophthalmology, trauma and orthopaedics and general surgery (such as colorectal surgery). Hospital episode statistics 2013/14 data showed that 20,864 patients were admitted for surgery at the hospital. The data showed that 53% of patients had day case procedures, 10% had elective surgery and 37% were emergency surgical patients.

There are five surgical wards and eight theatres that carry out emergency surgery procedures as well as some day case and elective surgery.

As part of the inspection, we inspected the main theatres, the pre-operative assessment unit, ophthalmic day case unit, ward A4 (the surgical assessment unit), ward A5 (the urology and general surgical ward), ward A6 (the general surgical ward), ward A9 (the trauma and orthopaedics ward) and ward B19 (the orthopaedic ward).

We spoke with seven patients. We observed care and treatment and looked at care records. We also spoke with a range of staff at different grades including nurses, doctors, consultants, ward managers, general managers, the theatres manager, the matron for general surgery, the matron for trauma and theatres, the divisional clinical lead and the associate divisional director for scheduled care. We received comments from our listening event and from people who contacted us to tell us about their experiences, and we reviewed performance information about the trust.

Summary of findings

Patient safety was monitored and incidents were investigated to assist learning and improve care. Patients received care in safe, clean and suitably maintained premises. Patients were supported with the right equipment. Medicines were stored safely and given to patients in a timely manner. Patient records were completed appropriately. The staffing levels and skills mix was sufficient to meet patients' needs and staff assessed and responded to patients' risks. Staff received mandatory training in order to provide safe and effective care. However, levels of mandatory training attendance within the division were variable, with some areas falling well below the trust target of 85%.

The surgical services provided care and treatment that followed national clinical guidelines and staff used care pathways effectively. Surgical services performed in line with similar sized hospitals and with the England average for most safety and clinical performance measures. Where these standards had not been achieved, actions had been taken and this had led to improvements in compliance with the national hip fracture audit and national emergency laparotomy audit. Patients received care and treatment by trained, competent staff that worked well as part of a multidisciplinary team. Patients spoke positively about their care and treatment. They were treated with dignity and compassion.

The majority of patients were admitted, transferred or discharged in timely manner. The surgical services

achieved the 18 week referral to treatment standards for most specialties and there had been recent improvements in performance where these standards had not previously been achieved, such as for trauma and orthopaedics. A number of inpatient beds in the surgical wards were occupied by patients receiving medical care (medical outliers). This meant that operations were sometimes cancelled due to the lack of beds available for surgical patients. The hospital was working to address this by reviewing the way surgical beds were allocated to patients. The majority of patients whose operation was cancelled for non-medical reasons were treated within 28 days.

There was clearly visible leadership within the surgical services. Staff were positive about the culture and support available. The management team understood the key risks and challenges to the service and how to resolve them.

Are surgery services safe?

Good

Patient safety was monitored and incidents were investigated to assist learning and improve care. Patients received care in safe, clean and suitably maintained premises. Patients were supported with the right equipment. Medicines were stored safely and given to patients in a timely manner. Patient records were completed appropriately and accurately.

The staffing levels and skills mix was sufficient to meet patients' needs and staff assessed and responded to patients' risks. Staff received mandatory training in order to provide safe and effective care. However, levels of mandatory training attendance within the division were variable, with some areas falling well below the trust target of 85%.

Incidents

- The strategic executive information system data showed there were 18 serious incidents reported in relation to surgical services at the hospital during 2013/14. This included seven incidents relating to ward closures.
- Trust data showed that between June 2013 and December 2013, there had been three full ward closures and four bay closures following the identification of patients with diarrhoea and vomiting symptoms. The ward and bay closures were a precautionary measure taken by staff to minimise the risk of spread of infection.
- There was also a closure of ward A4 (the surgical assessment unit) in October 2013 due to MRSA. The investigation found that there was a 'cluster' of MRSA infections identified as many different strains on the ward and there were inconsistencies in the way patients were screened for MRSA on admission to the hospital. The remedial actions taken to address the issue included targeted infection control, environment and equipment audits on the ward and training of staff in MRSA screening procedures. The associate divisional director for scheduled care told us there had been no further ward closure incidents reported since 2013.
- The remaining incidents reported by the trust included five incidents of patients acquiring grade 3 pressure ulcers, a surgical error, a confidential information leak and a safeguarding incident.

- There was evidence that these incidents had been investigated and remedial actions were implemented to improve patient care.
- Staff were aware of the process for reporting any identified risks to staff, patients and visitors. All incidents, accidents and near misses were logged on the trust-wide electronic incident reporting system. Complaints and allegations of abuse were also logged on the system.
- Logged incidents were reviewed and investigated by ward and theatre managers to look for improvements to the service. Serious incidents were investigated by staff with the appropriate level of seniority.
- Incidents were discussed during monthly staff meetings so shared learning could take place. Records of the meetings confirmed this.
- Patient deaths were reviewed by individual consultants within their surgical specialty area. These were also presented and reviewed at monthly clinical audit meetings within the scheduled care division.

Safety thermometer

- The NHS Safety Thermometer assessment tool measures a snapshot of harms once a month (risks such as falls, pressure ulcers, bloods clots, catheter and urinary infections).
- Safety Thermometer information between July 2013 and July 2014 showed that the surgical services performed within the expected range for falls with harm, catheter urinary tract infections and new pressure ulcers. The data also showed there had been an overall improvement in the rate of pressure ulcers since July 2013.
- Information relating to safety thermometer results was clearly displayed in the wards and theatre areas.

Cleanliness, infection control and hygiene

- Information supplied by the trust showed there had been one MRSA bacteraemia infection and five Clostridium difficile (C. diff) infections during the past year relating to surgery.
- Each MRSA and C. diff incident was investigated to identify the root cause. We looked at the investigation report and action plan for a C. difficile incident in the surgical assessment unit in July 2014 and an MRSA bacteraemia infection on ward A5 (the urology ward) in January 2014. These showed the incidents had been investigated appropriately, with clear involvement from nursing and clinical staff, as well as the trust's infection control team.
- Public Health England data from April 2013 to March 2014 showed there had been no surgical site infections following orthopaedic surgery reported by the trust.
- The wards and theatres we inspected were clean and well maintained. Staff were aware of current infection prevention and control guidelines. Cleaning schedules were in place, and there were clearly defined roles and responsibilities for cleaning the environment and cleaning and decontaminating equipment.
- There were arrangements in place for the handling, storage and disposal of clinical waste, including sharps. There was adequate access to hand wash sinks and hand gels. We observed staff following hand hygiene and 'bare below the elbow' guidance.
- Staff were observed wearing personal protective equipment, such as gloves and aprons, while delivering care. Gowning procedures were adhered to in the theatre areas.
- Patients identified with an infection were isolated in side rooms. During the inspection, there was an outbreak of diarrhoea and vomiting on two general surgical wards (wards A5 and A6). We saw that appropriate signage and control measures were used to protect patients, staff and visitors.
- The matrons produced a monthly infection control report which included results from hand hygiene, commode, environment cleanliness and high impact intervention (catheter care) audits. We looked at a report from October 2014, which showed there was a high level of staff compliance across the surgical wards.

Environment and equipment

- The wards and theatre areas we visited were well maintained, free from clutter and provided a suitable environment for treating patients.
- Equipment in the wards and theatre areas was clean, safe and well maintained. Staff in the theatres told us they always had access to the equipment and instruments they needed to meet patients' needs. Maintenance concerns were logged with the trust's estates department and these were prioritised based on risk.
- The majority of ward staff told us they were appropriately supported and maintenance issues were

resolved in a timely manner. However, we identified a bath on ward A4 (the surgical assessment unit) that had been awaiting maintenance since November 2014. Ward staff told us they had raised this with the estates department but had been told the delay was caused by the manufacturer. There was limited patient impact as showering facilities were available on the ward.

- Staff told us they used single-use, sterile instruments where possible. The single use instruments we saw were within their expiry dates.
- The service had arrangements with an external contractor for the sterilisation of reusable surgical instruments. The assistant general manager for theatres was responsible for overseeing the sterilisation contract and held monthly performance meetings with the sterilisation service provider to discuss issues such as defective or damaged items.
- There was sufficient storage space in the theatres and we saw that items such as surgical procedure packs were appropriately stored in a tidy and well organised manner.
- Emergency resuscitation equipment was available in all the areas we inspected and this was checked on a daily basis by staff.

Medicines

- Medicines, including controlled drugs, were securely stored in the surgical wards. However, the keys for the medication cabinets in the theatre recovery area were regularly left in the locks. Staff told us this was done to allow quick access to the cabinets and the keys were removed if there was no staff present in the area. This was not in line with best practice.
- Staff carried out daily checks on controlled drugs and medication stocks to ensure that medicines were reconciled correctly. There was also a weekly medication audit carried out by a pharmacy technician.
- Medicines were ordered, stored and discarded safely and appropriately. Medical staff were aware of the policy for prescribing antimicrobial medicines.
- Medicines that required storage at temperatures below 8ºC were appropriately stored in medicine fridges. Fridge temperatures were checked daily to ensure medicines were stored at the correct temperatures.
- A pharmacist reviewed all medical prescriptions, including antimicrobial prescriptions, to identify and minimise the incidence of prescribing errors. The ward staff confirmed a pharmacist carried out daily reviews on each ward.
- We looked at the medication charts for four patients and found these to be complete, up to date and reviewed on a regular basis.
- We identified three patients on the surgical wards that had received oxygen treatment and the use of oxygen had been prescribed and documented correctly on their medication charts.

Records

- The trust used paper patient records and these were securely stored in each area we inspected.
- We looked at the records for six patients. These were structured, legible, complete and up to date.
- Patient records included risk assessments, such as for falls, venous thromboembolism, pressure care and nutrition and were reviewed and updated on a regular basis.
- Patient records showed that nursing and clinical assessments were carried out before; during and after surgery and that these were documented correctly.
- Standardised nursing documentation was kept at the end of patients' beds. Observations were well recorded and the observation times were dependent on the level of care needed by the patient.

Safeguarding

- Staff received mandatory training in the safeguarding of vulnerable adults and children. However completion of safeguarding training was poor. Data provided by the trust showed only 53% of medical staff and 55% of nursing staff had completed training in level 2 adult safeguarding. Similarly, only 49% of medical staff and 37% of nursing staff had completed in level 2 children's safeguarding.
- The staff we spoke were aware of how to identify abuse and report safeguarding concerns.
- Information on how to report adult and children's safeguarding concerns was clearly displayed in each area we inspected. The wards and theatre areas also had safeguarding link nurses in place.

- Safeguarding incidents were reviewed by the departmental managers and also at trust-wide safeguarding strategy meetings that took place every three months.

Mandatory training

- Staff received annual mandatory training, which included key topics such as infection control, information governance, equality and diversity, fire safety, health and safety, safeguarding children and vulnerable adults, manual handling and conflict resolution.
- Mandatory training was delivered on a rolling programme and monitored on a monthly basis.
- The overall completion rate for mandatory training topics such as manual handling, fire safety, infection control and safeguarding training across the surgical services ranged between 60% and 80%. The trust's target of 85% completion had only been achieved for one core topic (health and safety).

Assessing and responding to patient risk

- Staff were aware of how to escalate key risks that could affect patient safety, such as staffing and bed capacity issues, and there was daily involvement by ward managers and matrons to address these risks.
- On admission to the surgical wards and before surgery, staff carried out risk assessments to identify patients at risk of harm. Patient records included risk assessments for venous thromboembolism, pressure ulcers, nutritional needs, risk of falls and infection control risks.
- Patients at high risk were placed on care pathways and care plans were put in place to ensure they received the right level of care.
- Staff used early warning score systems and carried out routine monitoring based on patients' individual needs to ensure any changes to their medical condition could be promptly identified.
- If a patient's health deteriorated, staff were supported with medical input and were able to contact the critical care outreach team if needed.
- We observed the theatre teams undertaking the 'five steps to safer surgery' procedures, including the use of the World Health Organization (WHO) checklist. The theatre staff completed safety checks before, during and after surgery and demonstrated a good understanding of the 'five steps to safer surgery' procedures.
- The theatres manager carried out a monthly audit to monitor adherence to the WHO checklist. The audit report for October 2014 looked at a sample of 20 patients and showed compliance was 99.9% with 14 errors and two gaps where no recording was shown to have occurred. The audit report showed that any issues identified during the audit were discussed with the theatre teams and followed up at the next audit to check that improvements had been made.

Nursing staffing

- The matron for surgery and matron for trauma and theatres told us staffing levels were monitored against minimum compliance standards using an acuity tool and this was reviewed every six months. The expected and actual staffing levels were displayed on notice boards in each area we inspected and these were updated on a daily basis.
- The ward managers carried out daily staff monitoring and escalated staffing shortfalls due to unplanned sickness or leave. The ward managers told us staffing levels were based on the dependency of patients and this was reviewed daily. Staffing levels on the wards were increased when necessary so patients needing 1:1 care could be appropriately supported.
- The wards and theatres had sufficient numbers of trained nursing and support staff with an appropriate skills mix to ensure that patients were safe and received the right level of care.
- Trust data showed that the vacancy rate for nursing staff in the five surgical wards ranged from zero to 4.4% during December 2014.
- Staffing levels were maintained by staff working overtime and with the use of bank and agency staff. Trust data showed that the average rate of use of bank and agency staff between January 2014 and September 2014 was 3.8% in surgery and 5.5% in trauma and orthopaedics.
- The ward managers told us they tried to use regular bank or agency staff and ensured temporary staff were accompanied by permanent trained staff where possible, so that patients received an appropriate level of care. Agency staff underwent induction and checks were carried out to ensure they had completed mandatory training prior to commencing employment.
- Theatre staff were trained as both anaesthetic and scrub / recovery nurses so they could be utilised more efficiently between the two disciplines.

- The ward managers were included as part of the staffing establishment but did not have any administrative days allocated for carrying out their management duties. Ward managers told us it was not always possible to carry out their management duties effectively as patient needs took priority over their administrative duties.
- Nursing staff handovers occurred twice a day and included discussions about patient needs and any staffing or capacity issues.

Surgical staffing

- The wards and theatres had a sufficient number of medical staff with an appropriate skills mix to ensure that patients were safe and received the right level of care.
- There was sufficient on-call consultant cover over a 24-hour period and there was sufficient medical cover outside of normal working hours and at weekends. The on-call consultants were free from other clinical duties to ensure they were available when needed.
- Trainee doctors and middle career doctors (e.g. senior house officers) told us they received good support and could easily access the on-call consultant if needed.
- The proportion of middle career doctors and junior doctors was greater than the England average. The proportion of consultants was slightly worse than the England average (37% compared with the England average of 40%). The proportion of registrars was also worse than the England average (26% compared with the England average of 37%).
- The associate divisional director for scheduled care told us the group of consultants, middle career doctors and registrars at the hospital were experienced so they were able to meet patient needs effectively.
- Trust data showed that overall staff turnover between July 2014 and October 2014 within the surgery and trauma and orthopaedic specialties was less than 8%. However, turnover of medical and dental staff during this time period was 18.84% in surgery and 20.34% in trauma and orthopaedics.
- Locum doctors were used to cover for existing vacancies and for staff during leave. Where locum doctors were used, they underwent recruitment checks and induction training to ensure they understood the hospital's policies and procedures.
- Daily medical handovers took place during shift changes and these included discussions about specific patient needs.

Major incident awareness and training

- There was a documented major incident plan and business continuity plan in the surgical services, and this listed key risks that could affect the provision of care and treatment.
- Guidance for staff in the event of a major incident was available in each of the areas we inspected.

Are surgery services effective?

Good

The surgical services provided effective care and treatment that followed national clinical guidelines and staff used care pathways effectively. The services participated in national and local clinical audits. The surgical services performed in line with similar sized hospitals and performed within the England average for most safety and clinical performance measures. Where these standards had not been achieved, actions had been taken and this had led to improvements in compliance.

The majority of patients had a positive outcome following their care and treatment. Patients received care and treatment by trained, competent staff that worked well as part of a multidisciplinary team. Staff sought appropriate consent from patients before delivering care and treatment.

Staff understood the legal requirements of the Mental Capacity Act 2005 and deprivation of liberties safeguards.

Evidence-based care and treatment

- Patients received care according to national guidelines. Clinical audits included monitoring of National Institute for Health and Care Excellence (NICE) and Royal College of Surgeons guidelines.
- During 2013/14, the surgical teams participated in 38 clinical audits. Findings from clinical audits were reviewed at the monthly clinical audit meetings and divisional integrated governance group meetings and any changes to guidance and the impact that it would have on their practice was discussed.
- Staff provided care in line with 'Recognition of and response to acute illness in adults in hospital' (NICE clinical guideline 50) and 'Rehabilitation after critical illness' (NICE clinical guideline G83).

- Staff in the surgical wards used enhanced care and recovery pathways, in line with national guidance, but these were only used for selected patients such as for fractured neck of femur surgery. Enhanced recovery pathways for colorectal surgery were being developed and were due to be implemented during 2015. Enhanced recovery is a modern, evidence-based approach that helps people recover more quickly after having major surgery.
- Staff told us policies and procedures reflected current guidelines and were easily accessible via the trust's intranet. We looked at three policies and procedures on the hospital's intranet and these were up to date and reflected national guidance.

Pain relief

- Patients were assessed pre-operatively for their preferred post-operative pain relief. Staff used pain assessment charts to monitor pain symptoms at regular intervals.
- Staff in the surgical wards and theatres were supported by a team of four acute pain specialist nurses that worked across both hospitals. The acute pain nurse told us they supported and monitored all of the patients undergoing major surgery including general surgery and orthopaedics.
- Patient records showed that patients received the required pain relief and they were treated in a way that met their needs and reduced discomfort.
- Patients told us staff gave them pain relief medication when needed.

Nutrition and hydration

- Patient records included assessments of patients' nutritional requirements.
- Patients who required support and assistance with eating and drinking were discreetly identified using a coloured jug system and supported by staff accordingly.
- Patient who required specialist dietary help were supported by specialist dieticians.
- Patients told us they were offered a choice of food and drink and did not highlight any concerns about the quality of the food offered.

Patient outcomes

- There was participation in national audits such as the national bowel cancer audit and the national hip fracture audit.
- The national emergency laparotomy audit (NELA) report from May 2014 showed that 11 out of the 28 standards were available at the trust. The audit highlighted that the hospital did not have a dedicated surgical assessment unit and did not have key policies and care pathways related to the care of emergency general surgery patients.
- The associate divisional director for scheduled care told us the findings from the audit had been reviewed and they had addressed some of the issues. For example, the hospital had a dedicated surgical assessment unit in place as well as a policy for the deferment of elective activity to prioritise emergencies. The trust was also in the process of developing care pathways for the management of patients with sepsis and enhanced recovery pathways for emergency surgical patients.
- The trust had also designed an emergency laparotomy care pathway to address several of the issues highlighted in the audit and this pathway was pending approval and due to be in place by April 2015.
- The national bowel cancer audit of 2013 showed that the trust had performed better than the England average for case ascertainment rate, the number of patients that had a CT scan, the number of patients that underwent surgery, the number of cases discussed at multidisciplinary team meetings and the number of patients for whom major surgery was carried out as urgent or emergency. The trust also performed better than the England average for patient length of stay above 5 days (59% compared with 69%)
- The national bowel cancer audit also showed that the trust was slightly worse than the England average for the number of patients seen by a clinical nurse specialist (86% compared with England average of 88%) and the number of patients with distant metastases at time of surgery (11% compared with 12%). The trust performed worse than the national average for the number of patients for whom laparoscopic surgery was attempted (32.2% compared with 49.2%).
- The associate divisional director for scheduled care told us clinical audits were routinely reviewed and could not attribute the bowel cancer audit performance to any specific factors.
- The national hip fracture audit of 2013 showed that this hospital performed better than the England average for five out of the 11 indicators, including the percentage of patients admitted to orthopaedic care within four hours,

the percentage of patients having hip surgery within 36 hours and within 48 hours, the number of patients developing pressure ulcers and the completion of falls assessments.

- However, the hip fracture report highlighted that only 10% of patients had a pre-operative assessment by an orthopaedic geriatrician compared with the England average of 54%.
- The associate divisional director for scheduled care told us they had recruited a consultant orthopaedic geriatrician since the last audit in order to improve compliance. Trust data from January 2014 to December 2014 showed that 71% of patients had a pre-operative assessment by an orthopaedic geriatrician and this was slightly better than the England average of 70% during that period.
- The hip fracture report highlighted that the hospital's performance was also worse than the England average for case ascertainment rate (86% compared with the England average of 96%), percentage of bone health medication assessments completed (83% compared with 85%) and the mean total length of patient stay (23.3 days compared with 19.2 days).
- Trust data from January 2014 to December 2014 showed that compliance had improved and 99% of bone health medication assessments were completed during that period and the total length of stay had slightly reduced to 22.8 days.
- Performance reported outcomes measures (PROMs) data between April 2013 and December 2013 showed that the percentage of patients with improved outcomes following groin hernia, hip replacement, knee replacement and varicose vein procedures was either similar to or better than the England average.
- Hospital episode statistics 2013/14 data showed the average length of stay for elective and non-elective patients across all specialties was similar to the England average.
- Hospital episode statistics 2013/14 data showed the number of patients that underwent elective and non-elective surgery and were readmitted to this hospital following discharge was similar to the England average for all specialties except elective urology where readmission rates were slightly worse.
- Trust data for 2013/14 showed that 178 out of a total of 3182 patients (6%) were readmitted to urology from other specialties for treatment. The data also showed that 102 out of a total of 3182 patients (3%) were readmitted following urology treatment during this period. The associate divisional director for scheduled care told us there were two factors that impacted on urology readmissions at this hospital. All surgical elective patients undertaken at Halton General Hospital were given information on discharge to attend the surgical assessment unit at Warrington Hospital if they had any concerns. There was also a poor community-based care infrastructure to support patients with urinary tract infections and catheter related problems, which meant these patients attended the emergency department or surgical assessment unit at this hospital.
- Both these groups of patients were recorded as readmissions rather than ward attenders that were not admitted overnight at the hospital. These patients accounted for 17 out of the 102 urology to urology readmissions reported by the trust.
- The associate divisional director for scheduled care told us readmission rates were routinely monitored to look for improvements to the service.

Competent staff

- Newly appointed staff had an induction and their competency was assessed before working unsupervised. Agency and locum staff also had inductions before starting work.
- Trust data showed 68% staff across the planned care division had completed their annual appraisals during the year (April 2014 to March 2015). Appraisals were on-going and the staff we spoke with told us they routinely received supervision and annual appraisals.
- Consultants had peer appraisals and were overseen by the medical director. Medical staff told us they received routine clinical supervision and appraisal and they did not highlight any concerns relating to revalidation.
- Trust data showed that 80% of surgical doctors had been revalidated and the remaining 20% had deferral requests approved by the General Medical Council.
- The nursing and medical staff we spoke with were positive about on-the-job learning and development opportunities and told us they were supported well by their line management.

Multidisciplinary working

- There was effective daily communication between multidisciplinary teams within the surgical wards and

theatres. Staff handover meetings took place during shift changes and 'safety huddles' were carried out on a daily basis to ensure all staff had up-to-date information about risks and concerns.
- 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.
- The ward and theatre staff told us they received good support from pharmacists, dieticians, physiotherapists, occupational therapists, social workers and diagnostic support such as for x-rays and scans.

Seven-day services

- Staff rotas showed that nursing staff levels were sufficiently maintained outside normal working hours and at weekends.
- Out-of-hours medical cover was provided to patients in the surgical wards by junior and middle grade doctors as well as on-site and on-call consultant cover.
- At weekends, newly admitted patients were seen by a consultant, and existing patients on the surgical wards were seen by the ward-based doctors.
- There was a 24 hour service with dedicated emergency and trauma theatres so any patients admitted over the weekend that required emergency surgery could be operated on.
- Microbiology, imaging (e.g. x-rays), physiotherapy and pharmacy support was available on-call outside of normal working hours and at weekends. The dispensary was also open on Saturdays and Sundays.
- The ward and theatre staff told us they received good support outside normal working hours and at weekends.

Access to information

- The trust used paper based patient records. 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.
- Information such as audit results, performance information and internal correspondence was displayed in all the areas we inspected. Staff could access information such as policies and procedures from the trust's intranet.
- The theatres department used an electronic system to capture information about patient scheduling and theatre performance.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff had the appropriate skills and knowledge to seek consent from patients or their representatives. Staff were clear about how they sought informed verbal and written consent before providing care or treatment.
- The patient records we viewed indicated that verbal or written consent had been obtained from patients or an appropriate person and that planned care was delivered with their agreement.
- Staff understood the legal requirements of the Mental Capacity Act 2005 and deprivation of liberties safeguards.
- If patients 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.
- Patient records showed that staff carried out mental capacity assessments for patients that lacked capacity and where deprivation of liberties safeguards applications had been made, the records for these were in place and completed correctly.
- There was a trust-wide safeguarding team that provided support and guidance for staff for mental capacity assessments, best interest meetings and deprivation of liberties safeguards applications.

Are surgery services caring?

Good

Patients spoke positively about their care and treatment. They were treated with dignity and compassion. Data for patient satisfaction surveys showed that most patients were positive about recommending the hospital's wards to friends and family. Staff kept patients and their relatives

involved in their care. Patients and their relatives were supported with their emotional needs, and there were bereavement and counselling services in place to provide support for patients, relatives and staff.

Compassionate care

- During the inspection, we saw that patients were treated with dignity, compassion and empathy. We observed staff providing care in a respectful manner.
- The areas we inspected were compliant with same-sex accommodation guidelines. We saw that patients' bed curtains were drawn and staff spoke with patients in private to maintain confidentiality. Patients could also be transferred to side rooms to provide privacy and to respect their dignity.
- We spoke with seven patients. All the patients said they thought staff were kind and caring and gave us positive feedback about ways in which staff showed them respect and ensured that their dignity was maintained. The comments received included: "nursing staff are totally caring" and "the treatment and physiotherapy support was good".
- The NHS Friends and Family Test is a satisfaction survey that measures patients' satisfaction with the healthcare they have received. The test data between April 2013 and July 2014 showed that all the surgical wards consistently scored above the England average, indicating that most patients were positive about recommending the hospital's wards to friends and family.
- The average response rates were better than the England average across three of the five surgical wards. Ward A6 (the general surgical ward) achieved a response rate of 25% and ward A9 (the trauma and orthopaedic ward) achieved a response rate of 30% which was worse than the England average of 32%.
- The matron for surgery told us the Friends and Family Test was routinely discussed at team meetings and ward staff were prompted to encourage more patients to complete the test.
- A review of the data from the CQC's adult inpatient survey 2013 showed that the trust was about the same compared with other trusts for all 10 sections, based on 374 responses received.

Understanding and involvement of patients and those close to them

- Staff respected patients' rights to make choices about their care. We observed staff speaking with patients clearly in a way they could understand.
- Patient included pre-admission and pre-operative assessments that took into account individual patient preferences.
- Patients told us they were kept informed about their treatment. They spoke positively about the information they received verbally and also in the form of written materials, such as information leaflets specific to their treatment.
- Patients told us the medical staff fully explained the treatment options to them and allowed them to make informed decisions. We saw that medical ward rounds occurred on a daily basis and included input from the nursing staff and other health professionals such as physiotherapists and social workers if needed.

Emotional support

- Staff understood the importance of providing patients with emotional support. We observed staff providing reassurance and comfort to patients. Patients told us they were supported with their emotional needs.
- There were information leaflets readily available that provided patients and their relatives with information about chaplaincy services and bereavement or counselling services. Patients and their relatives were also provided with a bereavement booklet if needed.
- Staff told us they were supported by the trust's palliative (end of life care) team and the trust-wide bereavement team for support and advice during bereavement.

Are surgery services responsive?

Good

Services were planned and delivered to meet the needs of local people. There were systems in place to support patients with particular needs. The majority of patients were admitted, transferred or discharged in a timely manner. The surgical services achieved the 18 week referral to treatment standards for most specialties and there had been recent improvements in performance where these standards had not previously been achieved, such as for trauma and orthopaedics.

A number of inpatient beds in the surgical wards were occupied by patients receiving medical care (medical

outliers). This meant that operations were sometimes cancelled due to the lack of beds available for surgical patients. The hospital was working to address this by reviewing the way surgical beds were allocated to patients. The majority of patients whose operation was cancelled for non-medical reasons were treated within 28 days.

Complaints about the service were shared with staff to aid learning and improve the service to patients.

Service planning and delivery to meet the needs of local people

- There were arrangements in place with neighbouring trusts to allow the transfer of patients for surgical specialties not provided by the hospital, such as vascular surgery.
- There was routine engagement and collaboration with staff from the neighbouring trust, such as on-site outpatient clinics and regular multidisciplinary team meetings.
- The hospital had a total of eight operating theatres. This included an elective orthopaedic theatre that was mainly used for elective patients that were assessed as high risk.
- There was an emergency general surgery and trauma theatre that was staffed 24-hours, seven day per week so that patients requiring emergency surgery during out of hours and weekends could be operated on promptly
- The hospital had a dedicated elective trauma theatre that operated from 8am to 6pm on weekdays and for six hours on Saturdays and Sundays.
- One theatre (theatre 7) had been closed since November 2014. This was used for vascular surgery prior to the transfer of vascular services to another acute trust. This theatre was mainly used for staff training.

Access and flow

- Patients could be admitted for surgical treatments through a number of routes, such as pre-planned day surgery, via accident and emergency or via GP referral.
- Patients admitted via accident and emergency or GP referral were directed to the surgical assessment unit, which had 12 inpatient beds. The unit also had two assessment rooms and a seated area for up to eight patients that were waiting to be assessed by staff.
- The surgical assessment unit collated performance data as part of the commissioning for quality and innovation (CQUIN) framework. Trust data between July 2014 and September 2014 showed that 94% of patients were assessed by a nurse within 30 minutes of admission and 95% of patients were assessed by a doctor within two hours against the target of 85%. Staff made us aware of two incidents during the past year where patients' health deteriorated because they did not receive timely treatment; however, the majority of patients arriving at the unit were assessed by staff in a timely manner.
- During the inspection, we did not highlight any concerns relating to the admission, transfer or discharge of patients from the surgical wards and theatres. The patients we spoke with did not have any concerns in relation to their admission, waiting times or discharge arrangements.
- 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 with the patient and other healthcare professionals to ensure patients were discharged in a planned and organised manner.
- Discharge letters written by the doctors included all the relevant clinical information relating to the patient's stay at the hospital. Trust data between April 2014 and September 2014 showed discharge summaries were given to GP's within 24 hours on 97% of occasions within the scheduled care division and the trust target of 95% had been achieved during this period.
- There was a discharge lounge but the majority of surgical patients were discharged directly from the wards, so staff could continue to monitor them during their wait.
- NHS England data showed that the overall hospital-wide bed occupancy rate between April 2013 and June 2014 ranged between 86% and 89%. The high level of bed occupancy was reflected in the surgical wards we visited as we found that all available beds were occupied. Bed occupancy was monitored on a daily basis and patients were transferred to other surgical wards if no beds were available within a specific surgical specialty.
- There was a winter pressures escalation plan in place. The associate divisional director for scheduled care told us approximately 19 beds across the five surgical wards were designated as escalation beds. These were mainly occupied by patients receiving medical care (medical outliers).

- Trust data showed the daily number of medical outliers on surgical wards ranged from 22 to 52 patients during December 2014. During the inspection, we found that these patients were routinely seen by doctors from the medicine specialties.
- Surgical doctors told us they were issued with a daily list of surgical patients across the hospital's wards and they made sure surgical outlier patients were seen daily.
- There was sufficient bed space in the theatres to ensure patients could be appropriately cared for pre and post-operation. There was a designated area in recovery for critically ill patients that required stabilising prior to transfer to the intensive care unit (ICU).
- Trust data between July 2014 and December 2014 showed the theatre utilisation (efficiency) target of 85% was achieved across all the theatres except for theatre 2, which was mainly used for specific elective orthopaedic patients.
- NHS England data showed national targets for 18 week referral to treatment standards for admitted patients at the end of September 2014 were being met for most specialties. The data showed that the trust did not meet the waiting time target of 90% for trauma and orthopaedics (82%).
- Trust data showed the performance against waiting time standards had improved significantly and the trust had achieved the 90% target for trauma and orthopaedics between October 2014 and December 2014.
- The associate divisional director for scheduled care told us performance against waiting time standards was routinely monitored and the improvements were achieved through better planning and routine multidisciplinary meetings.
- NHS England data showed that the number of elective operations cancelled was better than the England average from July 2014 to September 2014. Trust data between April 2014 and January 2015 showed there had been 165 operations cancelled at this hospital. The most frequent reasons for cancellations were that ward beds were unavailable (44%) and theatre lists overran or were overbooked (20%).
- The associate divisional director for scheduled care confirmed the main cause for operation delays and cancellations was the unavailability of surgical beds due to the number of medical outliers. There was an action plan in place to review and reconfigure the way patient beds are allocated in the surgical wards so that the impact to theatres would be reduced.
- NHS England data showed that between January 2012 and June 2014 the trust performed better than the England average for the number of patients whose operations were cancelled and were not treated within the 28 days. When an operation was cancelled, staff arranged a new date with the patient on the day of the cancellation.

Meeting people's individual needs

- Information leaflets about services were readily available in all the areas we visited. Staff told us they could provide leaflets in different languages or other formats, such as braille, if requested.
- Staff could access a language interpreter if needed.
- Staff received mandatory training in dementia care. The areas we inspected also had dementia link nurses in place. Staff could also contact a trust-wide safeguarding team for advice and support for dealing with patients living with dementia or a learning disability.
- Staff used a 'forget me not' document for patients admitted to the hospital with dementia. This was completed by the patient or their representatives and included key information such as the patient's likes and dislikes. The ward staff told us the additional records were designed to accompany the patients throughout their hospital stay. We saw evidence of this in the patient records we looked at.
- Staff could access appropriate equipment such as specialist commodes, beds or chairs to support the moving and handling of bariatric patients (patients with obesity) admitted to the surgical wards and theatres.
- The theatre recovery areas had two designated paediatric recovery bays but there were occasions when they were used for adults. Patient privacy was maintained by ensuring curtains were drawn.

Learning from complaints and concerns

- Ward and theatre areas had information leaflets displayed for patients and their representatives on how to raise complaints. This included information about the Patient Advice and Liaison Service (PALS). The patients we spoke with were aware of the process for raising their concerns with the trust.

- Notice boards included information such as the number of complaints received during the month. Staff understood the process for receiving and handling complaints.
- Complaints were recorded on the trust-wide incident reporting system. The ward and theatre managers were responsible for investigating complaints in their areas. The timeliness of complaint responses was monitored by the trust-wide complaints team, who notified individual managers when complaints were overdue.
- Trust data showed there had been 122 complaints raised across the scheduled care division during 2014. The top three reasons for complaints were waiting times and cancellations, the attitude of staff and the treatment received by patients.
- We looked at two complaints records and saw these were appropriately documented and had been responded to in a timely manner. Trust data between April 2014 and September 2014 showed that 97% of complaints across the trust had been responded to within specified timelines against a target of 90%.
- Staff told us that information about complaints was discussed during monthly governance meetings to raise staff awareness and aid future learning. We saw evidence of this in meeting minutes.

Are surgery services well-led?

Good

There was effective teamwork and clearly visible leadership within the surgical services. Staff were positive about the culture and support available. There was routine public and staff engagement and actions were taken to improve the services. The management team understood the key risks and challenges to the service and how to resolve these.

Vision and strategy for this service

- The trust had a vision and strategy with clear aims and objectives. The trust vision was 'to be the most clinically and financially successful integrated health care provider in the mid-Mersey region' and the trust outlined three key objectives relating to quality, people and sustainability.
- The scheduled care business plan 2015-16 incorporated the trust's overall strategy and had specific performance targets and action plans relating to quality, people and sustainability. These included plans for improving compliance with national clinical audits and developing care pathways, workforce development and improvements in patient admission processes.
- The trust vision, values and objectives had been cascaded to staff across the wards and theatre areas we inspected and staff had a good understanding of these.

Governance, risk management and quality measurement

- The associate divisional director for scheduled care told us the key risks to surgical services were the ability to meet performance targets and the ability to provide seven day, 24 hour services and medical cover. The matron for surgery and matron for trauma and theatres also told us medical outliers and bed capacity were key risks to the service.
- There was a clinical governance system in place that allowed risks to be escalated to divisional and trust board level through various committees and steering groups. There were action plans in place to address the identified risks.
- During the inspection, we looked at the scheduled care divisional risk register and saw that key risks had been identified and assessed. The risk register was reviewed at routine clinical governance meetings.
- In each area we inspected, there were regular staff meetings to discuss day-to-day issues and to share information on complaints, incidents and audit results.
- We saw that audit and monitoring of key processes took place across the ward and theatre areas to monitor performance against objectives. Information relating to performance against key quality, safety and performance objectives was monitored and cascaded to ward and theatre managers through monthly performance dashboards.

Leadership of service

- There were clearly defined and visible leadership roles across the surgical services. The overall lead was the associate divisional director, who was supported by the divisional medical director.
- Since December 2014 services were divided into four clinical directorates; trauma and orthopaedics, critical

care, surgery and special surgery (e.g. head and neck specialties). The leadership for each directorate consisted of a matron, a clinical lead and a general manager.
- The surgical wards were led by ward managers and there was a theatres manager in place to oversee the day to day running of services.
- Theatres and ward based staff told us they understood the reporting structures clearly and they received good support from their line managers.

Culture within the service

- Staff were motivated, proud of the service and spoke positively about the care they delivered. Staff told us there was a friendly and open culture. They told us they received feedback if they had made an error to aid future learning and they were supported with their training needs by the management team within their specific area.
- Trainee doctors and nurses also told us they received a good level of support from their peers and line managers.
- Trust data showed that between January 2014 and September 2014 the average staff sickness levels were 3.8% in surgery and 4% in trauma and orthopaedics and this was better than the England average during that period.

Public and staff engagement

- Theatres and ward-based staff told us they routinely engaged with patients and their relatives to gain feedback from them. Information on the number of incidents, complaints and general information for the general public was displayed on notice boards in the ward and theatre areas we inspected.
- Feedback from patients and staff was sought as part of a bed reconfiguration project to reduce the number of beds in the surgical wards in March 2014. There was also ad hoc engagement with the public via patient engagement groups that held monthly meetings.
- The trust produced monthly 'open and honest care' reports which included information for the public and staff on incidents, patient experience and staff experience. The report for December 2014 included feedback from 100 patients and 100 members of staff across the trust and the feedback was mostly positive.
- Staff told us they received good support and regular communication from their line managers. Staff routinely participated in team meetings across the wards and theatres. The trust also engaged with staff via email blogs, newsletters and through other general information and correspondence that was displayed on notice boards in staff rooms.
- The trust carried out a divisional temperature check audit during 2014 in which staff were asked if they would recommend this hospital as a place of work. Staff within the surgical wards and theatres either agreed or strongly agreed, indicating that staff were positive about recommending this hospital as a place of work. There was also a cultural 'barometer' action plan in place, which included specific actions relating to staff resources, support and opportunities for improvement.

Innovation, improvement and sustainability

- Since December 2014, ward B19 (the orthopaedic ward) had been designated as a hip fracture ward so all patients requiring this surgery were admitted to this ward. Staff had developed an integrated care pathway that included aspects of rapid discharge and enhanced recovery. Staff were confident this would lead to improved patient outcomes.
- The scheduled care business plan 2015-16 outlined the strategy for surgical services and included plans to meet financial and performance targets. The matrons and associate divisional director for scheduled care told us they were confident the services were sustainable.There was an on-going cost improvement programme in place. The theatres manager told us cost savings had been made through procurement changes and the standardisation of surgical components and instruments across the theatre areas.

Critical care

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

Information about the service

For the purpose of management and governance the critical care unit at the Warrington Hospital site sits in the scheduled care division. Physically the unit is divided into two separate areas totalling 20 bed spaces but only 18 are funded and in use. The unit is usually staffed to provide care for eight level 3 patients and ten patients at level 2. Although, the unit has the capability to take up to a maximum of 12 patients requiring artificial ventilation. There are two isolation rooms with a ventilation system that generates either a positive or negative pressure, preventing potentially contaminated air from flowing in or out of the room. The unit admits and cares for in the region of 840 patients per year and is a member of the Cheshire and Merseyside Critical Care Network (CMCCN).

We visited the critical care unit on the announced inspection and were able to talk directly with some of the patients and their relatives. We also spoke with many of the staff. These included junior and senior nursing staff, junior and senior doctors and managers. We observed care and treatment and looked at six patient's care records in detail. Before and during the inspection we reviewed performance data from, and about, the critical care service.

In addition, during the inspection we also visited the theatre recovery area that had been designated as a 'stabilisation bay'. The purpose of this area was to stabilise patients prior to their transfer to the critical care unit at Warrington or another local hospital. Patients admitted to the stabilisation area were the responsibility of the critical care medical team and admission was with the authorisation of the critical care consultant on duty.

Summary of findings

There were significant numbers of delayed discharges from critical care. During 2014, 27% of patients experienced delays in discharge of more than 24 hours. The occupancy figures collated by NHS England showed that the bed occupancy for December 2014 was 100%. However data provided by the trust indicated that occupancy overall for the month of December 2014 was 80%. Staff told us there were times, due to access and flow issues within the rest of the hospital, when pressure was applied to take more patients than they had the staffing levels to cope with. As a result, staff felt that on these occasions the acuity level of the patients on the unit outweighed the staffing numbers and skill mix.

In addition, we identified concerns relating to the management and utilisation of the theatre recovery 'stabilisation bay'. The standard operating protocol in place for the stabilisation bay stated that up to two patients could be admitted for a maximum of four hours. There were instances when more than two patients were admitted to the bay and they stayed in excess of four hours although it was not clear how often the stabilisation bay had operated outside of the standard operating protocol. We found examples of cases where patients were cared for in the stabilisation bay for up to two days. The stabilisation bay did not provide a suitable environment for caring for patients in the medium term.

Nursing documentation contained appropriate assessments. In medical records however, second daily

Critical care

consultant reviews were not always recorded. In addition, routine entries from the parent medical team were not present. We saw that in most cases people's care needs were assessed, planned and delivered in a manner that protected their rights and maintained their dignity.

Patients and their relatives were treated with understanding, compassion, dignity and respect. The team was good at involving patients, family and friends in all aspects of their care and treatment. Care was delivered in line with evidence- based, best practice guidance. The results from ICNARC showed that patient outcomes and mortality were within the expected ranges when compared with similar units nationally. There were clear systems in place and a transparent culture towards reporting, investigating and learning from incidents. There was good access to seven day services including out-of-hours intensivist support and pharmacy, physiotherapy and imaging services.

Are critical care services safe?

Requires improvement

We identified concerns relating to the management and utilisation of the theatre recovery 'stabilisation bay'. The standard operating protocol in place for the stabilisation bay stated that up to two patients could be admitted for a maximum of four hours. However, there were instances when more than two patients were admitted to the bay and they stayed in excess of four hours. We found examples of cases where patients were cared for in the stabilisation bay for up to two days. However, it was not clear how often these incidents occurred. The critical care governance reports we reviewed made no reference to incidents whereby the stabilisation bay had been used outside of the standard operating protocol.

The stabilisation bay was an unsuitable environment for caring for inpatients. There was no privacy; no facilities for relatives and at times paediatric patients would be in the same area as adults. Furthermore nurses working in the bay were recovery nurses supported by operating department practitioners (ODP). This meant that they didn't always have the competencies needed for managing critical care patients in the longer term.

Nursing documentation contained appropriate assessments. In medical records however, second daily consultant reviews were not always recorded. In addition, routine entries from the parent medical team were not present. These issues could present a problem for the continuity of care and treatment. The clinical management of the patient episode in ICU was co-ordinated by the intensivist with support from the parent medical team as requested and when preparing for facilitating the patient transition to ward. Completion of mandatory training and safeguarding training was variable.

There were clear systems in place and a transparent culture towards reporting, investigating and learning from incidents. We saw that in most cases people's care needs were assessed, planned and delivered in a manner that protected their rights and maintained their dignity. The hospital used an Acute Care Team to help to identify and monitor deteriorating patients.

Incidents

Critical care

- The trust had a policy for the reporting and management of incidents and investigations.
- The last serious untoward incident had been four years ago.
- Staff were aware of how to use the trust wide electronic incident reporting system.
- We were informed that there were usually between 20 and 40 incidents reported monthly.
- All incidents occurring in critical care were documented in a monthly governance report, which included a six months report of 'rolling data'. This information was then shared with staff via team meetings and safety briefings. The incidents were analysed, categorised and action plans for improvement developed. For example, in October 2014 there were 20 incidents reported. In terms of severity, two were judged as being moderate, nine were minor and nine with none or negligible impact for the patient. The main category of incident for October 2014 was pressure ulcers of which there were four reported. One of these was community acquired and three were developed in hospital. Root cause analyses were carried out and actions had been implemented to reduce the risk. These included utilisation of the tissue viability team and increased vigilance with assessment and documentation.
- Mortality and morbidity discussions were held during the monthly critical care unit audit meetings with detailed minutes recorded.

Safety thermometer

- The trust was planning to introduce 'how are we doing' boards outside each clinical area to inform people about safety thermometer indices but we were told they were not yet ready.
- Safety thermometer data was submitted from the unit and reported at trust level.
- There were low numbers of pressure ulcers, falls and catheter related urinary tract infections as would be expected in the critical care setting.

Cleanliness, infection control and hygiene

- The trust had infection prevention and control policies in place which were accessible to staff.
- The December 2014 figures available showed 93% of critical care staff had received infection control training.
- The environment was cleaned to a high standard and the trust's infection control policies were being audited. The December 2014 audit results showed some minor issues like sticky tape residue on a cot side.
- Monthly infection control surveillance reports for November and December 2014 showed 100% compliance with hand hygiene audits.
- Personal protective equipment was available for staff and we saw it being used appropriately. Staff adhered to the 'bare below the elbows' policy that was in place. There were sufficient hand washing facilities and antiseptic gels.
- According to the submitted and verified intensive care national audit and research centre data (ICNARC), the unit performed as well and sometimes better than similar units for unit acquired methicillin-resistant staphylococcus aureus (MRSA) and clostridium difficile infection rates.
- There were appropriate arrangements in place for the safe disposal of sharps and contaminated items.
- Each bed area had disposable curtains which were clearly labelled with the date they were put up. They were changed monthly or following a deep clean.

Environment and equipment

- Patients were cared for in two distinctly separate areas. Known as the 'front' with potentially 14 bed areas and the 'back' with six. The 'back' room also housed the two isolation rooms. Each room was well equipped with adequate equipment to meet patients' needs.
- All the equipment displayed a label indicating when it was last serviced and when the next service was due. Servicing was undertaken by the trust's electro-biomedical engineering department (EBME). All the equipment we checked had been serviced within the past 12 months.
- Resuscitation and emergency/difficult intubation equipment was available in both patient areas and staff were aware of its location in the event of an emergency. We saw that this equipment was checked regularly but the records we reviewed did show some gaps in the checklist where entries were missing.

Medicines

- Medicines were being stored correctly in locked cupboards and fridges where necessary.

- Fridge temperatures were being checked and recorded and we saw evidence of action being taken when the temperatures were out of range.
- There were two controlled drugs cupboards. The stock levels were checked twice daily and the records demonstrated that this was never missed.
- We observed staff administering medication in a patient centred way and saw that the appropriate checks were being carried out.
- There was a pharmacist involved in the multi-disciplinary ward round on three days per week.
- We noted that the unit was using a different prescription chart to the rest of the trust but we were told that these were due to be updated in the next few weeks.
- There was no electronic prescribing.

Records

- In the six medical records we examined, details of the second daily consultant review were not always being recorded. We also found routine entries from the parent medical team were not present. These issues could present a problem for the continuity of care and treatment. The clinical management of the patient episode in ICU was co-ordinated by the intensivist with support from the parent medical team as requested and when preparing for facilitating the patient transition to ward.
- The nursing documentation included appropriate risk assessments and the implementation of specific care bundles. For example, for ventilator acquired pneumonia (VAP), pressure ulcer bundle, haemodynamic assessments and cannula insertion (visual infusion phlebitis or VIP scores).

Safeguarding

- There was an internal system for raising safeguarding concerns. Staff were aware of the process and could describe what constituted abuse.
- Safeguarding formed part of the mandatory training programme for all staff. Completion of training was variable. 95% of medical staff had received training in level 1 and level 2 adult safeguarding but only 79% had completed level 1 or 2 training in children's safeguarding. Attendance rates for nurses were well below the trust's compliance target of 85% (65% had received level 2 adults safeguarding training and 60% had received level 1 and 2 children's safeguarding training).

Mandatory training

- Electronic records were kept at both unit and trust level to monitor compliance with mandatory training. Again attendance rates for mandatory training varied. For example, 86% of medical staff but only 52% of nursing staff had received training in equality and diversity.
- Critical care had one designated practice educator whose time had been split between the critical care unit and wider trust responsibilities. When on the unit they worked clinically to support nursing staff, especially the new starters.

Assessing and responding to patient risk

- The hospital regularly used what was known as a 'stabilisation bay' situated in theatre recovery. The purpose of this area was to stabilise patients prior to their transfer to the critical care unit at Warrington or another local hospital once a bed was available. Patients admitted to the stabilisation area were the responsibility of the critical care medical team and admission was with the authorisation of the critical care consultant on duty. The standard operating protocol stated that up to two patients could be admitted for a maximum of four hours. However, there were instances when more than two patients were admitted to the bay and they often stayed in excess of four hours. In some cases patients were cared for in the stabilisation bay for up to two days. It was in these instances staff told us they were concerned with the lack of timely review and lack of continuous medical supervision. Staff also told us of their concerns about the staffing levels and competencies. The nurses working in the bay were recovery nurses supported by operating department practitioners (ODP). This meant that they didn't always have the competencies needed for managing critical care patients in the longer term. We were given an example from the weekend prior to our visit when there were three patients within the stabilisation area, two of whom were ventilated. There were two nurses on duty, one of whom was an agency nurse plus two ODPs. Additionally the ODPs had to cover maternity theatres.
- The stabilisation bay was also an unsuitable environment for caring for inpatients. There was no privacy; no facilities for relatives and at times paediatric

patients would be in the same area as adults. We saw evidence to support that the unsuitability of the environment had been raised before by staff but it was not clear what action had been taken as a result.
- During their time in the stabilisation bay the patients did not have a documented plan of care and no ICNARC data was collected for these patients covering their stay. It is not clear therefore, whether this would have affected the robustness and reliability of the data submitted by the trust.
- We spoke with the resuscitation team who were based on the Halton Hospital site. They collected data on all cardiac arrests and contributed to the national cardiac arrest audit.
- There were tools in place for the early detection and escalation of changes in a patient's condition. The hospital used an early warning score system (EWS). EWS is a system that scores vital signs and is used as a tool for identifying patients who are deteriorating clinically. Once the patient had been admitted to the unit then critical care specific documentation was used.
- In the wider hospital, the critical care outreach functions were undertaken by the Acute Care Team (ACT), which had been in place for 12 months. The team comprised a clinical lead, matron, acute care nurse specialist/ practitioners (days and nights) and assistant practitioners. Dealing with acutely unwell and critically ill patients formed an integral part of the role, alongside teaching and audit work; supporting deteriorating patients, monitoring and tracheostomy care.
- The ACT collected a wide range of data to support its performance in attaining the relevant commission for quality and innovation (CQUIN) commissioning target. The data streams collected by the ACT included the following outcome measures: monitoring the numbers of cardiac arrests, numbers of patients followed up within 12 hours of critical care discharge and the number of patients seen at a follow up clinic.
- Follow up clinics were offered to patients two to three months after discharge from critical care when they had experienced an extended stay or been subject to artificial ventilation. This attendance included psychology input.

Nursing staffing

- The unit used an electronic self rostering system.
- We saw that the unit was staffed slightly in excess of funded establishment for band 6 and 7 but under establishment for band 5 and band 2 staff. The unit was managed by an acting matron and also had a practice based educator funded for two days per week.
- On the day of our inspection there were 13 trained nurses and a supernumerary band 7 shift leader looking after 16 patients (x8 level three and x8 level 2). The ideal nurse staffing numbers for the unit when full we were told was 14 trained nurses plus three support workers and a supernumerary shift leader.
- Attempts were made to fill any shortfalls in nurse staffing numbers from the unit's own bank staff. Failing this agency staff were used at times.
- Intensive Care Society standards for nursing levels state that for units with >10 beds there should be additional supernumerary staff on duty. There were times when the unit did not always meet this standard.
- There was usually an experienced band 6 nurse on duty within each patient area (x2 in the front unit and x1 in the back) to provide clinical support and advice to less senior nursing staff.
- We were told there were no plans to develop the advanced nurse practitioner role.
- The unit used an acuity tool to determine the numbers of staff required per shift. Though staff told us that at times they felt the unit was under pressure to take patients over and above the numbers it was staffed for. This had happened during the night shift prior to our inspection when a patient had been admitted who needed critical care.
- We witnessed a nursing shift handover. There was a safety briefing followed by patient allocation to the incoming team. There was a bedside handover between the nurses on the floor and a unit level handover between sisters, who also talked through any operational issues. The handover was systematic and comprehensive.

Medical staffing

- There were two consultants on duty during the day. They undertook a ward round together along with members of the multi-disciplinary team. For example, pharmacists, physiotherapists, speech and language therapists.
- There was a handover prior to the morning ward round and another at 20.00.

- They operated a consultant of the day rota so each day it was a different consultant. This could potentially have an impact on continuity of care. The Intensive Care Society standards for medical staffing recommends working blocks of days at a time to aid continuity.
- There was out-of-hours consultant cover available on call. The middle grade doctors told us that there was no issue securing out-of-hours consultant input.
- Two middle grade doctors were also on duty 24/7.
- Trainee doctors told us was a reliance on the use of trainee locum doctors which could impact on continuity of care.
- The consultant to patient ratio was no more than 1:9. This was in accordance with the Intensive Care Society standards.

Major incident awareness and training

- A major incident plan was in place and staff were aware of how to access their specific action cards.

Are critical care services effective?

Good

Care was delivered in line with evidence- based, best practice guidance. There was a commitment to clinical audit and evaluation. The critical care unit contributed to the collection of data for the Intensive Care National Audit and Research Centre (ICNARC) and continually evaluated its performance against other units. The results from ICNARC showed that patient outcomes and mortality were within the expected ranges when compared with similar units nationally. The trust was also part of the Cheshire and Mersey Critical Care Network (CMCCN) and so worked with other stakeholders (acute trusts and clinical commissioning groups) with a commitment to sharing and promoting best practice in critical care services.

All patients had their pain relief requirements assessed as s part of their individual care plan. This included observing for the signs and symptoms of pain. Staff utilised a pain scoring tool and referrals were made to the trust pain team as required. Guidelines were in place for initiating nutritional support for all patients on admission to ensure adequate nutrition and hydration. Nutritional assessments were undertaken within six hours of admission. There was good access to seven day services including out-of-hours intensivist support and pharmacy, physiotherapy and imaging services.

Evidence-based care and treatment

- The unit used a combination of national and best practice guidance to determine the care they delivered. These included guidance from the Intensive Care Society and the National Institute for Health and Care Excellence (NICE).
- The unit demonstrated continuous patient data contributions to ICNARC. This meant the care delivered and mortality outcomes for patients were benchmarked against similar units nationally.
- The unit was also subject to an annual peer review by the CMCCN. The purpose of the review was to demonstrate evidence at unit level of the range of standards applicable to critical care as outlined in their service specification.
- In the last published CMCCN peer review for 2013, the unit was compliant with the adoption and implementation of a range of expected guidance. For example, therapeutic hypothermia and major haemorrhage guidance.
- The unit was fully compliant with all the CMCCN data collection and audit requirements. There was a monthly consultant led audit meeting which presented and discussed on-going clinical audit.
- There was a range of local policies, procedures and standard operating protocols in place which were easily accessible via the trust wide intranet.

Pain relief

- As part of their individual care plan all patients in critical care were assessed in respect of their pain management. This included observing for the signs and symptoms of pain. Staff utilised a pain scoring tool and referrals were made to the trust pain team as required.
- We saw that epidurals and patient controlled analgesia systems were used in accordance with trust guidelines.

Nutrition and hydration

- Guidelines were in place for initiating nutritional support for all patients on admission to ensure adequate nutrition and hydration. Nutritional assessments were undertaken within six hours of admission.

- Nutritional risk scores were updated and recorded appropriately.
- We saw strict fluid balance monitoring for patients that included hourly and daily totals of input and output.
- The unit had access to a dietetic service when required.

Patient outcomes

- The results from ICNARC showed that patient outcomes and mortality were within the expected ranges when compared with similar units nationally. However, ICNARC data was not collected for patients during their time in the stabilisation bay. It is not clear therefore, whether this would have affected the robustness and reliability of the data submitted by the trust.
- The most recently verified ICNARC data that we saw (for the period July 2014 to September 2014) showed the following outcomes:
  - The mean length of stay for ventilated admissions was between 10 and 15 days. This was slightly longer than in comparable units.
  - The mean length of stay for patients with severe sepsis was 9 to 10 days and this was similar to comparable units.
  - The mean length of stay for elective surgical admissions was 2 to 3 days. And for emergency surgical admissions was 5 days. These results were similar to comparable units.
  - For the number of out of hour's discharges, the unit performed better than comparable units.
  - The readmission rates for both early (within 48 hours of discharge from the unit) and late (over 48 hours) were similar to comparable units.
  - The overall mortality ratio was 1.0 which meant the actual deaths on the unit met with the anticipated number.
- Analysis of the data collected by the acute care team showed that not all critical care patients were seen within 24 hours of discharge to the wards. In some instances this related to the fact that if the patient was otherwise stable then they might not be disturbed by the acute care team during the night. This may then mean they drifted beyond the 24 hour point. Also early warning score audits had revealed some design faults with the documentation and these had been since re-designed and were being tested.

Competent staff

- The unit had a practice development/educator in place to support staff and facilitate bed side teaching.
- Nursing staff received an annual appraisal. By October 2014, records showed 86% of nursing staff had received an appraisal in the last 12 months. Trainee medical staff stated that they were well supported and had a good appraisal and revalidation process with good opportunities for training. 91% of medical staff had received an appraisal in the last 12 months.
- All nursing staff were subject to an annual check of their registration with the Nursing and Midwifery Council.
- Only 42% of the trained nurses on the unit had achieved a post registration award in critical care. The Intensive Care Society standard was 50%.
- There was always a band 7 senior critical care nurse working each shift in a supervisory leadership role coordinating the critical care unit.
- All trained nurses had been trained in intermediate life support with many of the senior nurses also having obtained advanced life support qualifications.
- New staff to the unit were assigned a mentor and given a period of between four and six weeks supernumerary status depending on their previous experience in a critical care environment. During this time they worked through a handbook with associated teaching to make sure they were competent with all aspects of the critical care nurses role.

Multidisciplinary working

- Multi-disciplinary ward rounds took place each day that involved nursing, pharmacy, physiotherapy and others as appropriate.
- There was a policy in place for covering all aspects of the management of medical emergencies at the Halton Hospital site.
- Both nursing and medical staff described that there was 'good' multi-disciplinary working on the unit. Though we also heard that there was, at times, pressure on the unit to take patients when it would mean the overall patient acuity was then greater than the numbers of staff available to care for them in accordance with the desired nurse: patient ratio.
- A monthly governance meeting was held. According to the minutes seen this was predominantly attended by consultants with some nursing attendance if the workload on the unit allowed.

Seven-day services

Critical care

- A consultant anaesthetist/intensivist was available seven days a week including out of hours.
- Out-of-hours pharmacy, physiotherapy and imaging services were available during the daytime at weekends and then via on call.
- A critical care outreach service was provided by the hospital's acute care team seven days a week.

Access to information

- The critical care unit used a paper based record system which was accessible at the patient's bedside.
- When a patient was discharged to the ward then a transfer document was printed, which formed the basis for the nurse to nurse handover. The handover was undertaken face to face once the patient had been settled into their ward bed space.
- The patient's prescription chart was also hand written on the critical care unit prior to transfer to the ward.

Consent and Mental Capacity Act (include Deprivation of Liberty Safeguards if appropriate)

- Staff were able to demonstrate understanding of the issues surrounding consent and capacity for patients in critical care. Staff stated that if they were unsure in any circumstances they would seek guidance from senior staff or from the safeguarding lead.
- There was an assessment of mental capacity recorded in the patient record.

Are critical care services caring?

Good

Patients and their relatives were treated with understanding, compassion, dignity and respect. The unit was good at involving patients, family and friends in all aspects of their care and treatment. Conversations regarding a patient's condition, prognosis, care and treatment options were sensitively managed. The unit actively promoted the use of patient diaries. The diaries were completed by healthcare staff and relatives and helped to inform patients about their care and stay in critical care at times when they may have memory gaps as a consequence of sedation or their medical condition.

Compassionate care

- Relatives told us that their loved ones were cared for in a kind and compassionate manner by staff. Our own observations of care supported this.
- We observed unconscious patients being communicated with by nursing and medical staff in a compassionate manner.
- Conversations regarding a patient's condition, prognosis, care and treatment options were sensitively managed.

Understanding and involvement of patients and those close to them

- We saw evidence in the clinical notes that patients and their relatives were involved in making decisions about their care and treatment.
- Patients were allocated a named nurse for a span of duty on either a 1:1 or 1:2 basis depending on patients' level of need. This helped to ensure continuity of care.

Emotional support

- The unit actively promoted the use of patient diaries. These are a simple but valuable tool in helping patients come to terms with their critical care experience. The diaries were completed by healthcare staff and relatives and helped to inform patients about their care and stay in critical care at times when they may have memory gaps as a consequence of sedation or their medical condition.
- Patients' relatives were allowed to stay by the bedside to witness resuscitation if it was requested.
- As part of the bereavement service, relatives were invited annually to a memorial service.

Are critical care services responsive?

Requires improvement

There were significant numbers of delayed discharges from critical care. During 2014, there were 460 delayed discharges and 125 of those patients were still in critical care more than 24 hours after a decision had been made that they were fit for the ward. This represented 27% of all patients discharged from the unit in 2014. Remaining in a critical care environment when it is no longer required can

be stressful for patients. Furthermore, When patients experienced a delayed discharge then the unit was unable to provide single sex accommodation and breaches of the standard did occur.

The occupancy figures collated by NHS England showed that the bed occupancy for December 2014 was 100%. However data provided by the trust indicated that occupancy overall for the month of December 2014 was 80%. Staff told us that there were times, due to access and flow issues within the rest of the hospital, when pressure was applied to take more patients than they had the staffing levels to cope with. As a result, staff felt that on these occasions the acuity level of the patients on the unit outweighed the staffing numbers and skill mix. There had been five non-clinical transfers in the period April 2014 to December 2014. This was due to a lack of capacity within the unit which meant that patients had to be transferred to another hospital where they could receive critical care.

Service planning and delivery to meet the needs of local people

- There were a number of structured bed management meetings throughout the day. These were attended by representatives from all the specialties including critical care. The meetings gave an overview of the bed management situation within the trust. Up to date access and patient flow information within the trust was discussed. Details about staffing levels were included as were planned patient admissions and the numbers of beds available. At the time of our inspection the critical care unit was full and a bed was found for the one patient who was ready for discharge to the ward that day.
- When patients experienced a delayed discharge then the unit was unable to provide single sex accommodation and breaches of the standard did occur.

Meeting people's individual needs

- Patients were being reviewed in person by a consultant intensivist within 12 hours of their admission.
- The care plans that we reviewed demonstrated that peoples' individual needs were taken into consideration before delivering care.
- Interpreting services were available within the hospital if required.
- The annual complaints report for 2013/2014 showed that there had been no formal complaints made by patients who had stated that they had a learning difficulty or from carers of patients who had a learning difficulty.

Access and flow

- The critical care unit had a clear written operational policy for admission and discharge.
- From talking to staff on critical care there was a feeling that the unit had been stretched in terms of capacity in recent weeks. They told us that there were times when pressure was applied to take more patients than they had the staffing levels to cope with. As a result, staff felt that on these occasions the acuity level of the patients on the unit outweighed the staffing numbers and skill mix. The occupancy figures collated by NHS England showed that the bed occupancy for December 2014 was 100%. (It is recognised that occupancy levels above 85% can affect the standard of care provided). However data provided by the trust indicated that occupancy overall for the month of December 2014 was 80%.
- There were significant numbers of delayed discharges from critical care. Between January and December 2014, there were 460 delayed discharges and 125 of those patients were still in critical care more than 24 hours after a decision had been made that they were fit for the ward. This represented 27% of all patients discharged from the unit in 2014. Remaining in a critical care environment when it is no longer required can be stressful for patients.
- The delayed discharges were symptomatic of wider patient flow issues within the hospital including the pressures on A&E.
- One of the measures introduced to help manage patient flow into critical care was the creation of a stabilisation bay in theatre recovery. A standard operating protocol was in place which stated that the bay should be used for patients requiring emergency stabilisation prior to transfer to a critical care bed in Warrington or another hospital. The standard operating protocol stated that admission to the stabilisation bay was with the authorisation of a critical care consultant and that the stay should be for no more than four hours. However, we found the protocol was not always followed and patients regularly stayed in the stabilisation bay for longer.

- There had been 20 patients transferred from the critical care unit after 10pm and before 7am during the 12 months from January to December 2014. According to ICNARC data this was lower than the number of out-of-hours transfers in comparable units.
- There had been five non-clinical transfers in the period April 2014 to December 2014. These are transfers where a lack of capacity meant that the patient had to be transferred to another hospital where they could receive critical care.
- Once discharged from critical care, patients had their care overseen by the acute care team as well as their respective speciality teams. This meant that readmission rates were low because patients' individual care needs were usually managed effectively after discharge.

Learning from complaints and concerns

- There were low levels of complaints about critical care and evidence that the service responded promptly to people's comments and concerns.
- Staff were aware of the trust complaints policies and processes and any complaints were handled in accordance with the policy.
- The critical care unit received feedback a number of different ways. For example: via formal complaints, from the patient advice and liaison service (PALS), NHS Choices, Healthwatch and from the observations made through governor's visits.
- Complaints were reported to the board quarterly with a detailed annual report produced which looked at all complaints and concerns. These were analysed for emerging themes and lessons to be learned.

Are critical care services well-led?

Good

Delivering a quality service was stated as being central to the trust's core strategic objectives, so that patients were safe and had the best possible experience. From talking to staff we gained an understanding of how the unit had developed to its current position but no one articulated any specific vision and strategy for the future in order to achieve and maintain this objective.

The trust's governance team produced a monthly report for scheduled care which included information and figures on the key risk areas for monitoring around clinical and non-clinical governance in the unit. The report included a rolling six month report on incidents. These reports were made available for all staff and were displayed on the staff room noticeboard.

Senior medical and nurse leaders were committed to providing a safe service for their patients. The critical care unit had a designated consultant clinical lead and the nursing team was enthusiastically led by an experienced acting matron. Senior nursing staff reported that members of the trust board were often seen on the wards and it wasn't unusual for the director of nursing to put on a uniform and assist with patient care.

Service managers had plans in place to further reduce the use of the stabilisation bay. However these had not been implemented at the time of our inspection.

Vision and strategy for this service

- Delivering a quality service was stated as being central to the trust's core strategic objectives, so that patients were safe and had the best possible experience. From talking to staff we gained an understanding of how the unit had developed to its current position but no one articulated any specific vision and strategy for the future in order to achieve and maintain this objective.

Governance, risk management and quality measurement

- The service measured itself against both the Intensive Care Society core standards and the CMCCN service specifications. The unit was subject to annual peer review benchmarking against the present evidence base and agreed standards for critical care provision.
- We were unable to find evidence of a specific local risk register held at unit level. However, the risks were known to senior staff and were recorded at divisional level. One of the top risks identified was the low percentage of trained staff that had completed a critical care course. It was not clear what action was being taken to address this issue.
- Anaesthetic governance meetings were held monthly at which critical care related risks were discussed.
- The trust's governance team produced a monthly report for scheduled care which included information and figures on the key risk areas for monitoring around clinical and non-clinical governance in the unit. The report included a rolling six month report on incidents.

These reports were made available for all staff and were displayed on the staff room noticeboard. The report stated the importance of action plan and lessons learned from incidents and complaints with the aim of improving practice.

Leadership of service

- Senior medical and nurse leaders were committed to providing a safe service for their patients.
- The critical care unit had a designated consultant clinical lead and the nursing team was enthusiastically led by an experienced acting matron who was a positive role model for staff
- Senior nursing staff reported that members of the trust board were often seen on the wards and it wasn't unusual for the director of nursing to put on a uniform and assist with patient care.

Culture within the service

- There was a positive culture in the service and the acting matron provided good local leadership
- Staff were encouraged to report incidents and raise concerns openly.
- All staff were open and happy to tell us about what it was like to work in the service and as part of the trust.
- Trainee medical and nursing staff told us that they felt supported.

Public and staff engagement

- There was a nurse led patient experience team in place
- The trust website had a section on critical care which signposted the reader to the information available from NHS Choices on what to expect from a stay in critical care.
- There was a staff engagement and well-being group with a designated lead person.
- There was evidence of strong engagement with staff regarding equality action plans. Staff told us that only by working in partnership with people and staff can services be developed that meet local need.

Innovation, improvement and sustainability

- The wider corporate strategy included priorities for 2014/2015 of improved complaints management, falls reduction, listening to patients' feedback, continuing to reduce pressure ulcer incidence and improving outcomes for patients with stroke and pneumonia.
- These priorities would in turn become part of the critical care unit's agenda for improving quality.

Maternity and gynaecology

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

Information about the service

The maternity and gynaecology services for Warrington and Halton Hospitals NHS Foundation Trust are based at Warrington Hospital. They serve the population of Warrington and Halton and the surrounding areas. There were 3029 births at the trust from April 2013 to April 2014. This number had decreased by 40 births in the past three months; this was the lowest number of births the service had seen in the last two years.

The service was managed through the Warrington and Halton Hospitals NHS Foundation Trust's women's children's and clinical support services division and was led by a clinical director and a head of midwifery. The services provided include antenatal and post-natal care (inpatient and outpatient), delivery suite, ultrasound scanning, an early pregnancy unit, and gynaecology outpatient clinic and inpatient service. A team of community midwives also provide ante natal care, home birth and post natal care.

During our visit we spoke with twelve patients, seven doctors and approximately 30 midwives (between bands 5 to 7). We observed care and treatment to assess if patients had positive outcomes and looked at the care and treatment records for six patients. We gathered further information from data we requested from the trust, reviewed other information during our visit and compared their performance against national data.

In July 2014 we had carried out a responsive inspection of maternity services following a review of information provided to us by the trust in relation to 10 intrauterine deaths. The inspection in July 2014 was conducted to review the trust's management and safety related to promoting the wellbeing of low risk women having their babies at Warrington Hospital. As a result of the inspection we found the trust was not meeting the regulatory requirements in relation to: Regulation 9 care and welfare of people who use services and regulation 23 supporting workers. Following the inspection, the trust provided us with an action plan detailing how they planned to meet these regulations. We reviewed the progress with the action plan as part of our inspection.

Maternity and gynaecology

Summary of findings

Patients were at risk of avoidable harm as a result of the number of midwives being frequently below the safe staffing levels set by the trust. Staff were not up to date with essential training and regular safety checks on emergency equipment were not carried out appropriately and in a timely manner. There was a lack of action for improvement where data showed this was necessary. Access to the maternity services and the flow of patients through the departments was impeded by lack of adequate staff and insufficient capacity to meet the demand. The leadership of the service was reactive and staff were not clear on the future strategy for maternity services.

There had been some improvements since our last inspection in June 2014, in the assessment of patients and the care of those women who were assessed as being low risk. However systems were still new and there remained a risk averse culture among some staff. Progress had also been made towards collaborative working between midwifery and medical staff although further improvements were required.

Staff were caring, kind and patient and were committed to providing good care to patients.

Are maternity and gynaecology services safe?

Requires improvement

The numbers of midwives in all departments were frequently below the safe staffing levels set by the trust. The labour ward shift leader was often unable to be supernumerary as they were required to support staffing numbers. Levels of mandatory training attendance were below the trust's target of 85%. Performance was being monitored by the Maternity Risk Management Group.

Records on the post natal ward were not securely stored and the security systems on the post natal ward did not prevent unidentified visitors from accessing the ward. The required safety checks for emergency equipment were not completed in line with trust policy.

All areas were clean and tidy and infection control practices were adhered to. Medicines were safely stored however not all procedures were followed correctly for the management of controlled drugs.

Changes to the assessment of risks for patients in labour had led to more clear criteria for monitoring patients using technology. However this was a recent change and staff recognised further training and support was required to ensure consistency in practice.

Incidents

- Learning from incidents was shared with staff through the safety briefing that was part of the handover at each shift. A newsletter was also produced monthly that contained actions required by staff as a result of learning from incidents. However, midwives told us this came as an e-mail and they did not have the time to read their e-mails regularly while working and so could miss feedback provided in this way.
- There was a specific newsletter developed by medical staff that included learning from incidents.
- Meetings took place where serious incidents were reviewed and learning was discussed. These meetings were multi-disciplinary however they were poorly attended by midwives due to staffing shortages which

meant they could not be released from the wards. Ward managers who did attend the meetings reported content and learning back to staff during handover briefing.
- Staff confirmed that the system for reporting incidents was easy to access and they were clear about their responsibilities with regard to reporting incidents.
- Perinatal mortality and morbidity meetings were held every six weeks. These were joint meetings with midwives and consultants. Again we were told midwives found it difficult to attend as they had to remain on the wards.

Safety thermometer

- The safety thermometer was displayed outside of the maternity and gynaecology wards. Staff were unclear how this information was used to improve practice.
- A survey of staff entitled "Checklist for assessing safety culture and resilience within the department" had been carried out on the maternity unit in the past two months. 93% of staff answered "yes" to the statement: "Policies are in place to encourage everyone and anyone to raise risk and patient safety issues." This showed staff were aware of their own role in maintaining the safety of patients and the policies in place to support them.

Cleanliness, infection control and hygiene

- The wards and departments were clean and tidy.
- Hand sanitizer gel was provided at the entrance to each area and staff reminded visitors to use it.
- Personal protective equipment was available and used by staff when appropriate.
- Staff observed good hand hygiene practice and bare below the elbow guidance.
- There had been no reported cases of Clostridium Difficile or MRSA in the maternity unit in the past 12 months.
- An infection control audit was completed monthly. This included hand hygiene, environmental hygiene and spot checks on equipment. Where issues were identified these were recorded and addressed with the necessary staff member. The monthly scores were displayed outside the ward area and showed good compliance rates.
- Patients having an elective caesarean section were screened for MRSA prior to their surgery.
- 68% of nursing and midwifery staff in maternity and gynaecology services had completed infection control training. This meant that some staff may not be up to date with latest infection prevention and control best practice.
- Weekly infection control audits of all ward areas were in place. The monthly report for the women's health services in October 2014 showed two audits had been completed on the delivery suite when four should have been carried out. This meant that audits had not been performed in line with trust policy.

Environment and equipment

- There was an adequate supply of necessary equipment, such as cardiotogography monitors to support the needs of patients.
- Records showed not all the resuscitation equipment in maternity services, both adult and neonatal, had been checked daily. The divisional incident report for September 2014 showed the neonatal resuscitation equipment on the labour ward had not been checked for three or more consecutive days. On the post natal ward there were four times between the 1 and 28 January that the equipment had not been checked. In the obstetric theatre the resuscitaire had not been checked for two consecutive days. This showed that learning from the incident in September had not resulted in sufficient measures being taken to ensure equipment was checked adequately.
- The service had introduced a checking system for anaesthetic equipment in December 2014 however, there was no record of routine checks of the anaesthetic equipment in the obstetric theatres at the time of our inspection. Staff said the record book for this was held in the main theatres. This meant there was no evidence of routine checking of equipment in accordance with good practice.
- On the gynaecology ward the bedside oxygen and suction supply checking records were blank on four occasions from 1 to 28 January 2015.
- Two birthing pools were available. Equipment for the evacuation of a patient in an emergency was provided. All necessary maintenance checks had been carried out and recorded.
- The door entry system to the post natal ward was being change at the time of our inspection. There was no risk assessment in place for this process. Staff were unclear how to obtain swipe cards to gain entry with the new

system. During the alterations the door was left unattended without any locking mechanism and staff on the ward were unaware. This presented a risk of unidentified visitors entering this area and/or an abduction risk. Staff said they were vigilant to visitors entering and leaving the ward and CCTV was available in the corridor leading to the ward. However they agreed they would be unable to observe the doors when delivering care to patients.

Medicines

- Medicines were safely and securely stored in all areas.
- Records for medicine administration were completed appropriately.
- We observed the checking of controlled drugs stock in two maternity areas at shift handover and noted that staff omitted to check the expiry dates of controlled drugs. This was not compliant with the trust's policy for controlled drug checking.
- The service had recognised that there was no pharmacist allocated to maternity services. This had been added to the divisional risk register and an action plan was in place to address the identified shortfall.
- There was no fridge for the storage of medicines on the postnatal ward. This meant that some medicines that may be needed in the emergency situation such as a post- partum haemorrhage were not readily available. There was no risk assessment in place to identify and manage this risk.
- 89% of nursing and midwifery staff in the women's services division (which included maternity and gynaecology services) had completed medicine management training.

Records

- Patients' records were accurate, legible and current.
- On the post natal ward the records were stored in an unlocked filing cabinet in each bay area. The medical and nursing notes for each patient in that bay were accessible in these cabinets at all times. These records contained confidential information and were not stored securely. This did not meet with relevant guidance on the storage of confidential records and data protection.
- Risk assessments for specific risks relating to the health, safety and welfare of patients were available in their records and were up to date.
- The Child Health Record "Red book" was issued at birth and women were told about the purpose of the book and how to maintain the record.

Safeguarding

- Many staff were not up to date with the appropriate level of safeguarding training of both adults and children. In the women's services division 31% of nursing and midwifery staff and 67% of medical staff were up to date with level 2 adult safeguarding training. 73% of nursing and midwifery staff had completed level three safeguarding children training.
- Staff knew they had a responsibility to report any concerns they had for a patient's safety. They were aware of the signs of abuse and neglect and there were examples of when they had recognised and escalated such concerns appropriately.
- In maternity services, there was a midwife who had a lead role in safeguarding. However they had been absent from work and no other person had been appointed to cover this role. Not all staff were aware of the support provided by this specialist midwife.
- Community midwives stated that a large part of their time was spent ensuring the safety of vulnerable women. They said it was increasingly difficult to offer the appropriate level of support due to their increased workload.

Mandatory training

- Levels of mandatory training attendance for the maternity unit were below the trust's target of 85%. Compliance varied across the disciplines with 89% of staff completing medicines management training and 43% completing fire safety. An action plan had been developed to improve performance that was being monitored by service managers.
- Midwives and medical staff were expected to complete maternity specific mandatory training. 70% of staff were up to date with this training by the end of 2014 which meant there was a risk of some staff delivering care without up to date knowledge and skills.
- Figures provided by the trust showed 72% of staff in maternity services were up to date with resuscitation training. It was not stated if this was adult or infant resuscitation.

- Staff said there had been problems in the past year with access to mandatory training courses with a large number cancelled. They said this was due to shortage of staff meaning they could not be released to attend.
- Skills and drills training took place in maternity services to simulate obstetric emergencies such as shoulder dystocia, cord prolapse and post-partum haemorrhage. This was an annual update and most staff said they were up to date with this training, although one midwife told us they had not completed it since 2012.
- As part of the action plan from recent investigations staff were to attend specific training in the use of cardiotogography (CTG). 35 staff had attended this training, with a further 35 booked to attend in February. There were 127 qualified nursing and midwifery staff in total and staff described it as difficult to access this training due to limited places.

Assessing and responding to patient risk

- A number of risk assessments were used in maternity and gynaecology services including an Obstetric Early Warning chart, to identify mothers whose condition was deteriorating. A Neonatal Early Warning Score (NEWS) chart was in place for new-born babies. These were used at shift handover to identify any patient requiring increased observation or intervention.
- Safety checklists were completed in the obstetric theatres. Patients were in the care of recovery staff from the main theatres following a caesarean section which meant appropriately experienced staff were assessing a patient's condition following surgery.
- An inspection of the maternity services had been carried out by the Care Quality Commission in July 2014 which identified concerns that CTG monitoring was being used for low risk women, outside of best practice guidance. Following this inspection, some changes had taken place to improve the risk assessment process and reduce the need for CTG monitoring for low risk women. However midwives and medical staff had conflicting views as to whether this approach was appropriately used to ensure patients who were assessed as low risk at their initial assessment had their care managed using the low risk pathway through to and during labour.
- The process in place to assess a patient in labour and move them from the low to high risk pathway included the labour ward shift leader being involved in the assessment and resulting changes. Since the shift leaders on the labour ward were often not supernumerary this could present a risk of delay in this assessment occurring.
- In May 2014 a survey of midwives to assess their confidence to undertake midwifery led care had been completed. 55 midwives completed the survey and the results showed that 87% of midwives were quite or extremely confident to assess low risk women in labour. This number reduced to 75% who felt quite or extremely confident to offer a choice of fetal monitoring in labour. This showed not all midwives felt confident to provide care in a low technology setting, which could lead to inappropriate use of restrictive monitoring not based on the level of risk.
- Staff said they did have medical or surgical patients accommodated on the post natal ward if the respective wards were full. This included patients who required frequent observations from a registered general nurse who attended from another ward. However, staff said they felt this was inappropriate as they could not provide the level of care such a patient may require if their condition deteriorated.

Midwifery staffing

- Medical and midwifery staff of all grades said the numbers of staff working in all areas of the maternity unit were currently inadequate. They described how it was usual for wards to have a lower number of midwives than they should have with staff working extra hours and not having breaks during their shifts.
- Incident reports showed examples of low staff numbers leading to potential risks to patients on four occasions in September and on seven occasions in October 2014. The trust had set the number of midwives required on the labour ward as seven at all times with a band seven midwife as supernumerary. At times we found there were only five midwives on duty. Staff shortages would be discussed at the daily safety meeting on the ward and escalated by the lead midwife. To manage this risk staff were regularly moved from one area to another to cover shortages .Staff had been moved from the post natal ward to the induction of labour ward on 18 days between first and 28th January 2014. However this essentially meant the risk of low staff numbers was moved from one area to another.
- According to the trust's staffing policy, the band seven midwife on the labour ward should be supernumerary

at all times. This was achieved 20% of the time in October 2014 and staff reported this had not increased. This meant they were not available to support less experienced staff or in emergency situations.

- Inexperienced staff could be left in charge of ward areas, for example a band 5 midwife with two care assistants was caring for 14 patients with four babies requiring increased observation. In this instance a band 6 midwife was moved from the labour ward, which reduced the capacity in that unit. Changes to staffing were made at short notice to cover shortages with no evidence of advanced planning or assessment of skill mix.
- The ward had been closed 16 times in 2014, seven times of which were due to an inability to have sufficient staff on the unit to safely deliver care to the patients. This showed low staff numbers had significant impact for patients during these times.
- There was no specific tool in use to assess the adequate numbers of staff required. A management plan was in place to support staffing shortages including a longer term plan to include Birth Rate Plus. A target date for completion of a review of the midwifery staffing had been set at 31st October 2014 on the maternity governance action plan. This date had been extended to January 2015 to enable an intrapartum acuity assessment to be completed. Staff were hopeful this would lead to an increase in staff numbers.
- The midwife to patient ratio of 1 to 31 was not in line with the nationally recommended number of 1 to 28. The ratio of one to one care during labour was at risk because of this. We were told 100% of women received one to one care in active labour.
- Medical staff said they were unclear if the midwives with managerial roles who were supernumerary and the matrons were able to participate in practical care delivery. They said this impacted the number of midwives available to work in the ward areas.
- Handovers were completed three times per day, at the beginning of every shift change. This included discussion of every patient on the ward, their current health status, any increased risks and the plan for the day's work.The staff shortages were in part due to short and long term sickness.

Medical staffing

- There were eight consultants employed in the maternity department with middle grade doctors, juniors and trainees to support. One consultant told us there were always gaps in the rota for middle grade doctors. This was due to sickness and maternity leave. A locum was used to cover the gaps. Medical staff said this caused some delays for patients due to doctors covering more than one area.
- Out-of-hours cover was provided by consultants who did one week in eight on call. They were in the hospital Monday to Friday until 7pm and then on call overnight. At weekends the on call doctor provided three hours in the hospital when they completed a ward round for all patients. Junior doctors said they were well supported by the consultant on call.
- Medical handovers took place twice daily with written records used which assisted with the sharing of accurate information.
- There was a consultant obstetrician and anaesthetist allocated to provide 24 hour cover on the labour ward. This meant they were available in the case of an emergency.
- There was no designated doctor to provide medical cover to the ante natal day unit. This was covered by a junior grade doctor. This doctor could not discharge patients without a more senior doctor assessing them. This led to delays in people being discharged or moved from the unit and patients had waited up to five hours to be seen.
- There were monthly consultant meetings held and other doctors attended these as they wished. These provided a forum for medical staff to discuss issues and share learning.

Major incident awareness and training

- Managers told us they were aware of their responsibilities in the event of a major incident. Midwives were not aware of their role, within the wider hospital, should a major incident occur. They had not taken part in any drills.
- The maternity unit had been closed 16 times in 2014. A procedure was in place where patients were diverted to nearby units and any who were booked in for a procedure such as an elective caesarean were delayed when possible.
- There was no long term plan in place to help reduce the incidence of unit closures.
- During the inspection the labour ward was closed for 4 hours. The manager of the ante natal day unit had not

been informed and therefore was unaware high risk patients in that area may potentially need to be moved to another hospital. This could cause patients undue delay and distress through miscommunication.

Are maternity and gynaecology services effective?

Requires improvement

In the last six months there had been an emphasis in maternity services on improving the effectiveness of care of low risk women. This had resulted in actions to improve other clinical and quality performance outcomes being overshadowed. This was improving and audits regarding the clinical outcomes for patients were completed. Where audits showed poor performance there was limited evidence that actions had been taken to bring about improvement. Information regarding the safety of patients was collected. However there were no goals set for safety standards.

The service had been carrying out targeted work to reduce the rate of elective caesarean sections to meet the Clinical Commissioning Group (CCG) target of 25%. Performance was showing a downward trend. Breastfeeding rates at delivery had reduced in the last three months of 2014 from 68% to 62%. The rate of breastfeeding on handover of care to the health visitor was 38%. Staff stated that they would like to increase these rates however there was no plan of how this was to be achieved.

Midwifery staff were not up to date with their professional development reviews. There was a lack of multi-disciplinary working with other health professionals such as physiotherapists and diabetes specialists. However, there had been improvements, over the past few months, in the working relationships between the medical and midwifery staff. Information was not readily available in a variety of formats or languages. Staff were unclear about their responsibilities regarding the mental capacity of patients.

Policies and procedures were up to date and complied with relevant national guidance.

Evidence-based care and treatment

- The guidelines for the care of women in labour had been reviewed in June 2014. The exclusion criteria for midwifery led care was included and met NICE (National Institute for Care Excellence) guidance.
- A new system for scanning pregnant women (Gestational Related Optimal Weight) had been introduced in May 2014. The guidance for using this system was in line with Royal College of Obstetrics and Gynaecology best practice recommendations.
- Plans were in place to review policies and procedures to ensure they were in line with changes in NICE guidance.
- The maternity dashboard contained safety information such as the incidence of 3rd and 4th degree tears at delivery. This had ranged from 1% in November 2014 to 5% in December 2014. There were no targets set to measure performance and no record of how this information was used to improve patient care and experience.
- The surveillance of the cardiotogography monitoring was in line with NICE guidance including the use of “Fresh eyes” where the readings were reviewed by a second person.
- There was no facility for a patient to have a laparoscopic hysterectomy in the hospital. This meant these patients had to have more invasive surgery or travel to another hospital.
- There was an emphasis on developing normality during labour as it was recognised this aspect of the service required some improvement. Staff said a group was due to be set up to look at how this could be developed and set out terms of reference for this work.
- Weekly meetings to discuss cardiotogography monitoring had been set up in December. These were poorly attended by midwives and formally with the majority of staff.

Pain relief

- A choice of pain relief was available to patients and they said they had been able to discuss the choices and where possible their wishes were respected.
- Alternative therapies, such as hypnotherapy, were available to assist with pain relief and aid psychological wellbeing during pregnancy and labour.
- A 24 hour epidural service was available. An audit showed patients received this method of pain relief within the recommended timescale of 30 minutes.

Nutrition and hydration

- Breastfeeding rates at delivery had reduced in the last three months of 2014 from 68% to 62%. The rate of breastfeeding on handover of care to the health visitor was 38%. Staff stated that they would like to increase these rates however there was no plan of how this was to be achieved.
- The unit had not achieved 'Baby Friendly' status as they had one step still to complete. This is a recognised United Nations International Children's Emergency Fund UK initiative which consists of three stages of assessment, including parents feedback, with regard to support for breast feeding.
- Mothers in the neonatal unit told us that facilities and support for breast-feeding was good. Breast feeding mothers were offered food from the adult menu at no charge.

Patient outcomes

- The service had been carrying out targeted work to reduce the rate of elective caesarean sections to meet the Clinical Commissioning Group (CCG) target of 25%. Performance was showing a downward trend.The post natal readmission rate was within acceptable limits.
- Normal birth rates were 57% in the last three months of 2014 which had reduced slightly from 61% in the previous three months. Staff said the future focus for the unit was on normality in childbirth . However other issues had taken priority and as aresult 'normality' required more development.
- Patients who required a surgical termination of pregnancy had the procedure at Halton hospital. Capacity for this was available three times per week and the system meant these appointments were protected from cancellation.
- We were told the number incidents of post-partum haemorrhages was underreported as if it occurred in the operating theatres, staff saw this as being in a controlled environment. There was work ongoing to increase these reports as this meant the data may not accurately reflect the number of incidents that had occurred.
- Senior staff recognised the number of patients booked under the care of a midwife was lower than the national average. It was approximately 25% and reduced to 12% at birth. The trust planned to recruit a consultant midwife and it was to be part of their role to increase this rate.
- An audit of low risk care had been completed in February 2014. However, it was noted that only 20 records had been audited in a 5 month period.
- A number of clinical audits had been completed. Those completed included risk assessment in labour, shoulder dystocia and third and fourth degree tears.

Competent staff

- 69% of nursing and midwifery staff in the women's care division had completed a personal development review up until the end of December 2014. This meant not all midwives had the opportunity to discuss their performance or plan their future development.
- The ratio of supervisors to midwives was one to twelve. This met with the national recommendations of one to fifteen.
- Data provided by the trust showed the new-born screening was below the expected standard in three of the five areas in 2012. Staff stated this had been a recording error and data now showed 100% compliance with all five areas of the audit.
- There were opportunities available on request for midwives to expand their role within the organisation. However some felt the decision making process lacked clarity and that this limited their access to professional development opportunities.
- Staff said there were instances where patients had to wait for intravenous antibiotics. One example was given of a patient who waited three hours for treatment. Staff told us this was due to there being insufficient number of midwives competent to deliver intravenous drugs.

Multidisciplinary working

- Midwives and medical staff said the teamwork between them had improved in the past few months. They had completed a team building event in November and this had resulted in some positive developments such as more multi-disciplinary meetings.
- However, there was still work to do regarding multi-disciplinary working with other health professionals. There were meetings arranged, such as the perinatal meetings and CTG meetings which were open to all staff. These were poorly attended as a result of work pressures. There was no plan to improve the attendance at these meetings or ensure the information was shared in an alternative way.

- There were examples of when a patient had been discharged and had not received the required follow up by a community midwife. We were told this was usually if the patient was from outside the normal catchment area. This showed a breakdown in communication between the hospital staff and community midwives in the local area.
- There was a midwife with a lead role for supporting patients with mental health issues. They could assist patients to get access to specialist services and the inpatient mental health services could be used if required. Community midwives said access to specialist maternity mental health services was problematic for them and supporting such patients took up a large part of their time.

Seven-day services

- The early pregnancy unit was open five days per week. This meant that patients would need to access the scanning services via accident and emergency in the evenings or weekends.
- The antenatal day unit provided a seven day service between 9am and 5pm.
- There was a consultant on call from home to support junior doctors in the evenings and at weekends. They completed a review of each patient, during a ward round, on Saturdays and Sundays which facilitated discharges at weekends.

Access to information

- Information leaflets and posters were available and accessible for patients.
- There was no signage or leaflets in a language other than English. Staff said they could access this information if required via the "Hub" which was a central information centre.
- A translation service was available; however this needed to be booked in advance for face to face interpretation or they could be accessed via telephone. There were examples of where an interpreter had not been present during consultations and labour, with the reliance for interpretation being on family members. This meant there was no way that staff could be sure that they were communicating fully or independently with the patient.
- There was no specific information in an easy read format, such as pictures or accessible to patients with a sight impairment or learning disability.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- There was one consent form designed for the use of elective and emergency surgery across maternity and gynaecology services. This contained a lot of information with no capacity for the surgeon to insert any specifics of the procedure to be completed. In emergency cases where written consent was not taken, a record of the discussion and the patient's verbal consent should have been recorded electronically.
- In at least one instance of a patient who had required an emergency caesarean section where there was no consent form, the doctor had hand written in the notes "v consent taken." However, there was no subsequent retrospective explanation, from the doctor or the midwife, as to why the surgery was carried out without written consent. This meant it was not clear whether the patient had received an explanation of the surgery to be carried out or the potential risks in order to give their informed consent.
- Midwives were unclear as to their responsibilities regarding assessing the mental capacity of patients and how this may impact on their abilities to consent to care and treatment. Therefore patients who lacked capacity may not be offered choices or be supported to make decisions appropriately. There was e- learning available for midwives regarding the Mental Capacity Act. There was no training for midwives with regard to the Deprivation of Liberty Safeguards (DoLS) and those we spoke with were unaware of this legislation.

Are maternity and gynaecology services caring?

Good

Staff treated patients with dignity and respect and were kind and polite in their interactions. They understood when patients may need additional support due to emotional circumstances and systems were in place to provide this. Patients said they were involved in their birthing plans and their choices were listened to and respected.

There was recognition by the midwives and doctors that an increase in the normality of labour with a reduction in unnecessary interventions was required and plans were in place to support this achievement.

Maternity and gynaecology

Compassionate care

- Patients said staff were kind and caring. They said they had been treated with patience and respect.
- Patients said staff introduced themselves, were friendly and included them in their care. They said they would return to use the service again and recommend it to their friends.
- In the main, the privacy and dignity of patients was protected and signage was used to show care or treatment were taking place and reminding visitors to the room to knock.
- We saw an example of where a patient required accommodation away from other patients with new-born babies and this was facilitated. However we received information from another patient that their need for privacy had not been respected and they had not been supported when their baby was diagnosed with a genetic condition. This showed the processes in place for offering appropriate support during a difficult time for a patient, were not consistent.

Understanding and involvement of patients and those close to them

- Staff said they had increased the involvement of patients in their own birth plans in the past few months. This was improving with the increase of midwifery led low risk births.
- There was an acceptance that improvement in the normality of labour was required and staff were supportive of this. They were hopeful the future appointment of a consultant midwife would assist this and give patients more choice.
- 17 water births had taken place in the past month. Staff said this had increased from the previous month although figures were not available.
- Patients said they had been included in their own care and been able to discuss and choose the mode of delivery. Where possible their choices had been respected and when they had not, discussions with the patient had taken place and explanations had been clear.
- Partners could be present if they wished and could remain during induction of labour.

Emotional support

- There was a designated screening midwife who offered support and counselling to patients who had received bad news following diagnostic screening. They identified additional support for those patients who required this type of support.
- There was a designated support for patients following the loss or death of a baby. Staff on the wards did offer comfort and support when needed however recognised that this difficult situation often required specialist support.
- There was a designated suite for the parents of still born babies or those who died shortly after birth. This was a large room away from the main ward with facilities for parents to remain with their baby should they wish. It was a homely and sensitive environment and the decoration had been chosen and provided by a bereaved parents' charity.
- Staff were very supportive to parents and those close to them following the loss of a baby, and offered emotional support to provide comfort and reassurance. The trust provided memorial services for new born babies which were valued by the families. The Trust won a butterfly award for its baby loss bereavement service in 2014.

Are maternity and gynaecology services responsive?

Requires improvement

There were issues with staffing and capacity through the maternity unit that had resulted in the labour ward being closed on multiple occasions. Patients experienced long waiting periods to see a doctor in the ante natal day unit and the average length of stay on the post natal unit was slighty longer than the recommended guidance period of 24 hours.

The gynaecology ward was used for outlying medical and surgical patients on a regular basis. This impacted on the services ability to accommodate gynaecology patients and operations could be cancelled as a result.

Staff within the maternity services and accident and emergency were not clear as where to direct a patient who presented at the hospital for a termination of pregnancy for social reasons. There was also a lack of patient information leaflets in this regard.

Maternity and gynaecology

Transitional care facilities were not available on the wards which meant babies who required treatment such as phototherapy or intravenous antibiotics were transferred to the neonatal unit. This was not in line with best practice as it meant the mother and baby were separated.

Service planning and delivery to meet the needs of local people

- The termination of pregnancy service was provided for foetal abnormalities only or other medical reasons. This meant a patient requiring a termination for social reasons had to access this service in the community. Staff within the maternity services and at accident and emergency were not clear as to where to direct a patient who presented themselves at the hospital for social termination. There was also a lack of patient information leaflets in this regard.
- Transitional care facilities were not available on the wards which meant babies who required treatment such as phototherapy or intravenous antibiotics were transferred to the neonatal unit. This was not in line with best practice as it meant the mother and baby were separated.

Access and flow

- The labour ward had been closed 16 times in the past twelve months. On eleven occasions this was due to lack of capacity to safely admit patients.
- The average length of stay on the post natal ward was slightly longer than the NICE guidance of 24 hours.
- The ante natal day unit acted as a triage for patients with any pregnancy related issues, including abdominal pain and vaginal bleeding. There was no specific admission criteria which meant the ward could become very busy with patients waiting up to five hours to be seen. This did not provide a timely response to patients who had presented with concerns.
- There was no designated doctor for the ante natal day unit. A junior doctor was responsible for this area and the post natal ward with the second on call doctor (the registrar) who was responsible for the labour ward. This meant any patients who needed to see a doctor had to wait for one to become available. Staff said when the unit was due to close at 5pm they could have patients still waiting to see a doctor. The junior doctor could not discharge patients and some patients said this meant they had had to repeat their story to a second doctor. This meant there were delays in patients being admitted to the labour ward or being discharged from this unit.
- In order to reduce the delay in discharges at weekends, if possible a midwife with the competence to 'complete examination of the new-born' checks was available. If this was not possible there was a delay in accessing the paediatric doctors to complete the checks.
- To reduce delays in discharge due to lack of access to medicines staff on the post natal ward had access to a stock of those that were most commonly required. This helped patients being discharged in a timely way.
- The gynaecology ward was used for medical and surgical patients on a regular basis. There were five medical outliers and four surgical outliers on one day of the inspection. We were told this was usual. Staff said this impacted on their ability to accommodate gynaecology patients and operations could be cancelled as a result.

Meeting people's individual needs

- The design of the waiting areas and wards for the gynaecology unit and the early pregnancy unit meant patients could wait separately should this be in their emotional interests.
- There was no midwife with a specific role in supporting patients with a learning disability. There was a matron in the hospital with a specific role in supporting patients whose circumstances made them vulnerable and they would be used as support and to access resources for such patients if required.
- On the gynaecology ward the daily safety briefing record included any patients with specific needs and required additional support.
- If a patient required the support of an informal carer when using the maternity services this would be facilitated, including having a carer present during labour.

Learning from complaints and concerns

- Learning from complaints was shared in the newsletter, by email and in multi-disciplinary meetings.
- Complaints and learning from complaints were discussed at the divisional integrated governance group.

Maternity and gynaecology

Are maternity and gynaecology services well-led?

Requires improvement

During our inspection in July 2014, we found that there was a disconnect in the relationship between medical and midwifery staff as a result of the changes that had been implemented following a number of intrauterine deaths.

While work had been done to improve the relationships between medical and midwifery staff there was still a tangible division between them.There had been a strategic engagement event for staff in the women's health division. Staff were aware of the event, however they were unable to articulate the actions or strategy developed as a result. Medical and midwifery staff differed in their view of future developments and plans as to how these could be achieved. There was a reliance on the appointment of one senior staff member to improve the service with a lack of a whole team approach. There was no date for the appointment of this person and the role for this person was not yet fully defined. The sharing of information regarding proposed changes was inconsistent. The leadership of the service was reactive. Some work had been done to improve staff engagement however most staff felt more was required to bring the disciplines together into a cohesive team.

Following the inspection in July 2014 progress had been made to ensure all policies were in line with NICE guidelines. However a number of systems were still new and there remained a risk averse culture among some staff.

The governance structure was due to change to ensure the women's services were not included with other support services in order to streamline the governance processes. These changes had not yet been implemented at the time of our inspection.

Vision and strategy for this service

- Medical and midwifery staff stated that the future vision for the maternity service was to have a stand-alone midwifery led unit. Staff were of the understanding that commissioners of the maternity service had differing opinions as to how and where this should be developed therefore there were no plans in place until this issue was resolved.
- There had been a strategic engagement event for staff in the women's health division. Staff were aware of the event, however they were unable to articulate the actions or strategy developed as a result. The midwives reported that the medical staff did not recognise normality as a goal for the future whereas for them this was most important. Overall there was a lack of clarity about the future of the maternity service.
- When discussing the future of the unit midwives told us the appointment of a consultant midwife, would and could be the catalyst for change. Midwifery staff emphasised that they felt this post was vital for the future development of the service.
- Staff on the gynaecology wards were unaware of any planned strategy for their service.

Governance, risk management and quality measurement

- The governance of women's service (which included maternity and gynaecology services) sat within the women's, children's and clinical support services division directorate. This included women and children's services, out patients, rheumatology, pathology, pharmacy and genito-urinary medicine. This had been reviewed and the maternity unit and gynaecology services were to be separated from the other services. Staff felt this was positive and said this would help improve the focus on quality for maternity services and strengthen the structure and management of the service.
- There was a midwife with a lead in risk management. They carried out risk assessments and led on the progress of action plans.
- The results from these audits were fed back to team leaders and the practice development midwife for training needs analysis. The midwives could access the information via email. Community midwives had to access emails from home. This meant some of the information from audits did not always reach the midwives delivering the care.
- There was a blurring of the roles between the supervisors of midwives and their managerial duties. This had been reported in the annual audit review of the local supervisors of midwives in September 2014 which stated: "The maternity risk management denotes supervisors of midwives are "doubling up" in the substantive role for the labour ward forum attendance – this is not ideal and should be changed."The report also

stated the service should: "aspire to a robust system of a supervisor attending internal and external governance and risk meetings exclusively in their role of a supervisor and where possible not to mix attendance with any substantive role." There had been no action to address this issue.
- On the gynaecology ward the matron carried out monitoring checks of the service. Any improvements or risks identified were fed back to the lead nurse on the ward and discussed at the daily safety briefing.

Leadership of service

- Following a review carried out by the Royal College of Obstetrics and Gynaecology in August 2014 it was recommended that the clinical director undertook additional training. At the time of our inspection, the clinical director had begun leadership training.
- The budget responsibility for the unit was held by the head of midwifery. Any spending proposed by the clinical lead, including the use of locum staff had to be sanctioned by the business manager. This meant the clinical lead was restricted in their ability to manage their responsibilities within the service.
- There was no succession planning within the maternity service. The clinical director gave an example of this as the nurse who led the colposcopy clinic who was nearing retirement and no replacement had yet been identified.
- The ward managers and band seven midwives said they did not always have the time to carry out their managerial roles as they were often providing hands on care to patients.This included community midwives who told us they had management responsibility for large numbers of midwives. They said tasks such as appraisals for staff were not being completed as a result.
- The midwives were positive about the support they had received from the trust board during a difficult period in 2014 (following several serious incidents) and they had visited the ward often. However, they told us visibility of the board had since reduced and felt the maternity services were isolated from the rest of the hospital.
- There was a view that managers of the service worked in a reactive way. An example was given where managers made changes to policies and procedures as a result of incidents without consultation or assessing the impact. For example band 5 midwives had been stopped from administering medicines due to drug errors. This practice lasted for five days before the decision was reversed.
- Nurses on the gynaecology ward felt well supported by the ward managers who were visible, approachable and willing to discuss any concerns.

Culture within the service

- Midwives described the culture of the maternity service as open where they could discuss concerns and issues, particularly with each other and their immediate line managers. There was a perception that if concerns were raised higher than their immediate manager they nothing happened as a result. This has led to some frustration with the midwifery managers and a feeling that escalating concerns was pointless.
- The head of midwifery had an open door policy and matrons visited all areas twice daily to address concerns and issues.
- There was still a disconnect between medical staff and midwives although this had improved since our last inspection. Both disciplines had differing views as to the longer term future of the service and it was evident that there is work to be done in bringing the disciplines together into a cohesive team.

Public and staff engagement

- Staff on both the maternity and gynaecology wards said they were unable to attend ward meetings where issues such as future plans, learning and development opportunities were discussed due to the pressures of work and shortage of staff. This has left some feeling disengaged and remote from the leadership leaving them with very limited options to influence and support change.
- There was an active maternity services liaison committee (MLSC) at the trust. This consisted of patients with an interest in supporting the service, consultant obstetricians, midwives and a member of the local clinical commissioning group. They met bi-monthly and discussed issues specific to the delivery of maternity services at Warrington. They completed walks around the units making observations which were presented at the labour ward forum. Feedback from the group has been used to support service change.

Innovation, improvement and sustainability

- The senior medical staff differed in their opinion about the future of the maternity unit. This varied between believing there was no major threat to the unit and thinking some or all of the services may be closed or moved to a nearby facility.
- Staff were not clear about the strategy for the service and this had led to some confusion and anxiety. Staff were not aware of the plans in place for the future of the service, this had fostered and fuelled speculation and anxiety about the service.
- There had been visits to a nearby unit that provided maternity led care to understand how this model could be replicated in their service. A consultant midwife from that unit had also visited to offer advice and support with regard to positive changes which may improve the service. This indicated willingness within the service to improve and develop; however, it was difficult to ascertain how this would influence change in the absence of a strategic plan.

Services for children and young people

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

Information about the service

The trust provides medical and surgical services for children and young people. They also provide a paediatric A&E service. Services for children and young people at Warrington Hospital are mainly provided on two wards with a total of 37 beds. Children's surgery is performed at Warrington Hospital in a dedicated unit. The majority of surgery is performed as day cases.

The wards have a mix of bedded bays and single rooms with beds or cots. There is a playroom, teenager's room and facilities for parents and relatives. There is a designated outpatients clinic that is separate from the adult outpatient facilities.

There is also a paediatric assessment unit and a neonatal unit. The neonatal unit at Warrington is a designated level 2 unit (local neonatal unit). Local neonatal units provide special care and high dependency care and a restricted volume of intensive care (as agreed locally) and would expect to transfer babies who require complex or longer-term intensive care to a Neonatal Intensive Care Unit.

In 2013/14 there were 7070 admissions to services for children and young people. 91% of these were emergency admissions, 8% were day case admissions and 1% were for elective admissions.

As part of our inspection from 27 to 29 January we visited inpatient and outpatient areas, paediatric A&E, paediatric surgery services, the paediatric assessment unit and neonatal unit. We also visited the paediatric acute response team who are based at Bath Street Health and Wellbeing Centre. We spoke with a range of staff providing care and treatment in children and young people's services including: nurses, trainee doctors, consultants, health care assistants and senior managers.

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

We received comments from our listening events and from people who contacted us to tell us about their experiences, and we reviewed performance information about the trust.

Services for children and young people

Summary of findings

Evidence based care and treatment was delivered in line with best practice guidance. Good multidisciplinary team working was evident. There were suitable processes in place to ensure consent was obtained appropriately. Family centred care was the prevailing philosophy in children and young people's services. Parents were generally enthusiastic about the care their children received from the medical and nursing staff. We observed positive, compassionate interactions between staff and patients and their families.

Staff had a clear vision of how to develop and improve the service. The trust had developed a paediatric service strategy 2013-2016 plan. There were clear aspirations to develop the service, with each action allocated to a specific member of staff it. We also found clear examples of areas within the service that were being developed. For example, the service was working closely with commissioners to develop and expand the paediatric acute response team (PART) and define the future pathway for paediatric community services. The service was also in the process of developing a community respiratory service.

The risk register identified that staff shortages in the neonatal unit may lead to closure of the unit. This would result in babies being transferred to other units in the Cheshire and Merseyside area. The service had recognised this issue and were meeting the British Association of Perinatal Medicine (BAPM) 2014 staffing standards at the time of our inspection. However, BAPM recommendations for Local Neonatal Unit (LNU) out-of-hours Tier 1 medical cover were not adhered to.

Trainee doctors told us they had raised this as a serious concern. Neonatal nurses also told us that they had serious concerns related to the level of medical cover at night and weekends. Following our inspection the service undertook a review of the tier one support provided on the neonatal unit. The investigation found that whilst there had been no concerns identified in relation to patient safety or quality of care, the service should look at developing the nursing staff further to include an advanced neonatal nurse practitioner and enhanced practitioner team.

Are services for children and young people safe?

Requires improvement

The risk register identified that staff shortages in the neonatal unit may lead to closure of the unit which would result in babies being transferred to other units in the Cheshire and Merseyside area. The service had recognised this issue and were meeting the British Association of Perinatal Medicine (BAPM) 2014 staffing standards at the time of our inspection. However, BAPM recommendations for Local Neonatal Unit (LNU) out-of-hours Tier 1 medical cover were not adhered to. Trainee doctors told us they had raised this as a serious concern. Neonatal nurses also told us that they had serious concerns related to the level of medical cover at night and weekends. Following our inspection the service undertook a review of the tier one support provided on the neonatal unit. The investigation found that whilst there had been no concerns identified in relation to patient safety or quality of care, the service should look at developing the nursing staff further to include an advanced neonatal nurse practitioner and enhanced practitioner team.

Completion of mandatory training varied both between medical and nursing staff and between different subjects and was below the trust's target of 85%.

There were good systems in place at ward level for the safe administration, recording and disposal of medicines. However, the trust did not employ a paediatric pharmacist. Incidents were reported appropriately and there was evidence of learning from incidents to prevent reoccurrence. Staff followed good practice guidance in relation to the control and prevention of infection. Staff were aware of their role and responsibilities in relation to safeguarding and knew how to raise matters of concern appropriately.

Incidents

- Staff were familiar with and encouraged to use the electronic reporting system to report incidents within the department. There was evidence of shared learning from incidents to reduce the risk of reoccurrence.
- There had been two serious incidents reported in 2013/14 one was in relation to a child death and the other

was in relation to attempted suicide by an inpatient. Both incidents had been fully investigated and actions had been taken where appropriate to prevent further occurrence. For example, new policies and procedures were implemented following the attempted suicide incident. The child death had been deemed as appropriately managed.
- Although not mandatory, it was noted that not all parts of the children's ward had been ligature point checked, assessed or ascertained. To do so is considered best practice.
- Robust joint morbidity and mortality meetings between the neonatal unit and maternity services were held bimonthly.

Cleanliness, infection control and hygiene

- Staff followed good practice guidance in relation to the control and prevention of infection. For example, the 'bare below elbows' policy and the use of personal protective equipment.
- Both the neonatal unit and the children's unit were clean and were routinely serviced by a team of regular cleaners.
- There were ample supplies of hand hygiene facilities that were highlighted with prominent signage. Regular hand hygiene audits demonstrated high compliance rates throughout the department.
- An 'I've been cleaned' sticker system was in operation to inform staff at a glance as to the cleanliness of equipment and furniture.
- Monthly cleaning audits showed high levels of compliance. For example, the audit completed for November 2014 was 96% overall.

Environment and equipment

- The playrooms were clean and well equipped.
- Although clean throughout the service, some aspects of the décor were well-worn especially the flooring. This had been added to the risk register and refurbishment was scheduled. New flooring had already been laid within the children's emergency department.
- Entry to the children's and neonatal wards was accessed via intercom and was monitored at all times via CCTV.
- The resuscitation equipment within the children's and neonatal ward was inspected and trolley security ascertained. The drugs and equipment were in date and met national standards. When we selected a nurse on shift at random, they were quickly able to locate a laryngoscope from the resuscitation trolley on request.
- Ventilator provision within children's services was outdated and required replacing. This had been highlighted on the divisional risk register and was scheduled for implementation in early 2015.
- Hospital equipment was appropriately electrical tested.

Medicines

- There were good systems in place at ward level for the safe administration, recording and disposal of medicines.
- Medicines were stored appropriately and fridges temperatures were regularly checked and recorded.
- The principal pharmacist informed us that the hospital did not employ a paediatric pharmacist. The director of nursing told us she was unaware of this situation although we were told by the medical director that it has been on the risk register for a number of years.
- We reviewed the risk register for children and young people's services. A "risk of harm to patients or inappropriate treatment, due to errors associated with prescribing" had been added to the register in April 2014 and an action plan was in place due completion for March 2015. However, it was not clear whether this related to the lack of paediatric pharmacist support specifically.
- Mandatory and other updates related to medicines administration were primarily adult focused with little pertinent information about child or neonatal drug administration.

Records

- Records across children and young people's services were paper based. Four sets of patient notes were inspected and were found to be accurate and legible.
- Patient records were stored securely and with due regard to privacy and confidentiality.
- We inspected a range of paediatric and neonatal protocols and guidelines and these were all current and appropriately undated.

Safeguarding

- Staff were aware of their role and responsibilities and knew how to raise matters of concern appropriately.

- Relevant policies and procedures were available for staff to refer to.
- We were informed by the named safeguarding leads that the named nurse and named midwife is a combined role, this was not in line with national standards. However, there was one WTE (whole time equivalent) safeguarding children specialist nurse and the children's matron was the named deputy.
- Data provided by the trust showed that 90% of medical staff and 82% of nursing staff had received level 3 children's safeguarding training. The training and development nurse was confident that full compliance would be achieved by the end of 2014/2015.

Mandatory training

- The trust used an electronic staff records system which automatically sent emails reminders to individual staff members to attend scheduled updating programmes.
- However, data provided by the trust indicated that compliance with mandatory training requirements varied (the trust's target was for 85% of all staff to complete mandatory training). For example, 84% of nursing staff had completed training in infection control, but only 50% of medical staff had completed it. Completion of manual handling training was particularly poor with only 33% of nursing staff and 50% of medical staff having completed the training.
- Children's services employed a training and development nurse who scheduled mandatory training and other aspects of professional development .The budget for study days and conferences was limited but staff could apply for specific training if required.

Assessing and responding to patient risk

- A paediatric early warning score (PEWS) system was in use. This tool supported early identification of children at risk of deterioration.
- An audit conducted in November 2014 showed that all staff were competent at using PEWs.
- All surgical patients were offered preadmission pre assessment visits with play specialist support. There was a dedicated team of nurses to care for surgical children.
- National patient safety alerts were emailed via the trust executive team to staff and these were appended to the staff daily briefings.
- The children's unit and emergency department had frequent admissions from young people who self-harm. We were told that support from the CAMHS team for vulnerable patients was excellent. Patients requiring assessment were seen within 24 hours with weekend cover available.

Nursing staffing

- Staffing had been identified as a risk within the neonatal unit. The risk register identified that staff shortages in the neonatal unit may lead to closure of the unit which would result in babies being transferred to other units in the Cheshire and Merseyside area. The service had recognised this issue and were meeting the British Association of Perinatal Medicine (BAPM) 2014 staffing standards at the time of our inspection. However, BAPM recommendations for Local Neonatal Unit (LNU) out-of-hours Tier 1 medical cover were not adhered to.The director of nursing informed us they were also undertaking preliminary investigations into the potential role of advanced neonatal nurse practitioners.
- Nurse staffing within the children's ward was in line with Royal College of Nursing guidelines. The children's ward was supported by ward clerk cover from 8am to 8pm. However, staff felt this was not always sufficient which meant there was pressure on trained nurses who, as a result, diverted time away from frontline care e.g. to answer telephones.
- At the time of our inspection there was only one play specialist providing diversional therapy to the children's unit, the paediatric emergency department and the children's outpatient department as the other play specialist was on maternity leave.

Medical staffing

- BAPM recommendations for Local Neonatal Unit (LNU) out-of-hours Tier 1 medical cover (i.e. GP trainees, ST1-3, FY2 trainee doctors and advanced neonatal nurse practitioners) were not adhered to. Recommendations for LNUs are to have separate Tier 1 rotas for paediatrics and neonates to ensure compliance to the BAPM standards but this was not happening in practice at Warrington hospital. The doctors covered the neonatal unit, post natal wards, labour ward and the paediatric areas. There were no Tier 1 doctors allocated to the neonatal unit exclusively. Additional support was provided by a QIS (Qualified in Specialty) neonatal nurse who held the bleep for response to emergencies within the delivery department.Trainee doctors told us they had raised this as a serious concern but felt the situation

was not fully appreciated by senior medical staff. Neonatal nurses also told us that they had serious concerns related to the level of medical cover at night and weekends.

- Following our inspection the service undertook a review of the tier one support provided on the neonatal unit. The investigation found that whilst there had been no concerns identified in relation to patient safety or quality of care, the service should look at developing the nursing staff further to include an advanced neonatal nurse practitioner and enhanced practitioner team.
- There was a lack of continuity of senior care staff (i.e. consultant /middle grades) within the neonatal unit on a day to day basis. The consultant of the week was responsible for both NICU and the paediatrics wards, but was based in paediatrics. Ward rounds were covered by other consultants and by Tier 2 (registrar) trainees, who could vary daily.
- Annual figures for 2014 showed 419 intensive care days and 385 high dependency days, suggesting that the Warrington Unit is indeed functioning as an LNU, rather than a less intense Special Care Baby Unit.
- Medical handover meetings were well-led and clearly identified children and young people at risk of deterioration.
- Services for children and young people experienced significant medical staff vacancy rates. Data provided by the trust indicated a vacancy rate of 53%. Existing vacancies and shortfalls were covered by locum staff when required. All agency and locum staff underwent a local induction before they were allowed to work in the service.
- Paediatric cover within the children's emergency department was enhanced by the appointment of a part time paediatric consultant with another local specialist children's hospital.

Major incident awareness and training

- Staff were aware of their responsibilities in the event of a major incident.
- Major incident plans had been developed and business continuity plans were in place.

Are services for children and young people effective?

Good

Evidence based care and treatment was delivered in line with best practice guidance. The children's services had developed a children's respiratory team linking hospital and primary care services. The aim of this service, which was being offered as a pilot programme at the time of our inspection, was to reduce readmission rates. The National Paediatric Diabetes Audit 2013 found the trust had performed better than the national average for the percentage of children and young people achieving the NICE recommended HbA1c target of <58 mmol/mol.

We found that a child's or their parent's consent was appropriately sought prior to any procedures or tests being undertaken. Children were involved in giving their consent as appropriate. There was good multidisciplinary team working in the service. The deputy manager of the neonatal unit informed us that she wanted to upskill her nurses and fulfil a vison to employ neonatal advanced nurse practitioner. This had been recognised as part of the paediatric service strategy 2013-2016 action plan.

However, appraisal rates for both nursing and medical staff varied. For example 51% in neonatal nursing but 81% in paediatrics.

Evidence-based care and treatment

- Evidence based practice was underpinned by the use of the Marsden Hospital Manual of Clinical Procedures.
- Evidence based protocols and guidelines were readily available via the trust intranet.
- We witnessed the use of daily safety briefing which is given to both day and night staff. This covers patient issues, staffing, safeguarding, environment, equipment, medicines, polices and safety alerts.
- National patient safety alerts were available via the hospital intranet and were cascaded to staff through the daily briefings email. Staff were provided with updates if and when guidance was reviewed or practice changed.

Pain relief

- Children's pain was assessed using recognised pain assessment scales, for example the smiley faces pain score tool.

- Pain relief included using age-appropriate methods and both analgesic and non-analgesic interventions. Neonates were offered small amounts of oral sucrose to reduce procedural pain.
- A pan hospital pain relief team offer pain management support to children in hospital.

Nutrition and hydration

- Children and young people were offered a choice of meals that were age appropriate and supported individual needs such as gluten free diets. As part of the productive ward series, a new children's menu was introduced which demonstrated a good range of nutritional options for sick children.

Patient outcomes

- The National Paediatric Diabetes Audit 2013 found the trust had performed better than the national average for the percentage of children and young people achieving the NICE recommended HbA1c target of <58 mmol/mol (20% compared to a national average of 16%).
- The trust's multiple readmission rates for asthma, diabetes and epilepsy in children aged 1-17 years were slightly worse than the England average at 23%, 11% and 30% compared to 17%, 14% and 28% respectively.
- The children's services had developed a children's respiratory team linking hospital and primary care services. The aim of this service, which was being offered as a pilot programme at the time of our inspection, was to reduce readmission rates.
- The paediatric service strategy 2013-2016 action plan identified the need to improve patient pathways in order to reduce readmission rates and actions were underway to meet the requirements of the plan.
- The neonatal consultants had introduced high flow therapy to more effectively manage neonates who need respiratory support.
- The number of infants <33 weeks gestation having breast milk at discharge was below the neonatal quality and CQUIN target of 70%. In September 2014 the rate had been 50% and this had dropped to 33% in October 2014. Prior to this in July and August 2014 a rate of 100% had been achieved. An action plan was in place to improve support to breast feeding mothers with a view to improving continuation breast feeding rates on discharge from the neonatal unit.

Competent staff

- The deputy manager of the neonatal unit informed us that she wanted to upskill her nurses and fulfil a vison to employ neonatal advanced nurse practitioner. This had been recognised as part of the paediatric service strategy 2013-2016 action plan.
- Staff told us that training for IV drug administration was heavily focused toward adult care.
- Staff working with children received appropriate advanced paediatric life support training.
- According to data provided by the trust by October 2014 only 67% of medical staff and 51% of nursing staff had received an appraisal in the last 12 months.
- Student nurses informed they felt well supported by mentors and that their mentor appraisals were up to date.
- The CAMHS Team had a significant input to the children's unit and offered teaching to ward staff.

Multidisciplinary working

- Nurses, doctors and members of the CAMHS team informed us that multi-disciplinary working within children and young people's services was good.
- Links between the local community healthcare trust and the hospital were good ensuring effective follow up by paediatric community nurses as necessary following discharge.

Seven-day services

- The CAMHS team offered a seven-day service.
- A consultant was available seven days a week with cover out of hours provided by an on-call consultant. However, out-of-hours medical cover for the neonatal unit was not in line with best practice guidance and staff had raised this as a concern.
- All children and young people were reviewed by a consultant everyday as a minimum. However depending on clinical need this may be increased.
- Play therapy services were not currently offered seven days a week.

Access to information

- Trust policies and procedures were available to staff via the trust's intranet.
- Parents in the neonatal unit informed us that the information given to them by the doctors and nurses was good and conveyed to them in language they could understand.

Services for children and young people

- Information for parents and carers was provided through a variety of agencies including the wards, the children's A&E, the bereavement office, PALS and the well-equipped information centre situated in the foyer of the hospital.
- Information leaflets about health related topics and information about accessing hospital services were readily available.
- The quality and range of the information available for service users was good but primarily available in English only. Staff could access information in other languages via the central information centre when required.

Consent

- Staff were aware of consent procedures in place for children and young people.
- We found that a child's or their parent's consent was appropriately sought prior to any procedures or tests being undertaken. Children were involved in giving their consent as appropriate.
- The play specialist informed us that there was widespread use of diversional play materials to help with consent procedures.
- Parents told us that doctors and nurses fully informed their children before carrying out any procedure.

Are services for children and young people caring?

Good

Parents were generally enthusiastic about the care their children received from the medical and nursing staff. We observed positive, compassionate interactions between staff and patients and their families.

Family centred care was the prevailing philosophy in children and young people's services and we witnessed parental involvement with care under appropriate supervision. We were informed by members of the nursing staff that a key aim of the children's unit was to involve parents in the care of their sick children. Children's and young people's services had the support of a range nurse specialist's e.g. teenage pregnancy.

Compassionate care

- Parents we interviewed were generally enthusiastic about the care their children received from the medical and nursing staff. We observed positive, compassionate interactions between staff and patients and their families.
- Parents told us that doctors and nurses informed their children and gained their consent or assent before undertaking procedures. We witnessed nurses engaging positively with children and making good eye contact with them during any explanations. The nurses were generally empathetic with the children they cared for.
- Parents were confident with the care and support they were given in the neonatal unit. One parent told us: 'The doctors always came and explained what was going on, the communication has been excellent'
- Parents told us they were happy leaving their babies in the neonatal unit. One parent said: 'I can sleep well knowing my baby is well looked after.'

Understanding and involvement of patients and those close to them

- Parents told us that they were kept well informed about their children's medical condition. Parents told us that the doctors and nurses gave explanations in simple terms that they understood.
- Children requiring surgery were offered pre assessment visits prior to admission, which aimed to help promote understanding within the family as to the nature of the child's health care journey.
- We observed that parents were allowed to accompany their children to the anaesthetic room and the recovery area post-surgery.
- Mothers in the neonatal were encouraged to express their breast milk and that they received positive breast feeding support from the nurses and breast feeding advisers.
- Family centred care was the prevailing philosophy in children and young people's services and we witnessed parental involvement with care under appropriate supervision. We were informed by members of the nursing staff that a key aim of the children's unit was to involve parents in the care of their sick children.
- A large range of information leaflets were available to parents and carers within children's services and via the information centre in the foyer of the main hospital.
- The parents of children recovering post operatively told us they were made to feel welcome by the staff and kept well informed of their child's progress.

Services for children and young people

- Parents generally believed that staff always took their concerns seriously and that staff were always helpful and supportive in keeping them well informed.

Emotional support

- All staff we spoke to within children's and young people's services were highly complementary about the emotional support offered to young people via the CAMHS team.
- There was a dedicated bereavement office in the trust, which had good links with local hospices. The bereavement service provided helpful information and although this was available only in English, one to one translators were available on request.
- Children's and young people's services had the support of a range nurse specialist's e.g. teenage pregnancy. The PALS department which ran in conjunction with the information centre in the main foyer of the hospital provided significant emotional support to families with concerns.

Are services for children and young people responsive?

Good

Children with complex needs were appropriately cared for as inpatients within children and young people's services. All children's beds had free TV and young people had access to age related distractions such as games consoles. The play specialist had access to appropriate diversional materials. However, the decor throughout the children and young people's services was dated and not all areas were child friendly. For example, the corridors leading to the operating theatres and the theatre recovery areas. We were informed by the non-executive officer for children that a 15 Step Challenge audit had not been undertaken within the children's services but that the corridor route to theatres and the theatres themselves were scheduled for child friendly decoration funded by charitable monies within the near future.

The paediatric service strategy 2013-2016 action plan identified the need to improve patient pathways for diabetes and epilepsy in order to improve care in the community and actions were underway to meet the requirements of the plan. The aim was to establish multi-disciplinary or multi-professional clinics where possible to provide a 'one-stop-shop' model of care where appropriate.

Service planning and delivery to meet the needs of local people

- We visited the paediatric acute response team (PART) service, which was at the Bath Street Health and Wellbeing Centre in Warrington as a joint initiative between the trust and another local community healthcare trust. The service aimed to meet local need for paediatric ambulatory care and to reduce unnecessary admissions to the A&E and paediatric assessment unit. The team undertake post admission review, wound checks, and administer IV antibiotics, perform blood tests and see children who have been referred by a GP. The PART service was also accessible to patients discharged from the neonatal unit.
- Parents visiting the children's and neonatal wards were offered reduced price parking at the hospital.
- Basic parent accommodation and sleeping arrangements were available within the children's ward. However, separate bathroom facilities were not available; parents had to use the same facilities as the children. The neonatal unit also had parent rooms. Parents on both wards had access to facilities for making tea and coffee.
- The decor throughout the children and young people's services was dated and not all areas were child friendly. For example, the corridors leading to the operating theatres and the theatre recovery areas. We were informed by the non-executive officer for children that a 15 Step Challenge audit had not been undertaken within the children's services but that the corridor route to theatres and the theatres themselves were scheduled for child friendly decoration funded by charitable monies within the near future.

Access and flow

- Senior staff told us that the neonatal unit had only 23 hours of nurse outreach service per week (this service was not commissioned by the trust) and that this could result in unnecessary delays in discharge. However, the service reported that no incidents relating to delayed discharge had been reported via the electronic reporting system.

Services for children and young people

- Children with established health pathways had direct access to the children's ward
- The number of paediatric outpatient clinics cancelled (with less than six weeks' notice) was low. In October 2014, only one clinic was cancelled.
- The trust had a high follow up to new ratio for paediatric medicine and paediatric epilepsy. The paediatric service strategy 2013-2016 action plan identified the need to improve patient pathways for diabetes and epilepsy in order to improve care in the community and actions were underway to meet the requirements of the plan. The aim was to establish multi-disciplinary or multi-professional clinics where possible to provide a 'one-stop-shop' model of care where appropriate. For example, as of April 2014 a clinical psychologist was present in all diabetic clinics. The trust had also established an insulin pump service for diabetic children to allow for improved self-management and so reduce hospital follow ups.

Meeting people's individual needs

- Children with complex needs were appropriately cared for as inpatients within children and young people's services.
- Translation services such as language line were available as required.
- The provision of paediatric specialist nurses meets the needs of children in certain diagnostic groups.
- We were told that there was limited availability of skilled paediatric physiotherapists to treat and support children under three years of age.
- Children and young people's services did not have the 'You're Welcome' status for younger people. The You're Welcome quality criteria provide a set of non-mandatory standards for delivering young person-friendly health services for 14-19 year-olds in England. However, the children's ward did have a dedicated "teenage" recreation area where young people could go to.
- All children's beds had free TV and young people had access to age related distractions such as games consoles. The play specialist had access to appropriate diversional materials.

Learning from complaints and concerns

- Parents are well signposted to the PALS facilities within the trust and posters advertising this service were visible within the clinical areas we visited.
- We visited the PALS department and the associated information centre, and found that there were only 26-recorded complaints in relation to children and young people's services in 2014.
- Complaints, which were effectively dealt with, ranged from lengthy wait times in clinics through to delays over blood results.
- Learning from complaints was cascaded via team meetings.

Are services for children and young people well-led?

Good

Children and young people's services within the trust had recognised and identified the need for a separate children and young people's governance strategy. Prior to this governance was covered within the divisional governance reporting systems but it was recognised that this was not a robust enough process. The governance lead for the children's unit was appointed in December 2014 and a prospective governance strategy had been developed.

There was a tangible commitment to patient centred care among all members of the multi-disciplinary team. Staff felt supported by their line managers who were visible and accessible.

Staff had a clear vision of how to develop and improve the service. The trust had developed a paediatric service strategy 2013-2016 plan. There were clear aspirations to develop the service, with each action allocated to a specific member of staff. However, we also found clear examples of areas within the service that were being developed. For example, the service was working closely with commissioners to develop and expand the paediatric acute response team (PART) and define the future pathway for paediatric community services. The service was also in the process of developing a community respiratory service.

The risk register identified key risks and identified areas of need but it was not always clear what actions were being taken to fulfil the required actions or mitigate risk in the meantime.

Vision and strategy for this service

- Staff understood the organisation vision and values. Staff had a clear vision of how to develop and improve the service but we were unable to find evidence of a clear action plan to bring these ideas to fruition.
- The trust had developed a paediatric service strategy 2013-2016 plan. There were clear aspirations to develop the service, with each action allocated to a specific member of staff.

Governance, risk management and quality measurement

- Children and young people's services within the trust had recognised and identified the need for a separate children and young people's governance strategy. Prior to this governance was covered within the divisional governance reporting systems but it was recognised that this was not a robust enough process. The governance lead for the children's unit was appointed in December 2014 and a prospective governance strategy had been developed.
- The risk register identified key risks and identified areas of need but it was not clear what actions were being taken to fulfil the required actions or mitigate risk in the meantime. For example, the need for a paediatric pharmacist.

Leadership of service

- Staff felt supported by their line managers who were visible and accessible. Although, some staff felt that children and young people's services had fallen "below the radar "at trust board level.

Culture within the service

- There was a tangible commitment to patient centred care among all members of the multi-disciplinary team.
- The student nurses we interviewed thought the children's wards were well organised with a good atmosphere where they would be happy for members of their own families to be cared for. One person told us: "Overall we think it is a great place to work".

Public and staff engagement

- Children and young people's services did not have a formal patient and public involvement strategy.
- Neonatal information with regards to charities such as BLISS and other support available was well posted on the ward and surrounding areas. Leaflets were available within the parents' room on the neonatal unit.
- Information about how the public could provide feedback was displayed in the departmental areas and feedback mechanisms for the public to engage with the trust were also on the internet site.

Innovation, improvement and sustainability

- The children's unit had recognised that the route to theatre was not child friendly and they had a tangible plan to employ a mural artist to resolve this by making the environment more child friendly.
- The play specialist from the children's A/E had engaged with local schools to help inform children about potential admission to hospital.
- The medical and nursing staff informed us that they wanted to develop the role of the advanced neonatal nurse practitioner. The paediatric service strategy 2013-2016 recognised this also.
- The service was working closely with commissioners to develop and expand the paediatric acute response team (PART) and define the future pathway for paediatric community services. The service was also in the process of developing a community respiratory service.

End of life care

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

Information about the service

End of life care services were part of the unscheduled care division. Warrington Hospital's specialist palliative care team offer a Monday to Friday service with core hours of 9am to 5pm. There is a seven-day service available from the specialist palliative care team but no access to specialist advice out of hours. The team consists of 2.75 whole time equivalent (wte)specialist nurses, 0.6 wte palliative care medical consultant, 0.8wte personal assistant and administrative support and 1 wte nurse consultant.

People with palliative/end of life needs are nursed on the general wards in the hospital. They are supported by a specialist palliative care team.

We visited eight wards where end of life care could be provided. We also visited the chapel/multi-faith room, the hospital mortuary, viewing room and the bereavement services.

During the inspection we spoke with three patients and five relatives on the wards. We spoke with a range of 22 staff including: nurses, doctors, consultants, ward managers, anatomical pathology technicians and members of the senior management team. We also spoke with members of the hospital palliative care team, including the clinical lead for palliative care and consultant lead nurse for palliative care.

We observed care and treatment and we looked at care records. We looked at appropriate policies and procedures. We received comments from our listening event and from people who contacted us to tell us about their experiences, and we reviewed performance information about the trust.

End of life care

Summary of findings

There were sufficient numbers of trained clinical, nursing and support staff with an appropriate skill mix to ensure that patients receiving end of life care were well cared for in all the settings we visited. However, there was no access to specialist palliative medical support out of hours. Medicines were prescribed, stored and administered appropriately. Access to syringe drivers for people needing continuous pain relief was available.

The trust was introducing the "amber care bundle" and had appointed a designated member of staff who worked with the palliative care team to facilitate implementation across the trust. Where DNACPR (Do Not Attempt Cardio Pulmonary Resuscitation) forms were in place, we found that patients were involved in the discussion about their decision or there was a capacity assessment recorded in their medical notes.

However, we found that patients at the end of their lives could not always be assured of a single room to ensure their privacy. The management of risk was in place at a divisional level but further work was required to ensure that staff at all levels of the organisation were aware of the service risks and had access to feedback from governance systems.

Are end of life care services safe?

Good

There were systems for reporting actual and near-miss incidents across the hospital. Medicines were prescribed, stored and administered appropriately. Access to syringe drivers for people needing continuous pain relief was available. Syringe pumps were maintained and used in accordance with professional recommendations.

We looked at nine patient's care and treatment records and found they were accurate and clinical notes were completed to a good standard. All patients were assessed by nurses at the time of admission. Patients would be transferred to an end of life care plan if their condition required this so they could receive appropriate and timely care. The plan enabled staff to identify care requirements through risk assessment of the patient needs such as symptom and pain relief, skin care, hydration, and care of those people close to the patient.

There were sufficient numbers of trained clinical, nursing and support staff with an appropriate skill mix to ensure that patients receiving end of life care were well cared for.

Data provided by the trust showed that completion of mandatory training, including safeguarding training was variable and below the trust's target of 85%.

Incidents

- There were systems for reporting actual and near-miss incidents across the hospital. Staff told us they understood what to report and were able to show us how they would report an incident through the electronic reporting system.
- The mortuary service reported incidents through the pathology service governance structure.
- The data available from the trust electronic reporting system for the period April to September 2014 showed that there had been one incident in relation to palliative care.
- There had also previously had two concerns raised regarding the application of the end of care pathway staff had met with families to address their concerns.
- There was evidence of learning from incidents, for example how the service had responded to the delay in

seeking end of life support from the chaplaincy service. An alert had been sent out to advise staff on how to contact the chaplaincy service to be able to offer spiritual support in a prompt and timely manner.

Environment and equipment

- The mortuary was fit for purpose and had recently been improved. However we noted that one part of the roof was leaking and that a fault on one of the temperature gauges had been reported six months earlier and had not yet been resolved. We raised this at the time of the inspection with senior mortuary and pathology staff who assured us that this would be addressed. The lack of timely response to faulty equipment may impact on the provision of safe services.
- Staff indicated that the new flooring in the mortuary was difficult to clean but the team were working with the infection control team to ensure that a solution was in place to ensure that infection control processes could be maintained.
- The mortuary was secured to prevent inadvertent or inappropriate admission to the area. Fridges were lockable to reduce the risk of unauthorised access.
- Access to syringe drivers for people needing continuous pain relief was readily available. Syringe pumps were maintained and used in accordance with professional recommendations. There were systems in place for checks to be carried out in relation to the use of syringe drivers such as the volume of infusion remaining in the syringe.

Medicines

- There was guidance for the prescribing of drugs to be given via a syringe pump or as the patient required. Policies and procedures were accessible to staff on the electronic shared drive and staff were aware of the procedures to follow.
- We looked at the medication administration record charts for a number of patients and saw where appropriate end of life medicines were prescribed. Medical and nursing staff told us they were able to obtain advice and support from the specialist palliative care team regarding appropriate medicines for patients.
- Medicines, including those requiring cool storage, were stored appropriately and at the correct temperature. We saw controlled drugs were stored and managed appropriately.

Records

- Patient records were accurate and clinical notes were completed to a good standard.
- 'Do not attempt cardio-pulmonary resuscitation' (DNACPR) documentation had been completed appropriately with the relevant signatures in place in line with the trust's DNACPR guidance.
- Effective systems were in place in the mortuary to ensure that people were correctly admitted and safely placed.
- The correct release forms were signed before a deceased person was released to the undertaker.

Safeguarding

- There was a system in place for raising safeguarding concerns. Staff were aware of the process and could explain what was meant by abuse and neglect. This process was supported by staff training however figures obtained from the trust showed that only 67% of discharge and palliative care staff had completed the relevant training which was below the trust target of 85%.

Mandatory training

- Staff received mandatory training that covered a wide range of subjects. Staff told us they did have access to training but were behind in completing the mandatory training due to pressure of work. Figures provided by the trust showed that the service had not achieved the trust target of 85%. Completion of training ranged from 82% for infection control, 64% for safeguarding and 67% for fire safety.

Assessing and responding to patient risk

- Patients would be transferred to an end of life care plan if their condition required this so they could receive appropriate and timely care. This was an individualised plan of care and support developed for patients at the end of their lives. The plan enabled staff to identify care requirements through risk assessment of the patient needs such as symptom and pain relief, skin care, hydration, and care those close to the patient.

Nursing staffing

End of life care

- There were sufficient numbers of trained clinical, nursing and support staff with an appropriate skill mix to ensure that patients receiving end of life care were well cared for.
- The specialist palliative care/end of life team consisted of 2.75 whole time equivalent (wte) specialist nurse and 0.8 wte personal assistant and administrative support.
- The service had reported a 4% sickness rate as of September 2013 which was within an acceptable range.
- Nursing handovers took place at the start of each shift on all the wards providing care for medical patients. Any patients with end of life/palliative care needs were reviewed at the daily nurse handover.
- We observed the handover meeting held each morning by the palliative care team. We noted that due to both work patterns and limited capacity there was some lack of continuity as patients may not always see the same specialist nurse.

Medical staffing

- For patients with palliative/end of life needs, medical cover was provided on the general wards in the hospital.
- Trainee doctors told us that they knew where to get support for information on palliative care and symptom control.
- The palliative care consultant had recently been appointed in post and was employed to work 0.6wte in the trust and 0.4wte in the local hospice. They told us that plans were being developed to improve continuity and management of any local patients using the services.
- There was no access to specialist palliative medical support out of hours (overnight or at weekends).

Major incident awareness and training

- There was a clear policy in place of action to take if the hospital was involved in a major incident.
- There were escalation plans in place to ensure the delivery of the service was maintained. The mortuary staff were able to describe actions taken over the last two months to initiate escalation plans for increased capacity by utilising facilities at the Halton site.

Are end of life care services effective?

Good

Care was provided in line with National Institute for Health and Care Excellence (NICE) Quality Standard for End of Life Care for Adults (2013). The trust contributed to the National Care of the Dying audit. A comprehensive assurance action plan was in place as a result of findings from audits in order to address shortfalls and improve the quality of end of life care across the organisation.

In line with national guidance, the trust had phased out the Liverpool Care Pathway for end of life care. The trust had introduced individual plans of care and support for patients at end of their lives to replace the pathway. This was a working document and was in the process of being evaluated and reviewed. The palliative care team had reviewed the Department of Health's national End of Life Strategy recommendations and had identified the need to introduce the "amber care bundle". The trust had a member of staff who worked with the team to facilitate implementation across the trust .Where DNACPR (Do Not Attempt Cardio Pulmonary Resuscitation) forms were in place, we found that patients were involved in the discussion about their decision or there was a capacity assessment recorded in their medical notes. These showed that best interest meetings had been held and included discussions about DNACPR decisions.

The multidisciplinary team worked well together to coordinate and plan the care for patients at the end of their lives. Pain was reviewed regularly for efficacy and changes were made as appropriate to meet the needs of individual patients. Anticipatory prescribing took place to ensure pain relief was administered to patients in a timely manner. The National care of the dying audit results showed a mixed performance for the service. An action plan had been put in place to address the issues raised following the audit. Comprehensive training and information was provided to staff in relation to end of life care.

Evidence-based care and treatment

- In line with national guidance, the trust had phased out the Liverpool Care Pathway for end of life care. The trust

had introduced individual plans of care and support for patients at end of their lives to replace the pathway. This was a working document and was in the process of being evaluated and reviewed.
- The palliative care team based the care it provided on the National Institute for Health and Care Excellence (NICE) Quality Standard for End of Life Care for Adults (2013). The trust contributed to the National Care of the Dying audit.
- A comprehensive assurance action plan was in place as a result of findings from audits in order to address shortfalls and improve the quality of end of life care across the organisation. This showed that the service was proactive in assessing itself against good practice.
- Policies and procedures were accessible on the trust intranet and staff were aware of how to access them.
- The palliative care team had reviewed the Department of Health's national End of Life Strategy recommendations. They had identified the need to introduce the "amber care bundle", which is an approach to care management used in hospitals when doctors are uncertain whether a patient may recover and are concerned that they may only have a few months left to live. It encourages staff, patients and families to continue with treatment in the hope of a recovery, while talking openly about people's wishes and putting plans in place should the person die. The trust had a member of staff who worked with the team to facilitate implementation across the trust.

Pain relief

- Pain was reviewed regularly for efficacy and changes were made as appropriate to meet the needs of individual patients. Pain relief was available when required. Anticipatory prescribing took place to ensure that patients' pain and other symptoms were managed in a timely manner.
- Staff told us they were able to access clear guidance on the prescription of medications to be given 'as required' for symptoms that may occur at end of life, such as pain, nausea and vomiting. This meant that patients had timely access to the most appropriate pain and symptom relief.

Nutrition and hydration

- The ward staff supported patients to eat and drink normally for as long as possible. Patients had access to drinks and food suitable to their needs.
- Fluid and nutrition was accurately recorded when it needed to be. Staff maintained fluid balance charts, and these were accurately completed. This information could be used to inform clinical decisions as necessary.
- Patients were screened using the malnutrition universal screening tool to identify those who were nutritionally at risk. Staff were aware of these patients who required additional support with eating and drinking.
- Staff were to support people's religious and cultural needs regarding meals and dietary requirements.

Patient outcomes

- Patients received effective support from a multidisciplinary team, which included specialist palliative care nurses and a consultant.
- The hospital had an electronic referral process to the palliative care team which ensured that there was timely referral to the service when required.
- The National care of the dying audit results showed a mixed performance for the service. Out of 17 clinical and organisational indicators the trust had performed below national average in 8 including access to specialist support, communication, clinical provision/protocols promoting patient privacy and lack of formal feedback processes regarding bereaved relatives. The trust scored particularly well in "multi-disciplinary recognition that the patient is dying". An action plan had been put in place to address the issues raised following the audit.
- The service had completed the End of Life Care Quality Assessment Tool self-assessment. The latest assessment showed that the trust was compliant in over 80% of the key areas with the rest partially compliant. The service had identified actions to achieve full compliance within set timescales; progress against the timescales was regularly monitored.

Competent staff

- Training in end of life care was provided within the hospital and collaboratively with other providers in the area. Advanced communication skills training was provided by the consultant nurse to senior clinicians (band 6 and above).
- Records showed that "symptom control" training was provided at least twice per year to both the Medical and Surgical trainee doctors during their rotations through the specialities. Presentations were also given during the "grand round" clinical meetings.

End of life care

- A palliative care link nurse programme was in place with training provided on subjects related to palliative and end of life care. However some staff told us that they had not been able to attend the training due to pressure of work.
- Staff confirmed that they had received training regarding the implementation of the AMBER care bundle and individualised end of life care plans.
- Six 'difficult communication' workshops had been provided. Single point lessons had been developed which provided a five minute update on key points of symptom management or end of life care on a single PowerPoint slide. This information was then cascaded to all staff at handover meetings to ensure all staff received the same information. E-learning programmes were in place using national the e-ELCA (end of life care for all) model.
- We were shown copies of "Palliative Matters" a quarterly newsletter circulated electronically through the communications department to all staff. The newsletter provided information for staff and included updates on topics such as new methodologies of symptom management.
- Records showed that 45% of staff had received an appraisal in last twelve months. There was no formal process for clinical supervision but staff felt they could access support from any member of the team.

Multidisciplinary working

- The service held palliative care multidisciplinary team (MDT) meetings. Staff told us that a collaborative MDT was held weekly with video-conferencing to the specialist palliative care teams at one of the local hospices and representation from the other local hospice and community specialist palliative care team.
- The multidisciplinary team worked well together to coordinate and plan care for patients at the end of their lives. The team included occupational therapy, physiotherapy, chaplaincy support and members of the discharge planning team.

Seven-day services

- The palliative care specialist nurse team provided a seven days a week service from 8:30am to 4:30pm. They were available for wards visits to assess patients, to meet with relatives, to confer and advise medical and nursing teams and to liaise with community staff.

Access to information

- The service was developing a formal discharge pathway for people at the end of their lives. There was a clear process in place to communicate with community staff and ensure that records were available for patients on discharge.
- Records confirmed that letters were sent to a patient's GP on discharge and if any changes in medication had been made to pain relief then this would be faxed through to the individuals' GP.
- Any care plans and DNACPR forms moved across with the patient to ensure that information was shared appropriately.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We looked at nine patients records in relation to 'do not resuscitate' decisions. We found records included an entry by the medical staff, which included an explanation of the decision-making process, its rationale and details of conversations that had been undertaken with the patient's relatives. The entries were all signed and dated, with a review date included. We found that patients were involved in the discussion about their decision where possible or there was a capacity assessment recorded in their medical notes. These showed that best interest meetings had been held and included discussions about DNACPR decisions.
- The trust had signed up to the NHS North of England North West Unified DNACPR policy. It covered all aspects of consent including responsibilities for the consent process and mental capacity guidance and documentation for gaining consent. Medical staff were able to describe the procedures for DNACPR and the decisions were made by a senior clinician.
- We were shown copies of the DNACPR audits and related action plans. The latest audit report for 2014 showed that the trust still did not meet the 100% compliance standard set in the unified DNACPR policy around documentation. Overall all improvements had been noted in a number of areas. On one ward we spoke with staff who confirmed that as a result of the DNACPR audit they were trying to engage with families at an earlier stage to improve communication about decisions about resuscitation.

End of life care

Are end of life care services caring?

Good

The palliative care team, the chaplaincy, clinical staff across the staff, the mortuary staff and the bereavement service provided support to patients and those close to them. Patients told us that the staff were very supportive and caring.

Staff went out of their way to respect dignity for patients and their families where possible. Patients were treated with dignity, respect and compassion from the clinical setting to the mortuary. There was a single viewing room where relatives were able to spend time with their deceased relative.

Staff were very supportive to patients and those close to them, and offered emotional support to provide comfort and reassurance.

Compassionate care

- Feedback from the majority of bereaved families was positive about the end of life care their loved ones had received.
- We found numerous examples of staff providing caring, compassionate and individualised care. Staff were very supportive to patients and those close to them, and offered emotional support to provide comfort and reassurance.
- We saw examples of privacy and dignity signs used on a side room where end of life care was being delivered in order to respect and protect the person's privacy.
- Documentation showed that staff were able to identify individual spiritual and religious needs which were followed through both at end of life care and in the care of the deceased person.
- Staff gave sympathy cards to relatives after the death of a loved one.

Understanding and involvement of patients and those close to them

- Staff tried to facilitate overnight stays and open visiting for relatives where possible. Arrangements were made to support with car parking for the relatives of people at the end of their lives.
- Staff told us that "comfort bags" had been provided through general staff donations for patients at the end of their lives and their relatives.
- The trust had developed plans to involve families at an earlier stage for difficult conversations following the results of a DNACPR audit.
- Some patients told us that they would prefer more communication regarding their loved ones end of life care. Staff told us the new end of life care plan had helped them to start those conversations and ensured that detailed discussions were held with patients and families and that these conversations were recorded in a sensitive way.
- Feedback from both staff and relatives showed that there was not always access to a side room for patients receiving end of life care. On some of the wards we found there was limited access to private rooms and dedicated relatives room where sensitive conversations could be conducted. However, we found that staff went out of their way to respect dignity and privacy for patients and their families where possible.
- The service provided a resource pack with guidance for bereaved relatives on procedures such as registering a death and arranging a funeral.

Emotional support

- The palliative care team, the chaplaincy, clinical staff across the trust, the bereavement service and mortuary staff provided emotional support to patients and those close to them.
- Patients told us staff were supportive to both patients and those close to them and offered emotional support.
- Chaplaincy support was available 24 hours a day through an on-call system. There was access to spiritual support for other faiths, which was coordinated through the chaplaincy. There were appropriate provisions of care for the deceased and their families that met their personal or religious wishes.
- There was a single viewing room where relatives were able to spend time with their deceased relative.
- There was a functional multi-faith room which staff, patients or families could access for prayer and spiritual support.

Are end of life care services responsive?

End of life care

Good

The number of referrals received by the service for the period April 2013 to March 2014 was 1105. Data provided by the trust showed the service met its locally set target of assessing urgent referrals with 24 hours and non-urgent assessments within 48hrs. The level of new patient referrals to the team had increased by 92% in the period from April 2013 to April 2014, with a 36% increase in the number of direct patient interventions. This meant there was a risk that this increase in activity could impact on the ability of the service to respond in a timely manner to patients referred to the service.

Cross boundary documentation had been produced to facilitate administration of end of life care drugs post discharge by community staff for 48 hours after discharge. Rapid response for discharge to the preferred place of care was coordinated by the palliative care team. There was a multidisciplinary approach to discharge planning that involved the hospital and the community staff facilitating a rapid but safe discharge for patients. Complaints were handled in line with the trust policy.

We found that there was limited access to single rooms and dedicated relatives rooms on some of the wards where sensitive conversations could be conducted in private.

Service planning and delivery to meet the needs of local people

- There were good examples of collaboration with local community providers and commissioners to produce joint protocols for example, prescribing guidelines and individual plans of care and support for patients at the end of their lives.
- Cross boundary documentation had been produced to facilitate administration of end of life care drugs post discharge by community staff for 48 hours after discharge.
- The lead consultant nurse had close links with Cheshire and Mersey audit group which helped to review the needs of the local community.
- The bereavement service was very responsive and did not close for lunch in order to accommodate bereaved families so that they didn't have to wait at such a difficult time. It also provided support for trainee doctors who did not have experience in end of life processes and procedures.
- The service had a rapid discharge pathway for discharge to a preferred place of care (PPC).The rapid discharge pathway was available to enable patients to be discharged from the acute hospital to home in the last hours/days of life.

Meeting people's individual needs

- The hospital had a system which flagged palliative care patients arriving in A&E to ensure that they were seen promptly and their need could be met.
- Patient records included person-centred care plans. This meant that staff were able to deliver care in accordance with patients' individual preferences and wishes.
- Patients and families were involved in the assessment and planning for their end of life care. Information with regard to support services, e.g. community specialist palliative care teams, hospice inpatient and day therapy units, local support groups, and the local information centre was offered to patients and reinforced with written information leaflets.
- At the initial assessment visit every patient was given information about their specialist palliative care key worker and an information leaflet about the specialist palliative care team (including how to contact them). During our inspection we observed close liaison with other specialist palliative care workers throughout the locality.
- Translation services were available for people whose first language was not English. We did not see many examples of information leaflets for people whose first language was not English or for people who were visually impaired.
- We found that there was limited access to single rooms and dedicated relatives rooms on some of the wards where sensitive conversations could be conducted in private.
- One ward we visited had been provided with a recliner chair for relatives to stay by the bed side. This had been provided by private charity donation.
- A guidance document was available on the trust intranet linked to the learning disabilities community. This document provided advice to staff on a range of issues, including reasonable adjustments, carer

involvement, communication, consent and advocacy for people with learning disability to ensure that individual needs are met. Wards we visited used patient 'passports' that could aid in the assessment of patients who had problems communicating.
- There was a drop in session for a bereavement counsellor each week at the bereavement service. However we were told that this service had not been highlighted by the trust and could be further reviewed to meet the needs of the population.

Access and flow

- The number of referrals received by the service for the period April 2013 to March 2014 was 1105. Data provided by the trust showed the service met its locally set target of assessing urgent referrals with 24 hours and non-urgent assessments within 48hrs. The level of new patient referrals to the team had increased by 92% in the period from April 2013 to April 2014, with a 36% increase in the number of direct patient interventions. This meant there was a risk that this increase in activity could impact on the ability of the service to respond in a timely manner to patients referred to the service.
- Staff explained how they would refer a patient to the palliative care team and systems were in place for urgent referrals via a bleep system.
- Rapid response for discharge to the preferred place of care was coordinated by the palliative care team. Staff told us there was a multidisciplinary approach to discharge planning, which involved the hospital and the community staff facilitating a rapid but safe discharge for patients.
- As part of the assessment process for all referred patients, staff told us that the patients preferred place of care /death was ascertained. If the patient's condition deteriorated and patient/family had chosen an alternative place of care other than hospital, the discharge planning team were alerted to the wishes of the patient and any necessary paperwork was completed as a matter of urgency. For transfer back to a patient's own home or care home dialogue with/referral to supporting services such as occupational therapy, physiotherapists, district nurses, social carers occurred during the weekly palliative care MDT meeting and also on the wards. The discharge planning team acted as the co-ordinators of care.

Learning from complaints and concerns

- Complaints were handled in line with trust policy. Complaints were recorded on a centralised trust-wide system. The centralised patient experience team (PET) managed formal complaints. Staff understood the process for receiving and handling complaints and told us information about complaints was discussed during team meetings to raise staff awareness and aid future learning.
- Leaflets were available throughout the trust which contained information on how to raise a concern or make a formal complaint. During our visit we did not see any of the leaflets in a format for someone whose first language was not English or who had a visual impairment.
- There had been five complaints related to end of life care in the last three months. Most of these were related to communication or the lack of an available side room for patients at end of their lives and facilities for relatives. We were shown a copy of an action plan which was in place to address concerns such as plans for more training in advance communication skills for clinical staff to enable clear communication with patients and their families.

Are end of life care services well-led?

Good

The service had a strategy in place to address national end of life care initiatives and ensure care was provided in line with national guidance. The trust's vision and values had been cascaded to staff. Staff were proud of the work they did although they were uncertain about the imminent changes in staffing structures, there was a positive culture within the service and a willingness to learn and improve. The management of risk was in place at a divisional level but further work was required to ensure that staff at all levels of the organisation were aware of the service risks and had access to feedback from governance systems.

Both the palliative care team and ward staff were keen to continuously develop the service so that patients received the best care possible. Members of the palliative care team were proactive in driving forward improvements and sharing innovation and best practice from other services. The service had introduced a bereavement survey which

was sent out to families of all patients who had accessed end of life care services. The service had then developed an action plan to address any concerns raised including feedback to any individual ward areas with specific issues.

Vision and strategy for this service

- The strategy for end of life care was under review by the trust. End of life care was incorporated as part of the trust's 'Strategic Plan 2013-14' document which aimed to incorporate best practice as defined in the NHS' guide 'Route to success in end of life care for acute hospitals."
- The service had executive level representation and gave a presentation to the board meeting at the time of our inspection. The aim of the presentation was to ensure that the board were aware of the vision to develop end of life care within the trust in line with national guidance.
- The trust's vision and values had been cascaded to staff.

Governance, risk management and quality measurement

- The palliative care service reported risks through the unscheduled care division governance structures. Senior staff were aware of the service risks, performance activity, any recent serious untoward incidents and other quality indicators for the division.
- The divisional risk register included the risks we identified and ratings; progress and improvements were monitored through the unscheduled care divisional integrated governance group.
- Risks were rated from low to high with the lower risks being managed at service level and the higher risks being escalated corporately. We found there was no risk register for the palliative care service specifically. Senior staff told us staffing issues had been on the trust corporate risk register for twelve months and had not yet been resolved.
- We were told and records confirmed that the service had submitted a palliative care assurance action plan to the "Quality and Clinical Governance Sub Committee". This plan was monitored regularly by the service.
- Day-to-day issues, information around complaints, incidents and audit results were shared on notice boards around the department. Staff told us that they did hold staff meetings but had not been able to attend regularly due to the pressure of workload.
- The team worked closely with the rapid discharge service and held regular meetings to ensure the service was responsive to people's needs.

Leadership of service

- The new lead for palliative care services was the director of nursing
- There was also a consultant nurse who was due to retire in the near future although no formal plans for succession planning were in place. We discussed with a trust senior manager who was aware of the recruitment issues and assured us they were actively addressing the leadership of the palliative care service.
- The two clinical leads were working together to ensure that staff were supported and there was a shared commitment within the palliative care team and ward teams to provide the best for patients.

Culture within the service

- Staff across the trust were very positive about the palliative care team and felt that they were both responsive and supportive to staff managing the needs of patients requiring end of life care.
- Members of the palliative care team were proud of the care they delivered but were unsure about the future of their team due to the imminent staffing changes and increased demand.
- Staff were encouraged and supported to report any issues in relation to patient care or any adverse incidents that occurred.

Public and staff engagement

- Information about how the public could provide feedback was displayed in the departmental areas and feedback mechanisms for the public to engage with the trust were also on the internet site.
- Staff received communications in a variety of ways such as newsletters, emails and briefing documents and meetings. Staff told us they were made aware of new policies that were issued and any safety alerts.
- The service was continually looking for ways to improve the care for patients and worked closely with the bereavement service to ensure that patient and family feedback was sought and used to improve services. The service had introduced a bereavement survey which was sent out to families of all patients who had

accessed the specialist palliative care team. The service had then developed an action plan to address any concerns raised including feedback to any individual ward areas with specific issues.

Innovation, improvement and sustainability

- The trust acknowledged they wished to promote the role of the end of life care team more robustly. Both the palliative care team and ward staff were keen to continuously develop the service so that patients received the best care possible. Staff supported each other well and knowledge and skills were shared for the benefit of patients and those close to them.
- The service was closely linked with its local community providers and had been working in collaboration with both local hospices to improve the visibility of end of life care.
- The increase in referral rates year on year presented a challenge for the service and the trust acknowledged the need to further expand the service to meet the demand.
- Members of the palliative care team were outward facing and two staff members had presented at the Palliative Care Congress in March 2014.This showed they were proactive in driving forward improvements and sharing innovation and best practice from other services.
- The lead clinician had also worked with other clinicians across the area to develop a new working document for end of life care. The new end of life care plan was a collaborative document which was used in all settings across the Warrington area.
- The service continued to build on its relationships with local community providers and was keen to introduce the Electronic Palliative Care Co-ordinating System (EPaCCS) which would enable service providers across boundaries to share information.

Outpatients and diagnostic imaging

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

Information about the service

A range of outpatient services are provided by Warrington and Halton NHS Foundation Trust at Warrington Hospital. The main outpatients department at Warrington Hospital is located on the ground floor. There are 357,859 appointments each year at Warrington Hospital.

The outpatients department included a variety of services such as: orthopaedics, ophthalmology, gastroenterology, neurology, audiology therapy services and diabetes. There was also a phlebotomy service and a diagnostic imaging service. The trust provided a comprehensive range of diagnostic and interventional services to the patients of Warrington, including: general X-ray. CT scanning, MRI scanning, non-obstetric ultrasound, obstetric ultrasound, breast care screening unit.

We visited several outpatient clinics at Warrington hospital including: orthopaedics, plaster room, physiotherapy, ophthalmology, audiology, and surgical clinics. We also visited haematology, radiology and diagnostic imaging services.

During our inspection spoke with 14 patients, four relatives and 21 members of staff including volunteers, nurses, health care assistants, technical and clerical staff, doctors, physiotherapists and radiographers.

Summary of findings

Patients attending the outpatient and diagnostic imaging departments were treated in a dignified and respectful way by caring and committed staff. Staffing numbers and skills mix met the needs of the patients in the department. However we found that some clinic's over ran the times allocated. This meant that, at times, patients waited a long time to see their doctor.

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

Data provided by the trust showed that they had achieved over 97% availability of records for outpatient appointments. However staff told us that they had regular issues with the availability of a full set of notes and access to the appropriate information. There were occasions in the audiology and fracture clinics at Warrington Hospital when complete patient records were not available for an appointment. In such cases staff prepared a temporary file for patients that included the most recent diagnostic and test results coupled with essential patient information so that the patient's appointment could go ahead. Staff acknowledged that this was not ideal. However it meant the patient did not have to reschedule their appointment.

There was a clear process for reporting and investigating incidents, although some staff stated that they did not always have time to complete incident forms. Learning

Outpatients and diagnostic imaging

from incidents was shared and there were examples of changes in practice in response to incidents. Staff received training in safeguarding adults and children, the mental capacity act, health and safety, patient confidentiality and infection control.

There was good local leadership and a positive culture within the service. Staff worked well as a team and supported each other. Staff were confident and competent in their roles and responsibilities in relation to these matters.

Are outpatient and diagnostic imaging services safe?

Requires improvement

There were systems for reporting actual and near-miss incidents across the hospital. Staff told us they understood what to report and were able to show us how they would report an incident through the electronic reporting system. However some staff told us that they did not always report incidents on the system as they did not have time and would rather resolve the issue such as the availability of a complete record for a patient.

Data provided by the trust showed that they had achieved over 97% availability of records for outpatient appointments. However there were occasions in the audiology and fracture clinics at Warrington Hospital when complete patient records were not available for an appointment. In such cases staff prepared a temporary file for patients that included the most recent diagnostic and test results coupled with essential patient information so that the patient's appointment could go ahead. Staff acknowledged that this was not ideal; however it meant the patient did not have to reschedule their appointment. Going forward, there was a plan in place to implement an electronic records system throughout the service in 2015. A key risk for the service was the poor clinic efficiency due to the increase in waiting lists and clinics being arranged at short notice. We did not see a clear plan in place to ensure that the risk was managed effectively.

Staff were aware of the trust's vision and values but were unclear as to the future strategy for outpatient and diagnostic imaging services.

Staff followed good practice guidance in relation to the control and prevention of infection .Records showed that regular hand hygiene audits were undertaken which demonstrated high compliance rates throughout the outpatient areas. There were systems in place for reporting safeguarding concerns. Staff were clearly able to explain their role in safeguarding and how they would escalate concerns in this regard.

Incidents

Outpatients and diagnostic imaging

- There had been one serious incident in regards to radiology scanning in 2013/14 but none were reported in 2014.
- There were systems for reporting actual and near-miss incidents across the hospital. Staff told us they understood what to report and were able to show us how they would report an incident through the electronic reporting system. However some staff told us that they did not always report incidents on the system as they did not have time and would rather resolve the issue such as the availability of a complete record for a patient.
- There was evidence of shared learning from incidents supported with staff training to reduce the risk of reoccurrence. Managers in the diagnostic service used incidents positively to underpin service improvement and risk management within the service.

Cleanliness, infection control and hygiene

- There were ample supplies of hand washing facilities and personal protective equipment such as aprons and gloves.
- We observed that staff followed good practice guidance in relation to the control and prevention of infection.
- Records showed that regular hand hygiene audits were undertaken which demonstrated high compliance rates throughout the outpatient areas.
- Clinical areas were clean and tidy.

Environment and equipment

- Patients from the wards, hospital out-patient clinics and GP surgeries attend diagnostic services for x-rays. There were 4 general x-ray rooms in the main department plus one digital x-ray room and dental equipment. One of the rooms was dedicated to paediatric patients and one had a tomographic facility which was useful for demonstrating the organs of the body in more detail. There were also 2 fluoroscopy rooms in the main department where barium examinations such as enemas, meals and swallows were carried out.
- When entering the Magnetic Resonance Imaging unit (MRI) area the public, staff and patients were screened before entering the area to ensure they did not have any medical contraindications to visiting the scanner unit.
- Equipment was readily available and maintained in a timely manner.
- In the medical record department staff were not following good practice in regards to manual handling. We witnessed a member of staff using an unstable kick stool while trying to reach up to high shelves. We brought his to the attention of the manager who told us that a risk assessment had been carried out for the area but assured us they would revisit the storage of records and manual handling practices in the department.

Medicines

- Medicines were stored in locked cupboards and there were no controlled drugs or IV fluids held in the department.
- All outpatient clinic areas had a minimum of one registered nurse on duty during clinic opening hours and they signed for the medication storage keys for that area.
- Pharmacy staff reinforced medicine safety instructions and information to patients when they collected their prescriptions following their consultation. Many of the specialist nurses also provided information and support as part of the patient's consultation.
- The CT department had a CT checklist for administering drugs under PGD with consent forms.
- Often patients require an injection of an iodine-based agent as images are acquired, which highlights the blood vessels, rendering images clearer to the interpreting radiologist. We found that on our visit to the CT scanner we were able to walk into the room where this agent was stored as it was unsecured and found the cupboards open and unlocked. We raised this with the manager who said that normally this room was secure and immediately undertook to review the security of the agent.
- During our visit we also found prescription pads were available in the main area of the department and not locked away in line with trust procedures we brought this to the attention of the manger who immediately secured them as per normal protocol.

Records

- Data provided by the trust showed that they had achieved over 97% availability of records for outpatient appointments. However staff told us that they had regular issues with the availability of a full set of notes and access to the appropriate information. Staff in two clinics both told us they recorded the lack of availability of complete records and another department told us that that up to 25% of outpatient records were not complete for their clinic appointments. There were

occasions in the audiology and fracture clinics when patient records were not available for an appointment. In such cases staff prepared a temporary file for patients that included the most recent diagnostic and test results coupled with essential patient information so that the patient's appointment could go ahead. Staff acknowledged that this was not ideal; however it meant the patient did not have to reschedule their appointment.
- Going forward, there was a plan in place to implement an electronic records system throughout the service in 2015.

Safeguarding

- There was a system in place for raising safeguarding concerns. Staff were aware of the process and could explain what was meant by abuse and neglect. This process was supported by staff training however figures obtained from the trust showed that 65% of nursing staff had completed the relevant training which was below the trust target of 85%.
- The trust had a chaperone policy that was followed in the outpatient department.
- The staff we interviewed were clearly able to explain their role in raising safeguarding and how they would escalate concerns in this regard.

Mandatory training

- Staff received mandatory training that covered a wide range of subjects. Staff told us that they did have access to training but were behind in completing all the mandatory training due to pressure of work. Data showed that the service had not achieved the trust target of 85%. This had been recognised as an area requiring improvement and the service had taken steps to actively improve compliance levels.

Assessing and responding to patient risk

- Staff had clear guidance to follow should a patient's condition deteriorate while they were in the outpatient department.
- Staff had access to resuscitation equipment which was regularly checked and maintained. Staff felt confident in providing basic life support and knew how to access the hospital wide emergency team.
- The imaging department had implemented the interventional radiology care pathway for pre vascular procedures to ensure that patient risk was minimised.
- The WHO surgical safety checklist for radiological interventions was in place in the imaging department. This was an accredited process by the National Patient Safety Agency and Royal College of Radiologists.
- The hydrotherapy unit had its own evacuation procedures for a patient who may become unwell during treatment.
- There was robust second checking processes in place in the imaging department to ensure that all images were fully reviewed and any anomalies acted on.

Nursing staffing

- Nurse staffing levels were sufficient to meet the needs of the service. A review of nursing requirements had been carried out last year to ensure that the right number and appropriate skill mix was in place.
- Staff were able to plan rotas in advance to manage the workload.
- One area (orthopaedics) did describe recent staffing shortages but told us they had now recruited staff and felt that the staffing levels had been addressed.
- Managers determined the number of nursing staff required by the number of clinics running at any particular time but also the nature of the clinics. The type of specialist clinic and patient needs and dependency influenced the number of staff required for a particular clinic.

Medical staffing

- There was out-of-hours on call cover for diagnostics services for the hospital site. Staff we spoke with were very positive about the changes to the on call rota starting the day after our inspection to shorten the length of time on call and to improve access to support for junior staff.
- Medical consultants and other specialists arranged outpatient clinics directly with the outpatient department to meet the needs of the speciality.

Major incident awareness and training

- There was a clear policy of action to take if the hospital was involved in a major incident.
- There were escalation plans in place to ensure the delivery of the service was maintained. The staff were able to describe actions taken on the day of our visit in response to the weather conditions. They were also aware of the ability to manage capacity by utilising facilities at the Halton hospital site.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

Care and treatment followed evidence based national guidance Patients attending the outpatient and diagnostic imaging departments received effective care and treatment that was evidence based and followed national guidance. Staff were confident and competent in seeking consent from patients. Training had been provided and staff were able to explain benefits and risks in a way that patients understood.

Information relating to a patient's health and treatment was obtained from relevant sources before clinic appointments; information was shared with the patient's GP and other relevant agencies after the appointment to promote continuity of care for the patient.

Evidence-based care and treatment

- Care and treatment followed evidence based national guidance.
- The x-ray department had a duty to protect patients, visitors and staff from radiation by radiation safety laws, in particular the Ionizing Radiation (Medical Exposure) Regulations 2000.We found that this was the case and the department met all the required standards.
- NICE and best practice guidance was available to staff via the trust's intranet. We found that staff followed local policies and procedures.
- The trust provided a breast screening service which offered a range of screening tests in line with the NHS Breast Screening Programme.

Pain relief

- Staff had access to appropriate pain relief for patients in both clinic and diagnostic settings.
- Patients confirmed that pain relief was monitored for efficacy and changed to meet their needs where appropriate.
- We observed pharmacy staff giving out medication and explaining about an individual's medication with a telephone number for them to ring should the patient have problems with their medication.

Patient outcomes

- A range of local audits were carried out by different departments. This included general audits such as infection control and record keeping as well as audits of 'did not attend rates' and patient satisfaction by the ophthalmology and pharmacy department.
- Records of local audits showed that there was a high rate of compliance with good practice across the service.
- We found that the follow up to new appointments rates are above the England average. Rates were one of the highest in the country.

Competent staff

- Staff were supported in their development through the appraisal process. The appraisal rate for nursing staff in outpatients at the time of our inspection was 72%.
- The imaging department radiographers had successfully completed a Post Graduate Certificate in Image Interpretation which enabled them to provide a diagnostic evaluation (report) on x-ray examinations referred from accident and emergency and GP's.

Multidisciplinary working

- There was evidence of good multidisciplinary working in the outpatient and diagnostic imaging departments. Doctors, nurses and allied health professionals worked well together and valued each other's contribution to the ongoing management of patients' needs.
- Letters were sent out by the outpatients department to people's GPs to provide a summary of the consultation and any recommendations for treatment.

Seven-day services

- The trust was working towards 24/7 access for emergency care and diagnostic services. This was included in the trust's Operational Business Plan with plans to extend current care provision for emergency patients to ensure access to diagnostic support 24/7. The trust had developed community based radiology services to support enhanced ambulatory care pathways.
- The hospital ran most of its clinics between 8 and 5 Monday through Friday with waiting list initiatives carried at weekends as required. Work was already underway in the department to identify where the service requirements would need to adapt to deliver outpatient services into the evening or weekends.

Outpatients and diagnostic imaging

- Access to the diagnostic and imaging service was available 24 /7 seven days a week.

Access to information

- Patients reported to us that they had no concerns regarding access to information relating to their care or treatment.
- There was a range of leaflets available in the departments to help patients understand their condition and diagnostic tests.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff were provided with training and guidance on the Mental Capacity Act 2005. We spoke with ten members of staff specifically about the requirements of the Mental Capacity Act 2005 and found they were aware of the requirements to ensure that people were treated appropriately.
- The service did not have a specialist nurse for people living with a learning disability.
- Before having a procedure undertaken patients' consent was obtained verbally and signed in their records. For biopsies or more invasive tests, consent for procedures was formally documented using consent forms. The risks and benefits of treatment were discussed with the patient before starting the procedure.

Are outpatient and diagnostic imaging services caring?

Good

Staff provided patients with caring, compassionate and individualised care. Throughout our inspection we observed patients being treated with dignity and respect. Care and treatment was delivered in a way that took into account the patient's wishes.

Staff actively involved patients and those close to them in all aspects of their care and treatment.

There were a range of support groups facilitated by the hospital that were available to patients and their families. People were also encouraged to access the national support groups for a range of health conditions.

Compassionate care

- Staff provided caring, compassionate and individualised care. Patients were treated with dignity and respect.
- All of the patients we spoke positively about their experience of care. One patient told us: "I can't fault the staff or the treatment; they explain the treatment and any side effects".
- There were arrangements in place to provide patients with a chaperone during appointments if required or requested by a patient.
- We spoke with 14 patients and those close to them during our inspection and the majority spoke very highly of the service. One relative told us that the doctor had not included her daughter (the patient) in the consultation and would have preferred more discussion about treatment options.
- Staff were attentive to patients, regularly checking on their welfare in radiology while they were waiting for tests. It was snowing on the day of our visit and staff took steps to ensure the safety and comfort of patients. For example, those from the wards in gowns were regularly asked about their welfare and offered a blanket if they were cold.
- We visited the CT scanner waiting area which was very busy on arrival we noted that that one patient was waiting on a hospital bed with people waiting as outpatients. The staff told us that they felt this was not ideal to protect patients' privacy but plans were in process to re-model the waiting area which would improve the facilities for patients.
- Staff knocked on doors and waited for a response before entering. We noted that several consultation areas, including therapy areas were curtained which meant that staff had to be particularly mindful of ensuring patient confidentiality and private conversations were not overheard.
- Vulnerable patients were managed sensitively and attended to as quickly as possible.

Understanding and involvement of patients and those close to them

- We spoke with patients and those close to them about the care and treatment they received in outpatient services. Each patient we spoke with was clear about what appointment they were attending for, what they were to expect and who they were going to see. Patients and relatives said they felt involved in their care and were able to make informed decisions.

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- One patient told us: “It’s been good; they have explained everything and haven’t kept me waiting”.
- Within the outpatient areas there was dedicated literature for people to read, relating to specific clinical conditions such as diabetes and Crohn’s disease. We did not see evidence of literature available for people whose first language wasn’t English or who may have been visually impaired.
- There was evidence in the clinical notes that patients and their relatives were involved in making decisions about care and treatment.

Emotional support

- There were a range of support groups facilitated by the hospital that were available to patients and their families. People were also encouraged to access the national support groups for many and varied health conditions.

Are outpatient and diagnostic imaging services responsive?

Good

The service was consistently meeting the 18 week waiting target for orthopaedics. That meant the majority of patients had their initial appointments, investigations, tests and their treatment or surgery within 18 weeks of first being referred by their GP. The percentage of patients who were urgently referred on the two week pathway and seen by a specialist was about the same as the national average. The percentage of cancer patients waiting less than 31 days from diagnosis to first definitive treatment was better than the national average.

Did Not Attend (DNA) rates for Warrington Hospital were in line with the England average. However, staff and patients told us that some clinics over-ran and some patients experienced long delays.

There were systems in place to ensure that the service was able to meet the individual needs of people such as those living with dementia, a learning disability or physical disability. Although support was not always routinely offered to patients with a visual or hearing impairment. For patients whose first language was not English, staff could access a language interpreter if required.

Service planning and delivery to meet the needs of local people

- Extra clinics were held at weekends to reduce waiting times for patients.
- Trust data showed that they provided a number of consultant outpatient services and clinics at locations in the local community. This meant that hospital trained staff were delivering services closer to patients' homes.
- Clinic services were also available from a local community hospital facility. Patients requiring a blood test were able to attend the blood test clinic at either Warrington Hospital or at Halton General Hospital depending on what was most convenient for the patient.
- There was a team of musculoskeletal physiotherapists working between Halton hospital and Widnes (Health Care Resource Centre). They also held clinics at various GP practices both in Runcorn and Widnes.
- The audiology service offered patients a drop in to one of three community clinics for information and advice including re-tubing of hearing aid ear moulds and collection of spare parts and batteries.
- Ophthalmology had triage appointments for urgent or next day appointments.

Access and flow

- The outpatients department undertook 357,859 outpatient appointments during 2013/14, of which 69% were follow-up appointments.
- The service was consistently meeting the 18 week waiting target for orthopaedics. That meant the majority of patients had their initial appointments, any investigations, tests and their treatment or surgery within 18 weeks of first being referred by their GP.
- The percentage of cancer patients seen by a specialist within 2 weeks of urgent GP referral was about the same as the national average.
- The percentage of cancer patients waiting less than 31 days from diagnosis to first definitive treatment was better than the national average.
- Some clinics started late due to medical staff arriving in clinic at the clinic start time rather than beforehand. The lack of clear advance planning did not always ensure that the clinics were run as efficiently and timely as possible.

Outpatients and diagnostic imaging

- The patient 'Did Not Attend' rate for appointments had been about 7% for Warrington for the previous 12 months. Did not attend rates for Warrington Hospital were in line with the England average.
- We were shown that in order to reduce cancellations and DNA rates, the trust had devised a simple online form for patients to change, cancel or rearrange an outpatient appointment .The ophthalmology department had carried out an audit of DNA appointments and produced an action plan to try to understand and reduce the amount of DNA rates.
- Referral to treatment time performance for non-admitted treatment and incomplete pathways was in line with national expected range showing an improvement in performance in the last financial year.
- Several patients reported (and staff confirmed) they experienced long waiting times for their appointment. We were given examples of elderly patients still being in clinic late in the evening having been waiting in excess of 2 hours.

Meeting people's individual needs

- As part of the patient record there was a trigger to record 'long term conditions' or disabilities. Staff could add this information to a patient's records to assist with future management of patients when they attend the hospital. For example, if they were known to have a physical or sensory disability, or have diabetes or epilepsy.
- During our inspection we did not see any information that was suitable for people who are visually impaired. We did speak with one patient who told us they had not been offered any support with accessing treatment despite her visual impairment.
- For patients whose first language was not English, staff could access a language interpreter if required via language line.
- Information about a patient's medicines was provided in a variety of ways including: verbal, written and direct teaching of complex techniques, such as home intravenous administration.
- Clear risk assessments were carried out to manage and support individual needs.

Learning from complaints and concerns

- Complaints were handled in line with the trust policy. Complaints were recorded on a centralised trust-wide system. The centralised patient experience team (PET) managed formal complaints. Staff understood the process for receiving and handling complaints and confirmed that information about complaints was discussed during team meetings to raise staff awareness and aid future learning.
- Leaflets were available throughout the service and contained information on how to raise a concern or make a formal complaint. We did not see any of the leaflets in a format for someone whose first language was not English or who had a visual impairment.
- Complaints relating to outpatients and diagnostic imaging services were monitored through the Women's/ Children's/Support Services Quality Governance structures.

Are outpatient and diagnostic imaging services well-led?

Requires improvement

The trust's vision and values were displayed through the hospital. Staff were aware of the trust's vision and values but were unclear as to the future strategy for outpatient and diagnostic imaging services. Local managers demonstrated good leadership within the department.

The outpatient service reported risks through the women's, children's and clinical support services divisional governance structures. The divisional risk register included risks and ratings identified progress and improvements were monitored through the unscheduled care divisional integrated governance group.

However, a key risk for the service was the poor clinic efficiency due to the increase in waiting lists and clinics being arranged at short notice. We did not see a clear plan in place to ensure that the risk was managed effectively.

We saw staff being involved in audit to develop patient care. However there was no planned approach to innovation across outpatient services as a whole with individual services working in isolation.

Vision and strategy for this service

- The trust's vision and values were displayed through the hospital. Staff were aware of the trust's vision and values, but were not clear on the overall vision or future strategy for outpatient and diagnostic imaging services.

Outpatients and diagnostic imaging

- Locally we observed that the radiology service had a good vision regarding how they would deliver a service and develop staff to meet clinical demand.
- Therapy services had a clear understanding about where they wanted their service to go, how to expand and develop it and what they needed to deliver this service for the future.

Governance, risk management and quality measurement

- Senior staff were aware of the service risks, performance activity, any recent serious untoward incidents and other quality indicators for the division.
- The outpatient service reported risks through the women's, children's and clinical support services divisional governance structures. The divisional risk register included risks and ratings identified progress and improvements were monitored through the divisional integrated governance group.
- Risks were rated from low to high with the lower risks being managed at service level and the higher risks being escalated corporately. A key risk for the service was the poor clinic efficiency due to the increase in waiting lists and clinics being re- arranged at short notice. We did not see a clear plan in place to ensure that the risk was managed effectively.
- Day-to-day issues, information regarding complaints, incidents and audit results were shared on notice boards around the different departments. Staff held regular meetings within their own services.

Leadership of service

- Local managers had a strong focus of the needs of patients and the roles staff needed to play in delivering a good service. They were visible and respected by their colleagues.
- Staff were comfortable and able to discuss a range of issues with their line manager and felt able to contribute to influence the running of the department at a local level.
- The results of the NHS Staff Survey 2013 indicated that the trust had performed better than expected for the percentage of staff reporting good communication between senior management and staff.

Culture within the service

- Staff felt that there was an open positive culture within outpatient and diagnostic imaging services and felt confident to raise issues or concerns. They did state that occasionally the trust management team were slow to respond to issues but this was expected in a busy department.
- Staff supported each other and we saw examples of good team working within the departments.
- Staff were positive about the care they provided and were keen to continuously improve service delivery.

Public and staff engagement

- A manager stated that they had not recently carried out a full outpatient survey but had held patient focus groups as a different way of engaging with patients. This feedback fed into the service governance structure and patient experience and quality group.
- The public were regularly encouraged to provide feedback on the service on-site and through NHS Choices and social media.
- Information was displayed on message boards throughout the outpatient services to engage the public in messages about the service as well as encouraging feedback. There were examples of patient leaflets inviting patients to feedback their ideas and suggestions for improvement of services such as the pharmacy and ophthalmology departments.
- The trust had a 46% response rate to the national staff survey compared with the national average of 49%.The number of staff who would recommend the trust to work or receive treatment in was within national expected levels.

Innovation, improvement and sustainability

- The radiography department were part of an international research group and had presented at both national and international conferences.

Outstanding practice and areas for improvement

Outstanding practice

- The bereavement service provided support for families who experienced loss during pregnancy, birth and neonatal at Warrington and Halton Hospitals NHS Trust. In 2014, the bereavement service won the national Butterfly Award for “best hospital bereavement service”.
- The provision of a specialist dementia ward that was designed and supported high quality personalised care for patients living with dementia.
- The hospital ran a "Hello, my name is...would you like a drink?" campaign to raise awareness within the service of issues surrounding hydrating patients, the importance of accurately filling in fluid balance charts and the prevention and treatment of patients with Acute Kidney Injury.

Areas for improvement

Action the hospital MUST take to improve

- Ensure that medical staffing is sufficient to provide appropriate and timely treatment and review of patients at all times including out of hours.
- Ensure that medical staffing is appropriate at all times including medical trainees, long-term locums, middle-grade doctors and consultants.
- Ensure that nursing and midwifery staffing levels and skill mix are appropriate particularly in medical care services and maternity.
- Improve the levels of mandatory training compliance.
- Improve the rate of appraisals completion.
- Improve patient flow throughout the hospital to ensure patients are cared for on the appropriate ward for their needs and reduce the number of patient bed moves, particularly in the medical division.
- Ensure the protocols for the use of the stabilisation bay are followed to ensure patients do not stay there longer than four hours and that no more than two patients are in the bay at any one time.

Action the hospital SHOULD take to improve

In urgent and emergency services:

- Ensure staff complete the Malnutrition Universal Screening Tool (MUST) for all patients who require one.
- Ensure all staff in the department have time to take their allocated breaks.
- Look to improve compliance with the Department of Health target to treat 95% of patients within four hours.

In medical care services:

- Improve processes in place for providing feedback and learning from incidents and complaints.
- Review systems in place to ensure essential equipment is replaced in a timely manner.
- Aim to improve access to seven day services for all disciplines across the medical division.
- Improve processes in place to ensure risks within the division are clearly communicated to nursing staff.
- Review the admission process for the GP Acute Medical Unit to ensure patients are appropriately referred to the service.

In critical care services:

- Take action to reduce the number of delayed discharges.
- Ensure medical records are fully and appropriately completed, in particular the second daily consultant reviews and regular entries by the parent medical team.

In maternity & gynaecology services:

- Ensure there is a clear vision and strategy for both midwifery and gynaecology services that is clearly communicated with staff.

Outstanding practice and areas for improvement

- Improve local leadership in maternity services to ensure a cohesive approach to care delivery between medical and nursing staff.
- Continue to improve staff engagement
- Continue to embed and promote the care of low risk women in line with NICE guidelines.

In end of life care services:

- The increase in referral rates year on year presented a challenge for the service and the provider should ensure that the specialist palliative care team has the appropriate staffing levels and skill mix to meet the demands on the service.
- Review its access to specialist medical advice over 24 hours in line with national guidance for end of life care.
- Review accommodation at ward level to ensure that patients at end of their lives can be nursed in appropriate rooms that afford privacy for the patient and families.
- Ensure smooth transition of leadership within the palliative care team.

In outpatients and diagnostic imaging services:

- Take action to ensure that waiting times for outpatient clinics are improved.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing How the regulation was not being met: Appropriate steps had not been taken to ensure that there were sufficient numbers of suitably qualified, skilled and experienced nursing and medical staff working in the hospital to meet the needs of service users. There was a shortage of medical staff within the medical and emergency care division. There was insufficient medical staff out of hours in the critical care services. British Association of Perinatal Medicine recommendations for Local Neonatal Unit out-of-hours Tier 1 medical cover were not adhered to. Increased bed occupancy placed additional pressure on staffing levels and appropriate skill mix, particularly in relation to critical care and the use of the stabilisation bay. This was a breach of regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing, which corresponds to regulation 18 (1) HSCA 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff How the regulation was not being met: Suitable arrangements were not in place in order to ensure staff received appropriate training, professional development, supervision and appraisal.

This section is primarily information for the provider

Compliance actions

Appraisal rates and the level of mandatory training completion for nursing staff were variable with some areas falling well below the trust target of 85%.

This was a breach of regulation 23 (1) (a) HSCA 2008 (Regulated Activities) Regulations 2010: Supporting Workers, which corresponds to regulation 18 (2) (a) HSCA 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services How the regulation was not being met: People who use the service are not always protected against the risk of receiving care or treatment that is inappropriate or unsafe, because flow across the hospital meant that some patients could not be placed in the right bed at the right time for their needs. Delayed discharges led to extended lengths of stay and multiple bed moves. Some of the areas used for escalation beds did not provide an appropriate environment for the care of patients overnight. This particularly relates to the use of the stabilisation bay. This was a breach of regulation 9 (1) (a) (b) (i) (ii) HSCA 2008 (Regulated Activities) Regulations 2010: Care and Welfare, which corresponds to regulation 9 (1) (a) (b)HSCA 2008 (Regulated Activities) Regulations 2014.